Simon Warren
INTERIM MANAGING DIRECTOR

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

To: All members of the Health & Wellbeing Board

(Agenda Sheet to all Councillors)

Our Ref:
Your Ref:

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

16 March 2017

Your contact is: Nicky Simpson – Committee Services

NOTICE OF MEETING – HEALTH & WELLBEING BOARD – 24 MARCH 2017

A meeting of the Health & Wellbeing Board will be held on **Friday 24 March 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 27 JANUARY 2017**	1
3.	**QUESTIONS** Consideration of formally submitted questions from members of the public or Councillors under Standing Order 36.	-
4.	**PETITIONS** Consideration of any petitions submitted under Standing Order 36 in relation to matters falling within the Committee's Powers & Duties which have been received by Head of Legal & Democratic Services no later than four clear working days before the meeting.	-
5.	**BUCKINGHAMSHIRE, OXFORDSHIRE AND BERKSHIRE WEST (BOB) NHS SUSTAINABILITY AND TRANSFORMATION PLAN (STP) - UPDATE** A verbal update on the latest situation with the development of the BOB STP will be given at the meeting.	verbal report Cont/..

../Cont

6. CONNECTED CARE 21

A presentation and report giving an update on the progress of the Connected Care programme.

7. BERKSHIRE LOCAL SAFEGUARDING CHILDREN BOARDS (LSCBs) - DATA AND INFORMATION SHARING AGREEMENT FOR AGENCIES WORKING WITH CHILDREN AND YOUNG PEOPLE 34

Further to Minute 10 of the meeting held on 17 July 2015, a report presenting the Berkshire LSCBs' Data and Information Sharing Agreement for agencies working with children and young people.

8. THE BERKSHIRE SUICIDE PREVENTION STRATEGY 2017-2020 103

A presentation and report on the Berkshire Suicide Prevention Strategy 2017-2020, a Berkshire-wide action plan, and local action plans to reduce the current level of suicide by 10% by 2020.

9. CAMHS TRANSFORMATION PLAN – IMPLEMENTING FUTURE IN MIND ACROSS BERKSHIRE WEST CCGS AND READING BOROUGH COUNCIL 196

A report giving an update on service development and improvement across the comprehensive Child and Adolescent Mental Health Service (CAMHS) system.

10. MEETING THE NEEDS OF VULNERABLE PEOPLE IN READING - FINDINGS OF A HEALTHWATCH READING ROUNDTABLE MEETING 279

A report presenting findings of a roundtable meeting held by Healthwatch Reading on 13 February 2017 with voluntary sector organisations who support local, vulnerable people.

11. 0-19 (25) PUBLIC HEALTH NURSING SERVICE – PROCUREMENT UPDATE 296

A report on progress made in the project for the procurement of the integrated Public Health Nursing Service 0-19 (25).

12. HEALTH AND WELLBEING PERFORMANCE UPDATE 300

A report giving a brief overview of the partnership's performance in the priority areas identified in the Health and Wellbeing Strategy.

Cont/..

../Cont

13. INTEGRATION AND BETTER CARE FUND 305

A report providing an update on the progress of the Integration programme, including Better Care Fund Performance (BCF) and on information received to date in relation to 2017/18 & 2018/19 Better Care Fund requirements.

14. DIRECTOR OF PUBLIC HEALTH – ANNUAL REPORT 2017 313

A report presenting the Strategic Director of Public Health's Annual Report for Reading for 2017, focusing on avoidable and preventable mortality.

15. DATES OF FUTURE MEETINGS – Proposed Dates for 2017/18: -

Friday 14 July 2017 at 2pm
Friday 6 October 2017 at 2pm
Friday 19 January 2018 at 2pm
Friday 16 March 2018 at 2pm

READING HEALTH & WELLBEING BOARD MINUTES – 27 JANUARY 2017

Present:

Councillor Hoskin (Chair)	Lead Councillor for Health, Reading Borough Council (RBC)
Andy Ciecierski	Chair, North & West Reading CCG
Councillor Eden	Lead Councillor for Adult Social Care, RBC
Mandeep Sira	Chief Executive, Healthwatch Reading (as substitute for David Shepherd)
Bu Thava	Chair, South Reading Clinical Commissioning Group (CCG)
Councillor R Williams	RBC (as substitute for Councillor Gavin)

Also in attendance:

Melissa Arkinstall	Public Health Officer, RBC
Barbara Barrie	Chair, Berkshire West End of Life Steering Group
Jo Hawthorne	Head of Wellbeing, Commissioning & Improvement, RBC
Victoria Hunter	Equalities Coordinator, ACRE (Alliance for Cohesion & Racial Equality)
Lise Llewellyn	Strategic Director of Public Health for Berkshire
Maureen McCartney	Operations Director, North & West Reading CCG
Jenny Miller	Commissioning Manager, RBC
Eleanor Mitchell	Operations Director, South Reading CCG
Vernon Nosal	Head of Adult Social Care, RBC
Janette Searle	Preventative Services Manager, RBC
Nicky Simpson	Committee Services, RBC
Councillor Stanford-Beale	RBC
Liz Stead	Head of Safeguarding Children, Berkshire West CCGs
Kim Wilkins	Senior Programme Manager, Public Health, RBC
Thom Wilson	Interim Head of Commissioning, RBC
Cathy Winfield	Chief Officer, Berkshire West CCGs

Apologies:

Gabrielle Alford	Director of Joint Commissioning, Berkshire West CCGs
Councillor Gavin	Lead Councillor for Children's Services & Families, RBC
Councillor Lovelock	Leader of the Council, RBC
Councillor O'Connell	RBC
David Shepherd	Chair, Healthwatch Reading
Graham Wilkin	Interim Director of Adult Care & Health Services

1. MINUTES

The Minutes of the meeting held on 7 October July 2016 were confirmed as a correct record and signed by the Chair.

2. QUESTIONS IN ACCORDANCE WITH STANDING ORDER 36

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

(a) South Reading CCG's Operational Plan for 2016-17

"South Reading CCG's Operational Plan for 2016-17 contains the following sentence:

"This plan is supported by a suite of documents including our Financial Strategy, 16/17 Activity plans, Dementia Action plan, Cancer recovery plan, and the Systems resilience plan."

I requested these supporting documents from the CCG. The reply from the CCG was as follows:

"Further to your email below please note the following:

- Financial Strategy - content already included in 16/17 operational plan as specific chapter
- 16/17 Activity plans - these are technical spreadsheets completed through an online portal which we are unable to release
- Dementia Action plan - content already included as an Appendix to 16/17 operational plan
- Cancer recovery plan - this is a Royal Berkshire Hospital document and not owned by the CCG
- Systems resilience plan - this is a technical spreadsheet completed through an online portal which we are unable to release"

It is true that Chapter 3 of the Operational Plan is devoted to Financial Sustainability - it may be that the reference to a separate document was an error.

The Dementia Action Plan may be an appendix to the Operational Plan but it has not been published with it on the CCG website and was not provided.

With respect to the activity plans I accept that the information may be hard to extract from the forms in which support staff handle it. But without some understanding of the changing levels of activity it is not possible for the public to gain an understanding of the present shape of our health service and spending and hence to appreciate the various reconfigurations, QIPP projects and behaviour modification programmes that emerge.

Could the next Operational Plan contain a sufficient breakdown of activity to enable the public to gain an understanding of where demand is changing and what must be done to bring activity and expenditure into balance?"

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

"The 2017-19 Berkshire West Operational Plan was submitted to NHS England on the 23 December 2016; we currently await feedback on the plan prior to publication on our websites. Aligned to this we have also submitted activity spreadsheets to NHS England which have been agreed with our providers including Royal Berkshire Hospital, Berkshire Healthcare Foundation Trust and South Central Ambulance trust. In doing this we look at the activity from previous years and anticipated growth.

Expected percentage growth for emergency admissions to hospital (non-elective) is a 3.5% increase from 16/17; elective care is a 0.8% increase.

Where plans have exceeded activity we generally look to implement projects to manage this. As has been the case for a number of years our largest area of growth is in emergency admissions to hospital. Each of the chapters of the operating plan look at areas of activity, eg urgent care, elective care and set our plans/priorities for the forthcoming two years.

If when the plan is published this does not contain sufficient information we are happy to discuss this further."

In response to a supplementary question from Tom Lake about whether the CCGs had a flow model of patients between services and the rate that this could effectively take up patients, Dr Bu Thava said that he would endeavour to answer this question in a separate response to Tom Lake.

(b) Royal Berkshire Hospital Admissions

"In the Royal Berkshire Hospital's account of the festive season on its website it was stated that on many days of the season ADMISSIONS to the hospital were 25% higher than last year. What could be the possible causes of this much higher rate of admissions and what can be done to reduce it?"

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

"The information referred to in the question asked is in the archived section of the RBH website and refers to the pressure on A&E and admissions during the 2015 festive period. This year the numbers were similar to last but the activity was planned for and all partners in the health and social care system worked together to ensure that patients requiring onward care had a smooth transfer once they were fit to leave the hospital.

That said it is clear that health and social care services in Reading, and across the country, are facing major increases in demand coupled with increasing underfunding. Items 12 and 13 on the agenda of today's Board look at exactly these issues and the actions we are taking as partners in order to address them."

In response to a supplementary question from Tom Lake about asking the Royal Berkshire Hospital to date the articles on their website, Councillor Hoskin said that he would speak to the Chief Executive at the Hospital and pass on this request.

(c) Ambulatory A&E Attendance – Referrals

"The survey of ambulatory A&E attendance at RBH commissioned from Reading Healthwatch revealed that many of the ambulatory attendees had been referred, sometimes conditionally, to A&E by other parts of the NHS. What change is proposed, if any?"

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

"At its meeting today the Health & Wellbeing Board will receive a progress report on actions agreed in response to the Healthwatch survey "A week in A&E" . This confirms:

- The work that GP Practices are doing to review patients who have attended A&E more than 5 times in the previous 6 months and to consider how the needs of these patients could be more appropriately managed in future to reduce future A&E attendances.
- The proportion of callers that the NHS 111 service send to the A&E department is monitored by the CCGs. The Directory of Services used by NHS 111 is also regularly reviewed to ensure that all alternatives to A&E are included so that patients whose needs can be met elsewhere are directed to another service.
- The proportion of callers that the SCAS 999 service convey to the A&E department is also monitored and SCAS benchmark very well nationally on their non-conveyance rates.
- For both the 111 and 999 services Commissioners are working with SCAS to increase the number of calls being triaged by a clinician to ensure only those needing the facilities of a full A&E department are directed there.
- The ratio between numbers of patients attending A&E and those going on to be admitted is high so we know that the majority of people attending A&E are doing so appropriately although it is recognised that there is always further scope to ensure patients are aware of and utilising all alternative services."

The following question was asked by Caroline Hearst in accordance with Standing Order 36:

(d) Peer Support for Autistic Adults

"Why has peer support for autistic adults in Reading been stopped given there was a contract issued to offer this?"

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

"Reading Borough Council have commissioned Autism Berkshire to provide a peer support service for adults with autism. The agreement runs from June 2016 to May 2018. Funding has not been cut.

Autism Berkshire originally subcontracted with Autangel to deliver the service, but decided to terminate that agreement.

Under the terms of its Narrowing the Gap agreement, Autism Berkshire now facilitates peer support through a post-diagnosis social skills course, a fortnightly support group (the 197 Club), and a monthly women's group. There is also a Young Adults Group and Level Up. This is not the same offer as the courses Autangel was offering, but still fits with the outcomes required under this part of the Narrowing the Gap framework. We amended Autism Berkshire's funding agreement to reflect the variation. This means that Autism Berkshire is not in breach of any arrangement with Reading Borough Council by facilitating peer support in a different way now."

3. END OF LIFE CARE BRIEFING

Further to Minute 3 of the meeting held on 9 October 2015, when the Board had received a presentation on the role of Health and Wellbeing Boards in Palliative and End of Life (EOL) Care, Dr Barbara Barrie presented a joint report giving an updated overview of EOL Care locally and on how the Reading locality could further develop care and support for those at the end of life.

The report explained that EOL care was a cross-cutting theme across a wide range of conditions. A Berkshire West-wide EOL Steering Group met quarterly and had representation from all stakeholders, including the Council and the Reading CCGs, chaired by Dr Barrie. This group reported into the Long Term Conditions Programme Board, ensuring that all the Long Term Conditions work also aligned with the ambitions for EOL as well as other programmes of care.

A Reading End of Life working group had been set up following a decision at the October 2015 Health and Wellbeing Board meeting. This group had sponsored a local conference involving a range of stakeholders and the meeting had highlighted services available locally and some of the service gaps. The report gave details of the work being done and planned by the Council and the CCGs to ensure that care and health services were safe, timely, commissioned appropriately and delivered in a way that enabled a personalised and proportionate approach to EOL care. It highlighted, for example, the recent commissioning of "PallCall", a new 24 hour, 7 days a week palliative care coordination and support service, designed to support EOL patients to die in their preferred place and to prevent avoidable, unwanted admissions for that patient group. In its first six weeks of operation, PallCall had dealt with 100 calls, prevented 19 admissions and supported six patients to die in their preferred place.

The report stated that it was proposed to convene a multi-agency task and finish group to develop an implementation plan for EOL care service development locally and to ask the group to report back on its work to a future Health and Wellbeing Board.

A number of those present said they would like to be involved in the Task & Finish Group and it was suggested that it would be useful to involve voluntary and community groups in the Task & Finish Group, as they played a key role in EOL care. It would also be important to get a shared understanding of the legal powers, responsibilities, roles and abilities of all those involved in supporting people in EOL care.

Resolved -

(1) That the report be noted;

(2) That an End of Life Task & Finish Group be set up to produce an integrated implementation plan for the development of End of Life Care services locally, to include in its membership Councillor Rachel Eden, Vernon Nosal, Jo Hawthorne, Barbara Barrie, Eleanor Mitchell, Mandeep Sira and appropriate representatives from the wider voluntary/community sector;

(3) That a report on the work of the Task & Finish Group be submitted to a future meeting of the Health and Wellbeing Board.

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

Further to Minute 3 of the previous meeting, Cathy Winfield submitted a letter about and a document summarising the NHS Sustainability and Transformation Plan (STP) for Buckinghamshire, Oxfordshire and Berkshire West (BOB), which had been published in

December 2016 by the STP BOB Lead and Chief Executive of Oxfordshire CCG, David Smith. She also gave a verbal update on the latest situation on the BOB STP.

Cathy Winfield said that the BOB STP had been submitted on 23 December 2016, and a formal response was awaited from NHS England, whose Board would be meeting on 9 February 2017. Once the Quarter 3 financial position was known at the end of February 2017, a refreshed STP based on the latest financial outcomes was likely to be submitted. She explained that public engagement on the Berkshire West CCGs Operational Plan was being carried out, which included reference to the BOB STP, and that public engagement events for the BOB STP were being prepared for when it was formally signed off.

Cathy Winfield explained that, unlike other STPs, most of the BOB STP work was being done through the local health economies, including the Berkshire West 10, and so the work focus was bottom-up and it was not expected that things would be that different from currently – work would continue on the local programmes. She said that the funding allocation to spend on the NHS was being increased from £2.5 billion to £2.78 billion and that some funds were available in a central fund; local bids had been made to this fund for cancer services, strengthening digitisation work and mental health work, especially for support in mental health crises expanding psychological need. She said that current modelling suggested that, if things continued as currently, demand would outstrip supply, creating a £479m gap, and there were also many other pressures.

Councillor Hoskin expressed concern about the lack of consultation and transparency on the STP, but noted that the way that the STP changes were being developed and handled was under national control. He said that the Council was keen to know how the finances would work through to local provision and how activity and workforce plans would change, for example what changes to the movement of patients through the health system there would be with centres of excellence, but it seemed that at the moment this was not knowable. Cathy Winfield explained that any major changes would trigger a formal consultation, and the NHS would want to do engagement on these issues.

Councillor Hoskin reported that the Council had signed up to be involved in a joint scrutiny of the STP across Berkshire West, and would also be thinking about what scrutiny of the STP it would carry out locally, in order to look at how the plans would fit with the local population's needs and demands and how they would link to social care.

Resolved - That the documentation and position be noted.

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

Further to Minute 5 of the previous meeting, Janette Searle submitted a report on the adoption of Reading's second Health and Wellbeing Strategy, for 2017-20, which was attached to the report at Appendix C. The report also had attached the results of the consultation on the Strategy at Appendix A, an Equality Impact Assessment at Appendix B and a draft Action Plan at Appendix D.

The report explained that, as required by statute, the Strategy would set the basis for commissioning plans across both the local authority and the local CCGs. It was a joint strategy and its development to date had properly been driven by the Health and

Wellbeing Board but, as required by the Council's Constitution, the Strategy had also been submitted to the full Council on 24 January 2017 for formal approval.

The report explained the process of developing the three year Strategy, which retained the previous vision of "A healthier Reading" and had added a Reading Mission Statement "To improve and protect Reading's health and wellbeing – improving the health of the poorest, fastest".

The draft Strategy proposed the following 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 could live well with dementia;
- Increasing breast and bowel screening and prevention services;
- Reducing the number of people with tuberculosis;
- Reducing deaths by suicide.

Resolved –

(1) That the feedback from the formal consultation on Reading's second joint Health and Wellbeing Strategy (attached to the report as Appendix A) together with the Equality Impact Assessment (attached to the report as Appendix B), which had been considered and taken into account in the development of the Strategy, be noted;

(2) That the 2017-20 Reading Health and Wellbeing Strategy, as attached at Appendix C to the report, be endorsed and it be noted that it had been adopted by the Council at its meeting on 24 January 2017;

(3) That the supporting Health and Wellbeing Action Plan, as attached at Appendix D to the report, be approved;

(4) That the Board's thanks to the Well Being Team, key partners and all those involved in developing the Health and Wellbeing Strategy and Action Plan be recorded.

5. BERKSHIRE WEST CCGS OPERATIONAL PLAN 2017/19 AND READING ADULT SOCIAL CARE COMMISSIONING INTENTIONS 2017/18

The Board received a joint covering report presented by Jo Hawthorne, Eleanor Mitchell, Maureen McCartney and Thom Wilson, presenting the Berkshire West CCGs Operational Plan 2017/19 and the Reading Borough Council Adult Social Care Commissioning Intentions 2017/18. Copies of the documents were appended to the report, as well as a "Plan on a Page" summary of the Operational Plan 2017/19.

The report explained that two separate reports had been presented as the Berkshire West CCGs were required by NHS England to submit a separate plan in line with the NHS Operational Planning Guidance issued in September 2016, so a joint report had not been possible, but the plans had been prepared in close collaboration, and both

documents referred to the need to work more closely together, as well as including a range of specific objectives. During the past year, close working had included development of a Reading Integration Board to oversee local integration opportunities and priorities and the CCGs and Council had agreed to prioritise opportunities for joint commissioning through the Integration Board in the coming year.

a) Berkshire West CCGs Operational Plan 2017/19

The report stated that the NHS Planning Guidance described the following "must do" priorities, and the Operational Plan had to outline the CCG plans against these criteria:

- 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.

These priorities did not encompass the full breadth of CCG responsibilities and, in addition to the above, NHS England also set out specific areas where improvement was needed by 2020. This included 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.

The Berkshire West CCGs Final Operational Plans had been submitted to NHS England on 23 December 2016 and had been approved by the four CCG Governing Bodies. Initial feedback from NHS England had been positive. All contracts with main providers (Royal Berkshire Hospital, Berkshire Healthcare Trust and South Central Ambulance Service) were required to be and had been signed by 23 December 2016.

A "Plan on a Page" document had been produced by the CCGs to help illustrate and summarise the key elements of the plan on a single page, with specific CCG priorities highlighted on the reverse.

The report explained that, as in previous years, the Quality Premium scheme had been offered to CCGs, which had now become a two year scheme. The two Reading CCGs had been required to choose one Quality Premium target each and the report gave further details of the following targets:

- North and West Reading CCG - Increased number of Chronic Kidney Disease patients treated with an ACE-1 or ARB medication
- South Reading CCG - Increasing prevalence of hypertensive patients

It was reported at the meeting that the South Reading CCG had just heard that they had been successful in achieving their 2015/16 Quality Premium and were in the top 16 in the country on Quality Premium achievements.

b) Reading Borough Council Adult Social Care Commissioning Intentions 2017/18

The report explained that the key priorities for Adult Social Care Commissioning for 2017/18 were:

- 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.

The Commissioning Intentions document gave details of progress to date on each of the priorities and set out objectives for the year ahead.

It was noted that the plans and intentions involved a lot of areas which would need changes in culture and behaviour by the people of Reading to help in achieving the aims, and that it would be important to work out how to involve both service users and all residents in such changes. It was explained that the Wellbeing - Public Health intentions and Communications Plans had yet to be developed and it was hoped that this work could be done together.

Resolved –

(1) That the Berkshire West CCGs Operational Plan 2017/19 & Reading Borough Council Adult Social Care Commissioning Intentions 2017/18 be noted;

(2) That the Quality Premium Targets for the two CCGs for 2017/18 and 2018/19 be noted;

(3) That the Reading Integration Board continue to review and develop joint commissioning opportunities and an Implementation Plan.

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

Mandeep Sira submitted a report on a project carried out by Healthwatch Reading in September and October 2016 to find out Reading people's experiences of the NHS electronic prescribing service (EPS).

The report explained that the EPS allowed a patient prescription to get from a GP's computer to a patient's pharmacy computer, so people did not have to take a paper copy. Healthwatch Reading had been given evidence of some local problems with EPS and wanted to understand whether people knew about the service, what it was like to use the service and if people did not use the service, why not. It was hoped the findings would help influence any future local improvements to the EPS.

The report gave details of how the project had been carried out, visiting GP surgeries and pharmacies and by provision of surveys. 217 people had completed the survey, with 183 filling out a paper version and 34 answering online. Information had also been gathered from pharmacists, a GP and local NHS staff.

The report set out key highlights, gave details of patient and professional views and information from the NHS, and concluded:

> "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?"

The report had appended a response from the Local Pharmacy Committee and it was reported at the meeting that responses had also now been received from NHS England and Berkshire West CCGs. Mandeep Sira said that Healthwatch would approach NHS England centrally to encourage them to pilot a scheme for patients to receive a text message when their prescription was ready.

It was noted that the Health and Wellbeing Board had a potential item on its bringforward list for a future meeting on changes in funding for community pharmacies and it was suggested that the issues raised in the EPS report could be included in that agenda item.

Andy Ciecierski said that the EPS was still a relatively new system for both GPs and pharmacies and acknowledged that, whilst it had its benefits, it was not foolproof and it would be useful to review it in the future. He also noted that the role of clinical pharmacists in primary care was key, as there was a need for pharmacists to be able to help in this workload and it would be useful to review how this was being developed in local practices.

Resolved -

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

(2) That the issues raised in the report and the role of clinical pharmacists in primary care be considered as possible future agenda items for the Board.

7. ACRE'S FEMALE GENITAL MUTILATION (FGM) COMMUNITY ENGAGEMENT WORK & PROGRESS TOWARDS CREATION OF THE ROSE CENTRE, READING

Further to Minute 8 of the previous meeting, Victoria Hunter submitted a report giving an update on developments since October 2016 in relation to tackling Female Genital Mutilation (FGM) from the Alliance for Cohesion & Racial Equality (ACRE) (see also Minute 8 below).

The report explained that ACRE had recommended the development of a specialist FGM centre, the Reading Rose Centre, some funding for which had been committed by NHS England and the Office of the Police and Crime Commissioner, although there was currently still a shortfall in funding. However, two potential funds had recently opened under the Violence Against Women and Girls Strategy – The Service Transformation Fund and the Tampon Tax Fund. ACRE would be applying in partnership with the Office of the Police and Crime Commissioner and the Berkshire West CCGs to the Service Transformation Fund; ACRE would also be applying for the Tampon Tax Fund. If the bids were successful, the Rose Centre would be fully funded for three years.

Victoria Hunter said that, although the Rose Centre had originally been planned to serve Reading, as Reading was an FGM hotspot, it had now been widened out to all of Berkshire, with the potential to grow to serve the Thames Valley. It was the first time that such a collaborative co-commissioning process had been followed and this

approach would secure sustainability. She said that the National Police Chiefs Council's Head for FGM was coming to Reading to see the work. She noted that, although the Centre had been planned for FGM, it was now expected that it would also cover all community-based and honour-based issues and domestic violence, looking at how to address cultural issues and work across boundaries, looking at victims, families and perpetrators.

ACRE had now also secured funding from the Office of the Police and Crime Commissioner and NHS England to continue community engagement work in the run up to the forthcoming development of the Rose Centre and facilitate community participation in the planning of the service. ACRE had recruited four new community advocates and through responses to questionnaires, had collated information on 30 FGM survivors in the local area.

Resolved - That the report and the progress made so far be noted and welcomed and all those involved be congratulated.

8. ESTABLISHING A CLINICAL RESPONSE FOR ADULTS WHO HAVE SUFFERED FEMALE GENITAL MUTILATION (FGM)

Further to Minute 8 of the previous meeting, Liz Stead submitted a report from the Berkshire West Federation of 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 (see also Minute 7 above).

The report explained the current process for identifying cases of FGM, noting that, for women identified in the antenatal period, they were seen in routine hospital clinic appointments as there was currently no separate service for issues around FGM, and that there was also currently no provision for supporting women who were not pregnant but had issues relating to their FGM; the identification of these women in primary care was also currently poor. The report stated that partners had been working in collaboration to take a holistic standpoint to consider all aspects of the consequences of FGM and that plans had been made to establish a Reading Rose Centre to be based at the Oxford Road Community Centre. This would be a one-stop-shop for communities around addressing the issue of FGM and other BME issues and to access services such as English as a Second Language and back to work skills.

The report explained that, despite contributions and commitments from NHS England and the Office of the Police and Crime Commissioner, there was currently still a shortfall in funding to keep the Centre going for a minimum of three years. However, in December 2016, the Home Office had launched its funding strategy for the Violence Against Women and Girls Service Transformation Fund, a copy of the prospectus for which was appended to the report. The plans for the Reading Rose Centre satisfied virtually all of the requirements for the funding and an Expression of Interest had been submitted; if the bid was successful this should be known by the end of March 2017.

It was noted that, if the Home Office funding bid was not successful, an alternative plan would need to be made and a more streamlined proposal might be needed.

Resolved - That the report be noted and, if news on the bid had been heard by the next Board meeting on 24 March 2017, an update be given at that meeting.

9. ACCESS & EMERGENCY (A&E) DELIVERY BOARD AND IMPROVEMENT PLAN

Maureen McCartney submitted a report on:

- The role of the system-wide Berkshire West A&E Delivery Board in ensuring delivery of the NHS constitutional standard that 95% of patients should spend no more than four hours in an A&E department from arrival to admission, transfer or discharge;

- Progress on delivery of the local A&E Improvement Plan which was designed to support recovery of the standard at the Royal Berkshire Hospital;

- Actions agreed in response to the Healthwatch report "A week in A&E" which had been considered by the Board on 7 October 2016.

The report had a copy of the latest version of the A&E Improvement plan attached at Appendix 1 and a copy of the Terms of Reference of the A&E Delivery Board attached at Appendix 2.

The report explained that performance against the four hour constitutional standard was a barometer of flow across the health and social care system and required each part of the system to work in partnership to deliver their respective contributions to recovery of the target. The report gave details of performance, explaining that the target had not been consistently achieved in Berkshire West since quarter 3 of 2015/6, gave details of the rationale for the establishment of the A&E Delivery Board in September 2016 and set out its core purpose and membership.

The report also set out the requirement to have an A&E Improvement Plan, which was attached to the report, setting out progress to date against the five key interventions recognised nationally to be best practice and a number of additional actions agreed at two system-wide "Round Table" events held in July and September 2016, which had been organised by the Chief Executive of the Royal Berkshire Hospital in response to pressures within the Trust which required a whole system response and urgent action.

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 were set out in the report, and it also gave details of progress on actions agreed in response to the HealthWatch Report "A Week in A&E", which the Board had considered at its previous meeting.

Maureen McCartney reported at the meeting that the length of hospital stay had reduced significantly in the previous few weeks, and she also reported that the Royal Berkshire Hospital actions in response to the Healthwatch report which were still open were on the agenda for the Hospital Trust's next Board meeting.

It was noted that it was important to get appropriate messages out to the public about where to attend in different medical situations, to prevent unnecessary attendance at A&E. It was noted, for example, that in some circumstances people

were told not to attend A&E but to go to a minor injuries unit, but there was no such unit within Reading. Maureen McCartney reported that there had been a discussion at the A&E Delivery Board about developing a joined-up Communications Strategy and the Communications Teams had been asked to work together on this.

In response to an enquiry about the plans for the Reading Walk-In Centre and opportunities for a system-wide discussion about the vision for the Centre, Cathy Winfield explained that the contract for the provider had been extended for two years and consideration was being given as to how the Centre fitted with the urgent care strategy. The Centre had initially been set up with a primary care priority, for example providing cervical screening, but recently a system had been put in place for people to attend the Centre when the urgent care system was busy and consideration was being given as to how the Centre could contribute to the urgent care system. It was noted that it would be good if it could be used to provide a minor injuries resource for Reading.

Resolved - That the report be noted.

10. INTEGRATION AND BETTER CARE FUND

Jo Hawthorne submitted a report giving an update on the progress of the Integration programme, including Better Care Fund (BCF) Performance.

The report gave details of progress to date against the four key BCF performance indicators that each Health & Wellbeing Board was required to report on:

- Reducing delayed transfers of care (DTOC) from hospital
- Avoiding unnecessary non-elective admissions (NEA)
- Reducing inappropriate admissions of older people (65+) in to residential care
- Increase in the effectiveness of reablement services

It also summarised performance to date on the following key integration/BCF schemes:

- Discharge to Assess – Willows
- Community Reablement Team
- Enhanced Support to Care Homes
- Connected Care

The report also included information received in relation to 2017/18 & 2018/19 Better Care Fund requirements. The final policy and technical guidance had yet to be published and was not expected to be until late January 2017. This meant that the final funding, national conditions and planning requirements were still unclear.

As part of the BCF Policy Framework and Integration and BCF Planning for 2017-19, there was a proposed option for local areas to look towards 'graduation' from BCF. Areas that graduated would no longer be required to submit annual BCF Plans and quarterly returns. An expression of interest had been put forward on behalf of the Berkshire West localities but, as with BCF policy guidance, the graduation criteria and process were yet to be finalised, so the application would require review upon publication of the final policy. Any final application would return to the Board for formal approval.

It was noted that it was frustrating that the publication of the BCF criteria had been delayed, and Councillor Eden said that she had written to the Minister firmly requesting the publication.

Resolved - That the report and position be noted.

11. A HEALTHY WEIGHT STATEMENT FOR READING – PROGRESS UPDATE

Melissa Arkinstall and Kim Wilkins submitted 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. Reading's Healthy Weight Statement was attached at Appendix A and an initial Healthy Weight Strategy Action Plan was attached at Appendix B.

The report gave details of the ways that the Healthy Weight Position Statement for Reading had been developed, including an analysis of local data, scoping of current service provision and involvement of stakeholders at various stages of development. It explained that this work had helped to identify both the range of programmes already available to support people to be a healthy weight in Reading and had highlighted where it was necessary to further focus efforts.

Proposed areas of focus included:

- 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 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

The report set out initial emerging priorities which, if agreed, would form the basis of the action plan, in the following three tiers:

- Tier 1/Primary prevention: To prevent children and adults from becoming overweight or obese through supporting healthy eating and active lifestyle habits throughout life.
- Tier 2 services/Community Weight Management Programmes
- Tier 3 services – commissioned by the CCGs

The report stated that a draft action plan was in development which, as a starting point, included some of the work under way or planned by the Council, and was attached at Appendix B. The next step would be to further develop and enhance the action plan, including engagement with and input from key stakeholders and the formation of a task and finish group to develop the detailed action plan.

Councillor Hoskin said that he would be keen to be involved in the Task & Finish Group and noted that it would be important to include representatives from education and children's services as connections with the education community would be key in achieving the healthy weight aims. It was noted that achieving progress was likely to be challenging in light of the current budget situation for both the Council and the CCGs, as exemplified by the inability to fund the Beat the Street programme

for 2017, and the Task & Finish Group would need to look at other ways of doing things.

Resolved –

(1) That the work undertaken to date and the Healthy Weight Statement for Reading be endorsed;

(2) That the development of a Healthy Weight Strategy for Reading and the formation of a Task and Finish Group to develop a detailed implementation plan, to be progressed through engagement and in partnership with key stakeholders, be endorsed;

(3) That a further progress report and an updated action plan be submitted to the next meeting of the Board.

12. BERKSHIRE TRANSFORMING CARE PARTNERSHIP

Gabrielle Alford, who had been due to attend the Board to give the presentation on the work of the Berkshire Transforming Care Partnership (TCP), which had been deferred from the previous meeting, was unable to attend the meeting. Copies of the presentation slides had been included in the agenda, which gave an update on the work of the Partnership in delivering the Berkshire Transforming Care Plan.

The Plan had the following aims:

1. Making sure fewer people were in hospitals by having better services in the community.
2. Making sure people did not stay in hospitals longer than they needed to
3. Making sure people got 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

The presentation gave details of the programme's governance structure, work streams and project groups and TCP achievements in 2016. It also gave an overview of the 2017/18 TCP Programme Plan and outcomes, and of plans to develop an Intensive Support Team in the community to provide proactive community based support for people with a learning disability and/or autism who had associated mental health needs and/or presented with behaviour that could challenge.

Resolved - That the presentation be noted.

13. WEST OF BERKSHIRE SAFEGUARDING ADULTS PARTNERSHIP BOARD ANNUAL REPORT 2015-16

The Board received a report presenting the West of Berkshire Safeguarding Adults Partnership Board (SAPB) Annual Report 2015-16, a copy of which was attached to the report at Appendix 1, for the Health and Wellbeing Board to accept the report for information, to meet statutory requirements.

The covering report stated that the trend analysis contained in the Annual Report highlighted 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. Reading had 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 were for those aged 65 years or over.

A number of initiatives in the Reading area had contributed to how working together had 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 identifying health, housing and financial support to meet the needs of vulnerable people

Reading Borough Council's achievements had included:

- Establishing a new safeguarding team
- Increasing the learning lunches and safeguarding workshops for staff and increasing the amount of safeguarding training available
- Reducing the amount of outstanding Deprivation of Liberty Safeguards (DoLS) and creating a pathway for community DoLS

Resolved - That the West of Berkshire Safeguarding Adults Partnership Board (SAPB) Annual Report 2015-16 be noted and accepted.

14. READING LOCAL SAFEGUARDING CHILDREN BOARD ANNUAL REPORT 2015/16

The Board received a report presenting the annual report of the Reading Local Safeguarding Children Board (LSCB) 2015/16, which was appended to the report.

The report explained that the Reading LSCB was the key statutory mechanism for agreeing how the relevant organisations would co-operate to safeguard and promote the welfare of children in Reading and for ensuring the effectiveness of what they did, as outlined in statutory guidance Working Together to Safeguard Children 2015.

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

The report explained that the Annual Report focused on the achievements and ongoing challenges for the LSCB and partners specifically against priorities. The achievements and ongoing challenges were set out under the following headings:

- Domestic Abuse;
- Strengthening the Child's Journey and Voice;
- Child Sexual Exploitation and other Particularly Vulnerable Groups;
- Neglect;

- Effectiveness and Impact of the LSCB.

The covering report explained that the Annual Report related specifically to the 2015/16 year and gave details of a number of developments since March 2016.

It also gave details of the outcome of an Ofsted Inspection in May/June 2016. Ofsted had 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 had graded the LSCB as 'Requires Improvement' and made five recommendations which had been clearly included within the highlighted ongoing challenges for the Board. All challenges were included as part of the LSCB Improvement and Development Plan for 2017.

Resolved - That the annual report of the Reading Local Safeguarding Children Board 2015/16 be noted.

15. READING AUTISM STRATEGY AND ACTION PLAN

Jenny Miller submitted a report giving details of progress on the delivery of the Reading Autism Strategy's key objectives, and presenting a proposed revised Implementation Plan for 2017/18. The report had appended:

- 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 2017/18

The report explained that Reading's Autism Strategy had been approved by the Health and Wellbeing Board on 17 April 2015.

The following six priorities for improving support for people with autism in Reading had been 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

An Autism Partnership Board had been established to progress the delivery of the Strategy through an Action Plan, which had been developed in the context of reducing budgets delivered through the Council's extensive transformation plans, and the report noted that there had been no additional resource identified or available to deliver the Action Plan. The Plan was focused on how existing resources across partners could be used most effectively.

The report stated that, at the meeting on 9 October 2015 (Minute 7 refers), the Health and Well Being Board had 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 had been actioned. It had also been suggested that where the Autism Partnership Board reported internally in the Council should be considered further. This action would be taken forward in the next year.

The report stated that, in the last year, work had continued on the key actions identified. Appendix 3 provided details of 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 2016
- 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 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

The report stated that the Autism Partnership Board had recognised that the Action Plan would require updating on a regular basis as progress was made to deliver the objectives set out in the Autism Strategy. The current refresh of the Action Plan included: 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.

Councillor Eden reported that the Westminster Commission on Autism had published a report on the experience of people with autism in accessing healthcare services and she recommended it to members of the Board as a useful way of understanding the issues encountered.

Resolved -

(1) That the actions undertaken to address the Reading Autism Strategy Action Plan be noted;

(2) That the Reading Autism Strategy Implementation Plan for 2017/18 be agreed.

(Councillor Stanford-Beale declared an interest in the above item, but was not present for the item and therefore took no part in the debate or decision. Nature of interest: Councillor Stanford-Beale was Chief Executive Officer of Autism Berkshire.)

16. ANTIMICROBIAL RESISTANCE

Lise Llewellyn submitted a report which gave a briefing on Antimicrobial resistance (AMR), its impact on people's health, the need for support for antibiotic awareness, strategies to tackle AMR and what was being done locally.

The report explained that AMR was resistance of a microorganism to an antimicrobial drug that was originally effective for treatment of infections caused by it. Resistant microorganisms were able to withstand attack by antimicrobial drugs, so that standard treatments became ineffective and infections persisted. Alternative medications or higher doses that might be more costly or more toxic were therefore required, causing delay in treatment. Treatment could also fail altogether. AMR was a topic that was poorly understood by the general public and the recent increase in the use and abuse of antimicrobials had accelerated the rate at which resistance was developing and spreading.

The report noted that strategies to tackle AMR relied on three pillars of Antimicrobial Stewardship:

- Preventing infectious disease
- Protecting current antibiotics
- Promoting and monitoring infection prevention and control measures

It was noted that one of the prevention activities was avoiding contact with sick people, but it was suggested that many people came into work when they were ill and employers did not do enough to encourage their sick employees not to come in to work so as not to spread the sickness, especially to those more vulnerable or immuno-compromised than them.

Resolved -

(1) That the report be noted;

(2) That Lise Llewellyn bring a report back to the Board in July 2017 on messages for winter 2017/18 on how to change the attitudes of the public and employers to people not going to work if they were sick.

17. DATE OF NEXT MEETING

Resolved – That the next meeting be held at 2.00pm on Friday 24 March 2017.

(The meeting started at 2.10pm and closed at 4.45pm)

READING BOROUGH COUNCIL

REPORT BY DIRECTOR OF ADULT SOCIAL CARE & HEALTH

TO:	**HEALTH AND WELLBEING BOARD**		
DATE:	**24 MARCH 2017**	**AGENDA ITEM:**	**6**
TITLE:	**CONNECTED CARE**		
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 and 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 Connected Care programme.

2. RECOMMENDED ACTION

2.1 The Health and Wellbeing board are asked to note the general progress to date

2.2 To note the requirement to finalise work on the Reading Information Governance toolkit, and to support the recommendation to implement an officer led task and finish group to ensure that the toolkit is completed during May 2017.

3. POLICY CONTEXT

3.1 Data sharing and the use of the NHS number as the prime identifier remain important initiatives and are part of national policy regarding Integration. The sharing of data amongst front line professionals is a key enabler to integration allowing front line professionals to access information from both social care and health about people in a seamless way. This will lead to a greatly improved experience for people in need of Social care or health support.

4. CONNECTED CARE OVERVIEW

4.1 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.

4.2 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.

4.3 The benefits of the connected care project are:

Citizen

Citizens have choice and control, and better able to help themselves, more care can be based around home.

Operational

Resources are used efficiently and effectively, Comply with national directives, and enabler for service redesign

Staff

Enables capable, sustainable motivated teams, will lead to Improvements in safeguarding, and greatly increase coordination and collaboration across professionals.

Financial

Assists total system financial sustainability

4.4 There is a requirement for Reading to put in in place a technical connection to the new Connected Care system. The connection will ensure the secure interconnectivity between PSN and the NHS N3 secure network. This in turn will provide the ability to link to NHS (Rio) and Social Care (Mosiac) systems

4.5 Information, whether held in tacit, written or electronic formats should be treated as key assets of any organization. Information therefore requires corporate policy and governance controls to ensure it is used appropriately and in accordance with current legislation.

4.6 The most significant challenge for this project is around information governance, because our health partners need to be satisfied that appropriate standards are in place before any secure connection can be made.

4.7 The process of assessment is through the Information Governance (IG) Toolkit, an online system that allows NHS organisations and partners to assess themselves against Department of Health information governance policies and standards. Subsequent assessment takes place annually to ensure maintenance and development of information governance.

4.8 In order that Reading can meet the overall timescales of the Berkshire West Connected care programme it is necessary that the Information Governance Toolkit (as detailed in 4.7 above) is completed by May 2017. An information governance subgroup is in place to revise policy and data sharing agreements, as required, ensuring lawful handling and sharing of data. There is a however a need to put in place an officer led task and finish group to accelerate work on the toolkit and to ensure that the first deadline of May 2017 is achieved.

5. CONTRIBUTION TO STRATEGIC AIMS

5.1 The Connected Care project 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 Connected Care project 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 Members are under a legal duty to comply with the public sector equality duties set out in Section 149 of the Equality Act 2010. The relevant provisions are as set out below.

Section 149 (1) – A public authority must, in the exercise of its functions, have due regard to the need to:

(a) eliminate discrimination, harassment, victimisation and any other conduct that is prohibited by or under the Equality Act;

(b)advance equality of opportunity between persons who share a relevant protected characteristic and persons who do not share it; and

(c)foster good relations between persons who share a relevant protected characteristic and persons who do not share it.

Section 149 (7) - The relevant protected characteristics are:

- age;
- disability;
- gender reassignment;
- pregnancy and maternity;
- race;
- religion or belief;
- sex;
- sexual orientation.

In order to comply with the Public Sector Equality Duty, Members must seek to prevent discrimination, and protect and promote the interests of vulnerable groups who may be adversely affected by the proposals. Members must be therefore give conscious and open minded consideration to the impact of the duty when reaching any decision in relation to the Better Care Fund and Integration programmes. The Public Sector Equality Duty (S.149) to pay 'due regard' to equalities duties is higher in cases where there is an obvious impact on protected groups. This duty, however, remains one of process and not outcome.

8. LEGAL IMPLICATIONS

8.1 N/A – no new proposals or decisions recommended / requested.

9. FINANCIAL IMPLICATIONS

9.1 Funding has been agreed at the Berkshire West level, and Reading is not required to fund the project.

10. BACKGROUND PAPERS

10.1 Connected Care presentation

Connected Care – Health & Wellbeing Board Reading

Contents

- What is Connected Care
- Background and Progress to Date
- Where is Reading
- Next Steps & Timelines
- Key Benefits
- Questions

What is Connected Care?

Person held health and social care record for the citizens of Berkshire

A person centric view for professionals across health and social care with accurate real time data and information from commissioners, health and social care providers, and citizens, enabling the individual to hold/ manage their care and give consent to providers of services and carers to view their record based on an agreed data set.

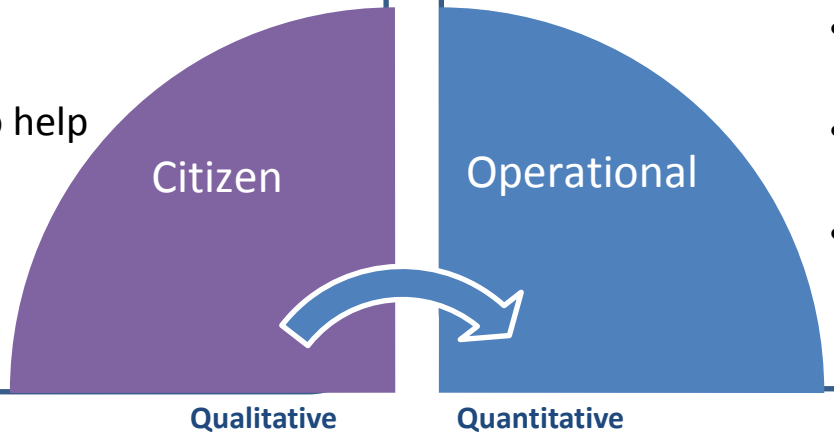
Interoperability and Information exchange between organisations

Share information and data across health & social care organisations.
Benefit of co-ordinating current and future service provision across care pathways, improving care, data analysis, support national initiatives such as paper free health records by 2020 and interoperability by 2017/2018 and legislative requirements such as the Care Act.

What is Connected Care?

South, Central and West Commissioning Support Unit

- Citizen have choice and control
- Citizen are better able to help themselves
- More care at home



- Resources are used efficiently and effectively
- Comply with national directives
- Enablement for service redesign

- A capable, sustainable motivated team
- Improvements in safeguarding
- Increased coordination and collaboration

- Assisting total system financial sustainability

Connected Care Progress to Date

South, Central and West Commissioning Support Unit

Phase 1 – Medical Interoperability Gateway (MIG) COMPLETE

- ✓ Primary care providers are sharing an agreed VIEW-ONLY data-set with Out Of Hours centres via the MIG

Phase 2 – (ORION PORTAL) COMPLETE

- ✓ Phase 2 portal – View only GP, Acute and Community patient data.
- ✓ 6 month evaluation period ends 30th April 2016

Phase 2 – (PROCUREMENT) COMPLETE

- ✓ End to end procurement process completed in 3 months
- ✓ 71 end users participated in the supplier demos (two day event)
- ✓ The final scoring matched the user expectations
- ✓ Decision made - no challenge

Phase 3 – IMPLEMENTATION OF FULL SOLUTION

- ✓ Graphnet awarded a 5 year contract for the CareCentric Solution
- ✓ Tranche 1 GO-LIVE scheduled for November 2016 (subject to detailed planning)

CONNECTED CARE

Reading Borough Council – Key milestones

- Public Service Network (PSN) Accredited
- NHS Number matching - ~60-80% Compliant
- Information Governance Toolkit (IGT) – In progress with submission **before May 2017**
- Logical Connection Architecture (LCA) – Can only be submitted once Reading are IGT Level 2 Compliant
- Change request to Vodafone to connect PSN to the N3 spine
- Configuration to connect to Connected Care
- Rollout and training – **Required by October 2017**

Next steps and timelines

Action	Date	Status
Project Definition Document (PDD) for year 1 is in development and will be presented at the next East Berkshire Connected Care Programme Board	27th September 2016	Completed
Project Initiation Document for Social Care Tranche 1 – Developed and will be signed off at the next East Berkshire Connected Care Board	27th September 2016	Completed
Test Strategy and Training Strategy	30th August 2016	Completed
Training for Tranche 1 – This will be a mixture of drop in sessions, classroom based and e-Learning	Between September and March 2017	In Progress
User Acceptance Testing for Tranche 1 – RBH testing complete, Bracknell Forest Council & Wokingham Borough Council testing still in progress and GP feed testing still in progress. Westcall Context launch from Adastra has been tested and signed off.	1st October 2016	In Progress
Implementation of Tranche 1 GPs, Royal Berkshire Hospital, Bracknell Forest Council & Wokingham Borough Council.	6th November 2016	In Progress
Implementation of Tranche 2 Royal Berkshire, BHFT Community & mental health, Royal Borough of Windsor & Maidenhead and enhanced data feed from other local authorities	May 2017	In Progress
Implementation of Tranche 3 all other organisations Slough Borough Council, Reading Borough Council, West Berkshire Borough Council, RBFT Test Results and Frimley.	TBC	Not Started

Key Benefits

Savings:

- Time; less time chasing data
- Cost – reduced duplicate tests, admissions, readmissions
- Clinical – greater clinical capacity, improved discharge and planning across care pathway
- Greater access to data – not just GPs but hospitals and social care
- Efficiency – reduction in adverse events and medication errors
- Interoperability saves lives and delivers higher level of care

Soft Benefits:

- Increased confidence from health and social care professionals
- Increased patient self-care
- Improvements in long-term health outcomes
- Patients live longer, more independently at home
- Improved public perception of local services
- Reduction in legal challenges/litigation
- Reduction in costs associated with paperless working e.g. fax and postal costs

If you have any questions or queries please contact the following:

Gary Mckelvey: Gary.Mckelvey@nhs.net

Tony.Marvell@reading.gov.uk

Connected Care Website

http://www.connectedcareberkshire.org

CONNECTED CARE

READING LOCAL SAFGUARDING CHILDREN BOARD

REPORT TO:	**Reading Health and Wellbeing Board**		
REPORT FROM:	**Fran Gosling Thomas, Independent Chair Reading Local Safeguarding Children Board (LSCB)**		
DATE:	**24th March 2017**	**AGENDA ITEM:**	**7**
TITLE:	**Berkshire Local Safeguarding Children Boards - Data and Information Sharing Agreement for Agencies Working with Children and Young People**		
REPORT BY **JOB TITLE:**	**Esther Blake** **Business Manager for Reading LSCB and Children's Trust Partnership**	**TEL:** **E-MAIL:**	**X73269** **Esther.blake@reading.gov.uk**

1. PURPOSE OF REPORT AND EXECUTIVE SUMMARY

1.1 A report from Reading LSCB was submitted to the Reading Health and Wellbeing Board in April 2015 following a joint letter from Government Ministers to all Chief Executives, Directors of Children's Services, LSCBs and Health and Wellbeing Boards. The letter followed the publication of the Government response to the child sexual exploitation cases in Rotherham and stated that a key factor in keeping children safe is the effective sharing of information.

1.2 This letter was discussed at the Reading LSCB in March 2015, with actions agreed to review the existing Information Sharing Agreement (ISA) and produce a revised document.

1.3 The Health and Wellbeing Board requested an update report when the ISA had been finalised.

2. RECOMMENDED ACTION

2.1 That the Health and Wellbeing Board note the attached Information Sharing Agreement. No action required – the report is for information only.

3. REPORT

3.1 A Task and Finish Group of the LSCB was initiated to review the existing Information Sharing Protocol and Agreement. The group included members from Reading LSCB, Reading Borough Council Legal Services, and was chaired by the Board member from the Royal Berkshire Hospital Foundation Trust who has championed this work throughout the process. This group reviewed the existing document against the pan Berkshire Online Child Protection Procedures and Government guidance.

3.2 In the course of this review, it was identified that Bracknell LSCB had updated the original Berkshire shared ISA and had signed this off locally. Reading LSCB agreed that it would be more beneficial to approach this as a pan Berkshire document, and therefore, although it meant the process would take longer, a revised document that could be accepted across all six LSCBs was drafted.

3.3 The Information Sharing Task and Finish Group reviewed the Bracknell ISA and the key changes made include:

- Addition of the Health & Social Care Act 2012
- Updated Caldicott Principles Annex 2 to reflect the 2013 review
- Addition of a link to NHS national data information sharing protocol/agreement that is current - Annex 4
- Extended the list of occasions that Berkshire organisations may need to share data/information (not child specific) using the NHS protocol/agreement

3.4 In the course of this review, reminders regarding the eight golden rules for information sharing were re-circulated to all Board partners. In addition a local Information Sharing Protocol was produced, agreed and disseminated by Reading LSCB in May 2016. This local document is useful for staff to understand information sharing requirements and is separate from the higher level strategic ISA.

3.5 All six Berkshire LSCBs, and therefore the partners that make up each Board, have now signed off the attached Information Sharing Agreement.

3.6 The Information Sharing Agreement will be included in the next upload to the online Child Protection Procedures which will go live in July 2017. The document will support the information already contained within the online procedures.

4. CONTRIBUTION TO STRATEGIC AIMS

4.1 This work meets the following Corporate Plan priorities:

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

5. EQUALITY IMPACT ASSESSMENT

5.1 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.

6. LEGAL IMPLICATIONS

6.1 A protocol, signed up to by all partner agencies, must be in place to allow effective and appropriate sharing of information and data for the protection of children and young people.

9. FINANCIAL IMPLICATIONS

9.1 None

10. BACKGROUND PAPERS

- Berkshire Local Safeguarding Children Boards - Data and Information Sharing Agreement for Agencies Working with Children and Young People

Berkshire Local Safeguarding Children Boards

Data and Information Sharing Agreement for Agencies Working with Children and Young People

February 2017

CONTENTS

Part 1 – Agreement for data and information sharing
1. Introduction – Principles for information sharing – Key points on information sharing – Sharing information as part of preventative services **2. Legal context of information sharing** **3. Berkshire Data and Information Sharing Agreement**
Part 2: Service / Project Specific Information sharing Agreement Template
To be used in the event of any project or service that requires more than one agency working together and will result in the need to share information / data in order to deliver the service / project.
Part 3: Annex Documents
Annex 1 - Consent and Fraser Competence guidelines **Annex 2** - Caldicott Principles **Annex 3** - Data request form.

This document is broken down into three separate parts:

1. Part 1 is the overarching Information Sharing Agreement which is approved by partners of the six Berkshire Local Safeguarding Children Boards.

2. Part 2 is the template for the development of a local Information Sharing Agreement to support the delivery of multi-agency work at an operational level, or to support specific multi-agency service delivery activity.

3. Part 3 consists of annex documents with additional information for practitioners.

PART 1 – INFORMATION SHARING AGREEMENT

1. INTRODUCTION

Information sharing within Berkshire services for children, young people and families

Sharing information is key to the goal of delivering better, more efficient public services that are coordinated around the needs of the individual, families and communities. It is essential to enable early intervention and preventative work, for safeguarding and promoting welfare of children and young people and for wider public protection. Information sharing is a vital element of improving outcomes for all.

Each time a Serious Case Review is published there is always a shortfall in the practice and process of sharing information between agencies which have led to failures in protecting the child. Continuous recommendations are made that systems are put in place in every local authority area to ensure that information about children and young people can be shared appropriately within and between agencies.

This Agreement provides a framework for agencies to share information about children, young people and families who are receiving services or for whom they have a concern and to support information sharing to develop services to support children, young people and families. It sets out the principles for sharing information and gives the legal context in which we share information.

If there are concerns that a child or an adult may be at risk of significant harm, then it is your duty to follow the relevant procedures without delay. Seek advice if you are not sure what to do at any stage and ensure that the outcome of the discussion is recorded.

Principles for Information Sharing – Seven Golden Rules from HM Government

1. **Remember that the Data Protection Act is not a barrier to sharing information** but provides a framework to ensure that personal information about living persons is shared appropriately.
2. **Be open and honest** with the person (and/or their family where appropriate) from the outset about why, what, how and with whom information will, or could be shared, and seek their agreement, unless it is unsafe or inappropriate to do so.
3. **Seek advice** if you are in any doubt, without disclosing the identity of the person where possible.
4. **Share with consent where appropriate** and, where possible, respect the wishes of those who do not consent to share confidential information. You should go **ahead** and share information without consent if, in your judgement, that lack of consent can be overridden in the public interest, or where a child is at risk of significant harm. You will need to base your judgement on the facts of the case.

5. **Consider safety and well-being:** Base your information sharing decisions on considerations of the safety and well-being of the person and others who may be affected by their actions.
6. **Necessary, proportionate, relevant, accurate, timely and secure:** Ensure that the **information** you share is necessary for the purpose for which you are sharing it, is shared only with those people who need to have it, is accurate and up-to-date, is shared in a timely fashion, and is shared securely.
7. **Keep a record** of your decision and the reasons for it – whether it is to share information or not. If you decide to share, then record what you have shared, with whom and for what purpose.

Key Points on Information Sharing

1	You must explain to children, young people and families at the onset, openly and honestly, what and how information will, or could be shared and why, and seek their agreement. *The exception to this is where to do so would put that child, young person or others at risk of significant harm or an adult at risk of significant harm, or if it would undermine the prevention, detection or prosecution of a serious crime, including where seeking consent might lead to interference with any potential investigation.*
2	You must always consider the safety and welfare of a child or young person when making decisions on whether to share information about them. Where there is concern that the child may be suffering or is at risk of suffering significant harm, the child's safety and welfare must be the overriding consideration.
3	You should, where possible, respect the wishes of children, young people or families who do not consent to share confidential information. You may still share information if, in your judgement based on the facts of the case, there is sufficient need to override that lack of consent.
4	You should seek advice where you are in doubt, especially where your doubt relates to a concern about possible significant harm to a child or serious harm to others.
5	You should ensure that the information you share is relevant, accurate and up to date, necessary for the purpose for which you are sharing it, shared only with those people who need to see it and shared securely.
6	You should always record the reasons for the decision, whether it is to share information or not.

Good information sharing is based on good recording practice. Records should be accurate, relevant, kept up to date, and kept for no longer than is necessary for their purpose. An audit trail of requests made and disclosures given will provide a record of events if required in the case of investigations or local inspections

Sharing information to support children

When there are child protection concerns consent is desirable but not necessary. The information needs to be proportionate. Each Local Authority will have developed an information sharing agreement for their Multi-Agency Safeguarding Hub (MASH), please contact your local MASH for further information.

There is an increasing emphasis on integrated working across children's services so that support for children, young people and families is provided in response to their needs. The aim is to deliver more effective intervention at an earlier stage to prevent problems escalating and to increase the chances of a child or young person achieving positive outcomes.

Whether the integrated working is across existing services or through specific multi-agency structures, success depends on effective partnership working between universal services (such as education and primary health care) and targeted and specialist services for those children, young people and families at risk of poor outcomes.

Preventative services working in this way will be more effective in identifying concerns about significant harm, for example, as a result of abuse or neglect. However, in most situations children, young people and family members will require additional services in relation to education, health, behaviour, parenting or family support, rather than intervention to protect the child or young person from harm or to prevent or detect serious crime.

Effective preventative services of this type will usually require active processes for identifying children and young people at risk of poor outcomes, and passing information to those delivering targeted support. Practitioners sometimes express concern about how this can be done lawfully.

Statutory guidance **Working Together to Safeguard Children (2015)** states that effective sharing of information is essential for effective identification, assessment and service provision. It also states that early sharing of information is the key to providing effective early help where there are emerging problems.

Specific information sharing guidance has been developed by health partners – Female Genital Mutilation and Child Sexual Exploitation.

Female_Genital_Mutilation_GL837_V6.1.pc	Management of Female Genital Mutilat	FGM_Decision_Making_and_Action_Flowcl	Information sharing for CSE RBFT FINAL.P
Appendix 1	Appendix 2	(included in Appx 1)	Appendix 3

There are clear statutory requirements to share information in the event of a child death. For more information please see the Berkshire Child Death Overview Panel (CDOP) website:

http://www.westberkslscb.org.uk/professionals-volunteers/cdop/

Sharing data and information to support organisations in their duty to safeguard

This list is not exhaustive.

- Flagging on IT systems – children with Child Protection plans and Looked After Children
- Provision of appropriate care services
- Monitoring and protecting public health, improving the health of the population
- Managing and planning services (where data has been suitably anonymised)
- Commissioning and contracting services (where data has been suitably anonymised)
- Developing inter-agency strategies
- Performance management, audit and quality assurance
- Research (subject to the Research Governance Framework)
- Investigating complaints or serious incidents
- Reducing risk to individuals, service providers and the public as a whole e.g. Domestic Abuse data with Community Safety Officers
- Staff management and protection e.g. Local Authority Designated Officer (LADO)
- Statutory inspections

2. LEGAL CONTEXT OF INFORMATION SHARING

There is no general statutory power to share information, just as there is no general power to obtain, hold or process data. The Data Protection Act 1998 governs the obtaining, holding and processing of personal information while some Acts of Parliament give public bodies 'express statutory powers' to share information. These are often referred to as 'statutory gateways' and are enacted to provide for the sharing of information for particular purposes.

The Human Rights Act 1998 and the European Convention of Human Rights

The European Convention on Human Rights has been interpreted to confer positive obligations on public authorities to take reasonable action within their powers (which would include information sharing) to safeguard the Convention rights of children. These rights include Article 8, and recognise a right to respect for private and family life:

Common law duty of confidentiality

The common law duty of confidentiality requires that unless there is a statutory requirement to use

information that has been provided in confidence, it should only be used for purposes that the subject has been informed about and consented to.

Data Protection Act 1998

This Act deals with the processing of personal (i.e. sensitive and non-sensitive) data. Personal data is data which relates to a living person, including the expression of any opinion or any indication about the intentions in respect of the child or young person is considered personal data. Sensitive personal data is personal data relating to racial or ethnic origin, religious or other similar beliefs, physical or mental health or condition, sexual life, political opinions, membership of a trade union, the commission or alleged commission of any offence, any proceedings for any offence committed or alleged to have been committed, the disposal of proceedings or the sentence of any court in proceedings. Organisations which process personal data must comply with the data protection principles set out in schedule 1 of the Act.

Specific legislation containing express powers or which imply powers to share

The Children Act 1989

Sections 17 and 47 of the Children Act 1989 place a duty on local authorities to provide services for children in need and make enquiries about any child in their area who they have reason to believe may be at risk of significant harm. Sections 17 and 47 also enable the local authority to request help from other local authorities, education and housing authorities and NHS bodies and places an obligation on these authorities to co-operate. The Act does not require information to be shared in breach of confidence, but an authority should not refuse a request without considering the relative risks of sharing information, if necessary without consent, against the potential risk to a child if information is not shared.

The Children Act 2004

Section 10 of the Act places a duty on each Children's services Authority to make arrangements to promote co-operation between itself and relevant partner agencies to improve the well-being of children and young people from pre-birth to 19 years (25 in case of those with disabilities) in their area. Relevant partners must cooperate with the local authority to make arrangements to improve children's wellbeing. This statutory guidance for section 10 states that good information sharing is key to successful collaborative working and that arrangement under section 10 of the Act should ensure that information is shared for strategic planning purposes and to support effective service delivery. It also states that these arrangements should cover issues such as improving the understanding of the legal framework and developing better information sharing practice between

and within organisations.

Section 11 of the Act places a duty on key people and bodies to make arrangements to ensure that their functions are discharged with regard to the need to safeguard and promote the welfare of children. The section 11 duty does not give agencies any new functions, nor does it override their existing functions, it simply requires them to:

- Carry out their existing functions in a way that takes into account the need to safeguard and promote the welfare of children;
- Ensure that the services they contract out to others are provided having regard to that need.

In order to safeguard and promote the welfare of children, arrangements should ensure that:

- All staff in contact with children understand what to do and the most effective ways of sharing information if they believe a child and family may require targeted or specialist services in order to achieve their optimal outcomes;
- All staff in contact with children understands what to do and when to share information if they believe that a child may be in need, including those children suffering or at risk of significant harm.

Education Act 2002

The section 11 duty of the Children Act 2004 mirrors the duty placed by section 175 of the Education Act 2002 on LAs and the governing bodies of both maintained schools and further education institutions to make arrangements to carry out their functions with a view to safeguarding and promoting the welfare of children and follow the guidance in Safeguarding Children in Education (DfES 2004). The guidance applies to proprietors of independent schools by virtue of section 157 of the Education Act 2002 and the Education (Independent Schools Standards) Regulations 2003.

Education Act 1996

Section 13 of the Education Act 1996 provides that an LA shall (so far as their powers enable them to do so) contribute towards the spiritual, moral, mental and physical development of the community, by securing that efficient primary and secondary education is available to meet the needs of the population of the area. Details of the number of children in the local authority's area and an analysis of their needs is required in order to fulfil this duty so there may be an implied power to collect and use information for this purpose. Section 434 (4) of the Act requires LAs to request schools to provide details of children registered at a school.

Learning and Skills Act 2000

Section 117 provides for help to a young person to enable them to take part in further education and

training. Section 119 enables Connexions services to share information with the Benefits Agency and Jobcentre Plus to support young people to obtain appropriate benefits under the Social Security Contributions and Benefits Act 1992 and Social Security Administration Act 1992.

Education (SEN) Regulations 2001

Regulation 6 provides that when the LEA are considering making an assessment of a child's special educational needs, they are obliged to send copies of the notice to social services, health authorities and the head teacher of the school (if any) asking for relevant information. Regulation 18 provides that all schools must provide Connexions Services with information regarding all Year 10 children who have a statement of special educational needs.

Children (Leaving Care) Act 2000

The main purpose of the Act is to help young people who have been looked after by a local authority move from care into living independently in as stable a fashion as possible. To do this it amends the Children Act 1989 (c.41) to place a duty on local authorities to assess and meet need. The responsible local authority is to be under a duty to assess and meet the care and support needs of eligible and relevant children and young people and to assist former relevant children, in particular in respect of their employment, education and training. Sharing information with other agencies will enable the local authority to fulfil the statutory duty to provide after care services to young people leaving public care.

Protection of Children Act 1999

The Act creates a system for identifying persons considered to be unsuitable to work with children. It introduces a 'one stop shop' to compel employers designated under the Act (and allows other employers) to access a single point for checking people they propose to employ in a child care position. This will be achieved by checks being made of criminal records with the National Criminal Records Bureau and two lists maintained by the Department for Children, Schools and Families.

Immigration and Asylum Act 1999

Section 20 provides for a range of information sharing for the purposes of the Secretary of State:

- To undertake the administration of immigration controls to detect or prevent criminal offences under the Immigration Act;
- To undertake the provision of support for asylum seekers and their dependents.

Local Government Act 2000

Part 1 of the Local Government Act 2000 gives local authorities powers to take any steps which they consider are likely to promote the wellbeing of their area or the inhabitants of it. Section 2 gives local authorities 'a power to do anything which they consider is likely to achieve any one or more of the following objectives:

- The promotion or improvement of the economic wellbeing of their area;
- The promotion or improvement of the social wellbeing of their area;
- The promotion or improvement of the environmental wellbeing of their area.

Section 2 (5) makes it clear that a local authority may do anything for the benefit of a person or an area outside their area, if the local authority considers that it is likely to achieve one of the objectives of Section 2(1). Section 3 is clear that local authorities are unable to do anything (including sharing information) for the purposes of the wellbeing of people - including children and young people - where they are restricted or prevented from doing so in the face of any relevant legislation, for example, the Human Rights Act and the Data Protection Act or by the common law duty of confidentiality.

Criminal Justice Act 2003

Section 325 of this Act details the arrangements for assessing risk posed by different offenders:

- The "responsible authority" in relation to any area, means the chief officer of police, the local probation board and the Minister of the Crown exercising functions in relation to prisons, acting jointly.
- The responsible authority must establish arrangements for the purpose of assessing and managing the risks posed in that area by:
    - **a.** Relevant sexual and violent offenders; and
    - **b.** Other persons who, by reason of offences committed by them are considered by the responsible authority to be persons who may cause serious harm to the public (this includes children).
- In establishing those arrangements, the responsible authority must act in co-operation with the persons identified below. Co-operation may include the exchange of information.

Crime and Disorder Act 1998

Section 17 applies to a local authority (as defined by the Local Government Act 1972); a joint authority; a police authority; a national park authority; and the Broads Authority. As amended by the Greater London Authority Act 1999 it applies to the London Fire and Emergency Planning Authority from July 2000 and to all fire and rescue authorities with effect from April 2003, by virtue of an amendment in the Police Reform Act 2002. It recognises that these key authorities have responsibility for the

provision of a wide and varied range of services to and within the community. In carrying out these functions, section 17 places a duty on them to do all they can to reasonably prevent crime and disorder in their area.

National Health Service Act 1977

The Act provides for a comprehensive health service to England and Wales to improve the physical and mental health of the population and to prevent diagnose and treat illness. Section 2 provides for sharing information with other NHS professionals and practitioners from other agencies carrying out health service functions that would otherwise be carried out by the NHS.

Health Act 1999

Section 27 of the Health Act replaces section 22 of the NHS Act 1977. Section 27 states that NHS bodies and local authorities shall cooperate with one another (this allows for practitioners to share information) in order to secure the health and welfare of people.

Health and Social care Act 2012

The Health and Social Care Act 2012 underpins wide ranging reforms of the NHS since it was founded in 1948. Changes include the establishment of a National Health Service Commissioning Board and Clinical Commissioning Groups, as well as Health and Wellbeing Boards. The changes became operational on 1st April 2013. The Act sets out provision relating to public health in the United Kingdom; public involvement in health and social care matters; scrutiny of health matters by local authorities and co-operation between local authorities and commissioners of health care services. The Act establishes a National Institute for Health and Care Excellence, and establishes the provision for health and social care. The clinical commissioning organisations established by the Act must have a secure legal basis for every specific purpose for which they wish to use identifiable patient data. Where there is no such statutory legal basis either the consent of the patient is required to process personal confidential data or the data must be fully pseudonymised.

The Adoption and Children Act 2002

For further information about the Adoption and Children Act 2002 and Regulations see www.education.gov.uk/childrenandyoungpeople/families/adoption

3. BERKSHIRE DATA AND INFORMATION SHARING AGREEMENT

Partners to this Agreement

This Information Sharing Agreement has been approved by all partner members of the six Berkshire Local Safeguarding Children Boards.

Purpose

The aim of this agreement is to facilitate the lawful exchange of personal and sensitive data in any form, within and between organisations for notified and defined purposes, respecting the rights of individuals set out in legal acts and common law. When the records of deceased people are required by their relatives or other parties, ethical and confidentiality issues will be safeguarded in the same way as if the person was living.

The public expects and the Data Protection Act 1998 requires that personal information held by statutory agencies will be properly protected. However, there is also a public expectation that there will be an appropriate sharing of information in working in partnerships for specific pieces of work with statutory obligations.

The purpose of sharing information between partner organisations is to:

- Ensure the provision of appropriate services for children and young people in need or at risk or likely to be at risk of suffering significant harm: sections 17 (10) and 47 (1) of the Children Act 1989 - or who otherwise are considered to be at risk of social or educational exclusion.
- Obtain the assistance for the local authority from other local authorities, in order for the local authority to perform its functions of providing services to children, young people and families under Part 111, Section 27, Children's Act 1989.Promote or improve the economic, social or environmental well being of children, young people and families in need in Bracknell Forest. This will include the provision of improvements to health and/or educational opportunity as well as the reduction or elimination of risk factors for children and young people within the city.
- Prevent or reduce crime and identify and apprehend offenders or suspected offenders Section 115, Crime and Disorder Act 1998.
- Ensure that children and young people who are missing education or at risk of going missing from education, are identified and supported.
- Provide information to assist in the planning and development of services for children and young people.
- Provide information for statistical analysis.

By sharing information, partner organisations will be able to identify children and young people considered to be in need or at risk of social or educational exclusion at an early stage of concern and provide effective multi-agency intervention in order to promote their health and well-being. Nominated representatives from organisations which are signatories to this agreement will be engaging in regular, multi-agency discussions in order to secure services for identified children, young people and their families.

The type and extent of information to be shared

Routine information sharing:

The information shared will be the minimum amount necessary; it will be relevant and only used for the purposes of this agreement. This is necessary to ensure compliance with the second and third principles of the Data Protection Act 1998:

Principle 2: "Personal data shall be obtained only for one or more specified and lawful purposes, and shall not be further processed in any manner incompatible with that purpose or those purposes".

Principle 3:" Personal data shall be adequate, relevant and not excessive in relation to the purpose or purposes for which they are processed."

Anonymised information: Whenever possible data should be anonymised, if large volumes of data is provided for Management Information (MI), research and/or planning by partner organisations, as a matter of courtesy the outcome of that research/planning should be provided to the organisation(s) supplying the data.

Data Sharing Categories

Aggregated/Statistical Information - aggregate and management information to plan and monitor progress of the service. This information can be shared without client consent.

De-Personalised/Anonymous Information - Individual level information may be depersonalised/ anonymised by the removal of any client identifiable information (such as name, address, unique identifiers, etc) and therefore outside the ambit of the Data Protection Act 1998, then shared by organisations within the context of this protocol. This information can be shared without client consent.

Personal Non Confidential/Non Sensitive Information - Information needed to identify and maintain contact with all clients in order to provide an effective service, such as Name, Address and Date of Birth. This information may be shared with the Informed Consent of the client.

Personal Confidential/Sensitive Information - Information needed to provide comprehensive support to clients and can be subdivided into broad categories:

Confidential - This information deemed to be 'professionally' sensitive, such as client characteristics (e.g. homeless, substance misuse, etc), assessment data or opinions.

Sensitive - This is information defined within the Data Protection Act 1998 as sensitive such as ethnicity, religious beliefs, criminal procedures or health related issues.

Confidential and/or sensitive information cannot be shared unless the client has given their Explicit Consent. There is other overriding legislation and exceptional circumstances.

Data Quality

Information held must be accurate and kept up to date. Steps must be taken to validate information, such as checking with the person who originally provided the information, if there is any doubt as to its accuracy. Sharing inaccurate information can lead to decisions being made on false information. Data owners will ensure they amend any incorrect details and inform partners of the correct information. Information discovered to be inaccurate, out-of-date or inadequate for the purpose should be notified to the Data Controller who will be responsible for correcting the data and notifying all other recipients of the information who must ensure the correction is made.

Designated Officer

In order to ensure compliance with the Data Protection Act, participants to this Agreement shall nominate a Designated Officer to whom all requests and from whom all disclosures of personal information will be made. Disclosure requests, disclosure decisions and the details of personal information that has been disclosed will be in writing and the designated officer will maintain a record. The identity of the data owner must also be recorded against the relevant data. No secondary use or other use may be made unless the consent of the disclosing party to that secondary use is sought and obtained.

Information discovered to be inaccurate or inadequate for the purpose will be notified to the data owner who will be responsible for correcting the data. The data owner will then notify all other recipients of that data, who must ensure that the correction is applied. Decisions on disclosures reached at meetings must be minuted.

The designated officer will ensure that appropriate security arrangements are in place within their respective organisations to prevent unauthorised access to and disclosure of personal data. A list of designated officers will assume responsibility for data protection, security and confidentiality issues and compliance with legislation within their respective organisations will be made available to partner organisations as a matter of routine.

Disclosures and Transfer of Information

Where information is shared, disclosed or exchanged requests for information will be specific to the purpose, recorded and made on a need to know basis. When disclosing personal information, many of the data protection issues surrounding disclosure can be avoided if the consent of the individual concerned has been sought and obtained. The organisation that originally discloses personal information to another party to this Agreement always retains ownership of the data (the data owner), each organisation must therefore decide the propriety of any particular disclosure. The identity of the

data owner must always be recorded against that data.

A recipient of personal information must obtain the consent of the data owner before making a secondary disclosure to another party to this Agreement. For the purpose of this requirement, each council department will be treated as a separate organisation.

Partner organisations will have appropriate information systems and records about information transfers. These records should cover when information has been given, when it has been refused and what medium has been used, including paper, electronic and conversational. The records should also cover the disposal and amendment of information. Where information is exchanged on a case by case basis, it should be ensured that requests are specific and recorded. Disclosure of information should be authorised by the appropriate personnel and should be provided on a need to know basis only. This "need to know" principle is a fundamental part of ensuring information is shared appropriately and is in compliance with the Data Protection Act 1998.

Data retention, review and disposal

Partner organisations will apply relevant regulations and timescales to the retention, review and disposal of information, (electronic and paper based), only keeping information for as long as is necessary in relation to the original purpose

Appropriate Security

General

The partners to this agreement acknowledge the security requirements of the Data Protection Act 1998 applicable to the processing of the information subject to this agreement. Each partner will make sure they take appropriate technical and organisational measures against unauthorised or unlawful processing of personal data and against accidental loss or destruction of, or damage to, personal data. In particular, each partner must make sure they have procedures in place to do everything reasonable to:

- Make accidental compromise or damage unlikely during storage, handling, use, processing transmission or transport.
- Deter deliberate compromise or opportunist attack.
- Dispose of or destroy the data in a way that makes reconstruction unlikely.
- Promote discretion to avoid unauthorised access.

Access to information subject to this agreement will only be granted to those professionals who 'need to know' to effectively discharge their duties.

Additional arrangements

To determine what security measures are appropriate in any given case, partners must consider the type of data and the harm that would arise from a breach of security. Information obtained in confidence may be regarded as requiring a higher level of security. In particular, they must consider:

- Where the information is stored.
- The security measures programmed into the relevant equipment.
- The reliability of employees having access to the information.

Complaints and breaches

All complaints or breaches relative to this agreement will be notified to the designated Data Protection Manager of the relevant organisation in accordance with their respective policy and procedures. Partner organisations will need to have appropriate arrangements to:

- Tackle any breach of agreement.
- Handle internal discipline.
- Monitor security incidents.
- Deal with malfunctions.

Indemnity

In return for the provision of any information by a partner organisation to another (the Receiving Partner) under the terms of this Agreement, the Receiving Partner undertakes to indemnify the Partner that provided the information in respect of all claims and liabilities arising from the use of the information by the Receiving Partner or it's failure to comply with its obligations under the Agreement.

Subject Access Requests

All Subject Access Requests must be made in writing to the relevant data controller and the subsequent actions taken must be fully recorded within the organisation's system. Information obtained from a partner organisation without the prior consent of the data subject cannot be disclosed to that individual without the agreement of the originating organisation. This does not prevent the individual making a separate Subject Access Request to the originating partner organisation. Agencies must make sure that data will be received by the requester no later than 40 days from receipt of request.

Children under 12 years of age

When a child does not have the capacity to understand the request, a parent/ guardian/carer can make a Subject Access Request in respect of their child. Information on consent and Fraser competence guidelines are attached as annex 1 of this document.

Parent/guardian/carer

Parents/guardians/carers of individuals with sufficient understanding of their rights have no automatic rights of access to the subject's data (in accordance with Data Protection Act 1998) It is considered good practice to ensure that the parent/guardian/carer of those under 16 years old is informed that the gathering, recording and possible sharing of information is taking place.

Parents/guardians/carers will normally only be able to access an individual's data (if they are deemed competent) with the signed consent of the subject. All parent/guardian/carer requests to access data must be referred to the designated manager within the relevant organisation. Access may be granted in cases where the designated manager is satisfied that an individual is not capable of representing themselves and that the parent/guardian/carer constitutes the client's legitimate representative. Where a Subject Access Request has been granted to the parent/guardian/carer the reasons for doing so must be fully recorded and clearly referenced to the evidence and information on which the decision is made

Freedom of Information Act considerations

If a party receives a request for information under the Freedom of Information Act 2000 and the information requested is identified as belonging to another signatory party, it will be the responsibility of the receiving agency to contact that party to determine whether the latter wishes to rely on any statutory exemption under the provisions of the Freedom of Information Act 2000 and to identify any perceived harm.

General operational guidance

Partner organisations must consider the staff time and resource implications that are involved for the Data Controller extracting the data. If a request is made and then the data is no longer required there should be a process for withdrawing the request. Partner organisations to this agreement will need to identify:

- A named individual to lead on the Agreement
- How they will champion training on the Agreement.

Partners will work within the accompanying Operational Agreement and Arrangements governing the collection, transfer, storage and disposal of information.

Review Arrangements

This Information Sharing Agreement will be formally reviewed annually unless legislation or government guidance necessitates an earlier review. Any of the signatories to the Agreement can request an extraordinary review at any time where a joint discussion or decision is necessary to

address local service developments.

Closure/termination of agreement

Any partner organisation can suspend the Information Sharing Agreement for 30 days, if they feel that security has been seriously breached. This should be done in writing and evidence provided. Any suspension will be subject to a risk assessment and resolution meeting, comprising of the signatories of this agreement or their nominated representative. This meeting will take place within 14 days of any suspension.

Signatories to this Agreement:

The Agreement was signed off by the six Berkshire LSCBs on the following dates:

LSCB Area	Date
Bracknell Forest	25th November 2016
Reading	26th May 2016
Royal Borough of Windsor and Maidenhead	7th December 2016
Slough	10th November 2016
West Berkshire	September 2016
Wokingham	26th October 2016

PART 2

Template for developing an Information Sharing Agreement on specific areas of work

SERVICE / PROJECT SPECIFIC INFORMATION SHARING AGREEMENT

(Put in here description of service of subject of agreement :)

PURPOSE OF THE AGREEMENT

The purpose of this agreement is to provide the framework to enable lawful exchange of personal and sensitive data in any form, within and between the specified organisations. This is an agreement between XXX and XXX. It is made under the auspices of the Berkshire Local Safeguarding Children Boards Data and Information Sharing Protocol for Agencies Working with children and Young People.

The Data Protection Act 1998 requires that personal information held by statutory agencies will be properly protected.

PARTIES TO THE AGREEMENT

The parties to this agreement are:

INFORMATION ABOUT THE SERVICE

(In this section the lead manager should provide details about the project / service and include: A clear statement of why there is a need to share information between the organisations party to this Information Sharing Agreement.)

DATA ITEMS TO BE SHARED

In this section specify:

- What data / information will be shared?
- How will the data / information be shared?
- How will the information be stored / secured?
- How will consent be gained (if appropriate) and how will this be recorded?
- If consent is not gained need to say why and record clearly.

Data Sharing Requests

(The service will have an agreed set of data that it will routinely share with the parties to this agreement in order to provide evidence of performance management linked to the service objectives / targets). (Where data is being requested of the service which is in addition to the data agreed by all parties a data request form will be completed and returned to xxxxxxxxxxxxx).

A data request form is attached as annex 3

A decision will be made about the data request by the lead manager and will then be processed accordingly.

BASIS FOR SHARING INFORMATION

The Data Protection Act 1998 governs the obtaining, holding and processing of personal information while some Acts of Parliament give public bodies express statutory powers to share information.
For the purpose of this framework the key legislation informing the work of the XXX includes:

- *Insert here the key legislation that underpins the service being provided*.

ACCESS AND INDIVIDUALS RIGHTS

(Lead manager to determine who will have access to the information within the parties signed up to the agreement). (Where a project is hosted by one agency/authority the service will operate under the policies and procedures of the host agency/authority.)

Freedom of Information Requests

The parties in this agreement are subject to legal duties under the Freedom of Information Act and any other applicable legislation governing access to information. Each party in the agreement will assist the others to enable compliance with the obligations. All parties in the agreement are entitled to any and all information relating to the performance of the agreement.

INFORMATION GOVERNANCE

Governance of the service will be the responsibility of the Lead Manager/Management Board who will be responsible for the agreement of service delivery outputs and outcomes and for monitoring all aspects of the service. *The following areas will need to be considered for this section:*

- Agreement about what datasets will be shared to ensure it is reasonable/and not too excessive.
- Looking at ways to ensure the quality of the data, and the accuracy of the data.

- Ensuring consistency of data recording and ensuring compliance with the data sharing agreement and policies and procedures.
- Agree the retention and destruction processes of shared items and a process for dealing with potential challenges if there is disagreement.
- Agree the security and storage arrangements and a process for dealing with any breaches.
- Agree a process for dealing with FOI and data requests.
- Agree a process for keeping data and information sharing under review.
- Agree timescales for review of agreement

INFORMATION SECURITY

The parties to this agreement acknowledge the security requirements of the Data Protection Act 1998 applicable to the processing of the information subject to this agreement. Each partner will make sure that they take appropriate technical and organisational measures against unauthorised or unlawful processing around personal data and against accidental loss or destruction of, or damage to, personal data. In particular each partner must ensure they have procedures in place to ensure that all reasonable steps are taken to:

- Make accidental compromise or damage unlikely during storage, handling, processing transmission or transport.
- Deter deliberate or opportunist attack.
- Dispose of or destroy the data in a way that makes reconstruction unlikely.
- Promote discretion to avoid unauthorised access.

Access to information subject to this agreement will only be granted to those professionals who "need to know" to effectively discharge their duties. To determine what security measures are appropriate in any given case, the parties to this agreement must consider the type of data and what risk /harm there would be in the event of a security breach. Key to the process is considering:

- Where the information will be stored
- The appropriate level of security measures within the ICT equipment
- The training of all staff in information security and data protection.

REVIEW ARRANGEMENTS

This Information Sharing Agreement will be reviewed by xxx at least annually and more frequently where there are significant changes to the service.

Information Sharing Agreement Signed

Name	Role	Organisation
Date Signed:		
First Review Date:		
Second Review Date:		

Part 3: Annex Information

Annex 1: Consent and Fraser Competence Guidelines

In many instances, you will seek consent to share information from the parent/ carer. This is particularly the case in work with younger children and in any interventions which include support work with the family. However in some cases the child/young person will be able to give consent without referral to their parent/carer. This is possible if they are judged to be Fraser Competent. Children under 16 should always be encouraged to involve their parent/carer unless to do so could put them at risk of harm. Particular care should be taken with children with a disability, who are sometimes wrongly assumed not to be able to give consent. The term, 'Fraser competent', arises from the case in the 1980s when Victoria Gillick attempted to set a legal precedent which would have meant that medical practitioners could not give young people under the age of 16 treatment or contraceptive services without parental permission. (Gillick vs West Norfolk and Wisbech Area Health Authority, 1985). The ruling was initially successful but then the House of Lords ruled that young people who are under 16 are competent to give valid consent to a particular intervention if they have sufficient understanding and intelligence to enable them to understand fully what is proposed and are capable of expressing their own wishes. Lord Fraser was the leading Law Lord for the review. Although the ruling was initially in regard to medical consent, it is now generally felt that the ruling applies to consent for other services.

Annex 2: Caldicott Principles

Caldicott Report 1997 – And the Caldicott 2 Review 2013

In December 2011 the Government announced that it wanted to allow patients' records and other NHS data to be shared with private life science companies, to make it easier for them to develop and test new drugs and treatments. Concerns were raised about what that might mean for patient confidentiality. This and other issues prompted the instigation of Caldicott 2, in which Dame Fiona was asked to review information issues across the health and social care system. Dame Fiona first investigated issues surrounding confidentiality when she chaired a similar review in 1996-7 on the use of patient data in the NHS. That review recommended that the NHS adopt six principles (see below) for the protection of confidentiality, which became known as the "Caldicott principles". The review also recommended that NHS organisations appoint someone to take responsibility for ensuring the security of confidential information. These people became known as "Caldicott Guardians". The reach of Caldicott 2 is far wider than the 1997 report. Its recommendations affect all organisations working in the health and social care sector – including local authorities. Its

recommendations, if adopted, will have a significant impact on the way that local authorities operate.

1. Justify the purpose(s) for using confidential information - Every proposed use or transfer of patient-identifiable information within or from an organisation should be clearly defined and scrutinised, with continuing uses regularly reviewed, by an appropriate guardian.
2. Only transfer/use patient-identifiable information when absolutely necessary - Patient-identifiable information items should not be included unless it is essential for the specified purpose(s) of that flow. The need for patients to be identified should be considered at each stage of satisfying the purpose.
3. Use the minimum identifiable information that is required - Where use of patient-identifiable information is considered to be essential, the inclusion of each individual item should be considered and justified so that the minimum amount of identifiable information is transferred or accessible as is necessary for a given function to be carried out.
4. Access should be on a strict need to know basis - Only those individuals who need access to patient-identifiable information should have access to it. They should only have access to the information items that they need to see. This may mean introducing access controls or splitting information flows where one flow is used for several purposes.
5. Everyone with access to identifiable information must understand his or her responsibilities - Action should be taken to ensure that those handling patient-identifiable information, both clinical and non-clinical staff, are made fully aware of their responsibilities and obligations to respect an individual's confidentiality.
6. Understand and comply with the law - Every use of patient-identifiable information must be lawful. Someone in each organisation handling patient information should be responsible for ensuring that the organisation complies with legal requirements.

The new Caldicott principle

The duty to share personal confidential data can be as important as the duty to respect service user confidentiality. Registered social workers working with a patient should be considered to be part of the patient's care team. This means that the patient is taken as having given their implied consent to relevant information being shared with the social worker for the purpose of their care. Only the NHS and Social Care are required to apply these principles and to nominate a senior person to act as a Caldicott Guardian responsible for safeguarding the confidentiality of patient information.

Annex 3: Data Request Form in relation to xxx service / project

In requesting information and signing this request you are agreeing to comply with the principles of the Data Protection Act 1998. The Data Protection Act is not a barrier to sharing information, but provides a framework to ensure that personal information is shared appropriately and securely. All requests for information / data will be assessed against the rules for information sharing, and against relevant legislation and guidance, and where relevant legal advice will be sought before a decision is made to share.

Name of requester: ***(NB this is the person to whom the data/information will actually be sent)***	
Job Title:	
Organisation:	
Date request submitted:	
Deadline/date required: ***(NB Please be as realistic as possible or put 'to be discussed'. If you write 'asap' we will contact you anyway to discuss)***	
Tel:	
e-mail (if external): *(***Please note all information will be sent via electronic means through either GCSX or through an encrypted email, information will not be sent if it is considered insecure to do so)**	
Details of data/information required: ***(Please be as specific as possible about breakdown (e.g child/school/Borough level) and format (e.g spreadsheet map/chart etc) If spreadsheet ideally please supply a list of the headings you need or a template in Excel)***	
Frequency that data is required *(***Please specify if this is a one off request or**	

if this is a regular requirement, and note that this will be kept under review to ensure ongoing data protection compliance)	
Purpose data will be used for: ***(this will not only enable us to prioritise requests but also help us understand and***	
Confidentiality /Data Protection? ***(Is the information likely to lead to anyone being identifiable? Where will it be stored once it is sent to you?)***	
Any additional information? ***(e.g is this for an FOI request? Is it a statutory requirement? Is the request a one-off or a regular requirement?)***	

Please submit your data request to:

Xxxxxxxx

Email address:

Annex 4: Useful Information Links

HM Government: Information Sharing: Advice for Practitioners providing safeguarding services to children, young people, parents and carers.	**https://www.gov.uk/government/publications/safeguarding-practitioners-information-sharing-advice**
Information Commissioners Office (ICO)	**https://ico.org.uk/**
NHS: Inter-agency information sharing protocol	**http://www.this.nhs.uk/fileadmin/IG/interagency-information-sharing-protocol.pdf**

Royal Berkshire NHS
NHS Foundation Trust

Female Genital Mutilation (circumcision) guideline (GL837)

Approval

Approval Group	Job Title, Chair of Committee	Date
Maternity & Children's Services Clinical Governance Committee	Chair, Maternity Clinical Governance Committee	13th November 2015

Change History

Version	Date	Author, job title	Reason
1.0	2004	Jill Ablett (Consultant Obstetrician), Marianne Flynn (Midwife)	Trust requirement
2.0	Oct 2007	Jill Ablett (Consultant Obstetrician)	Reviewed
3.0	Nov 2010	Jill Ablett (Consultant Obstetrician)	Reviewed
4.0	Dec 2012	Jill Ablett (Consultant Obstetrician)	Reviewed
5.0	February 2014	D Parris, Specialist Midwife for Domestic Abuse & Social Inclusion	Change to process and documentation required
6.0	Oct 2014	Jill Ablett (Consultant Obstetrician), Leila Rushamba (SAS Obstetrics & Gynaecology)	Reviewed in line with National guidance
6.1	Oct 2015	Leila Rushamba (SAS Obstetrics & Gynaecology)	Reviewed in line with new National guidance and Legislation

***Overview**: Female genital mutilation can have profound effects on childbirth. Sensitive management is essential.*

What is Female Genital Mutilation?

Female Genital Mutilation, (FGM), is the intentional alteration or injury to the female genital organs for non-medical reasons. This can be divided into four different types;

Type 1 – Removal of all or part of the clitoris (a small, sensitive and erectile part of the female genitals), sometimes removing the skin fold around the clitoris

Type 2 – Removal of the clitoris with all or part of the inner labia (lips), with or without cutting of the outer labia of the female genitals. .

Type 3 – (Infibulation) Narrowing of the vaginal opening through the creation of a covering seal by cutting and repositioning the inner and outer labia with or without removal of the clitoris

Type 4 – all other harmful procedures for non- medical reasons, including pricking, piercing, incising, scraping and cauterising the genital area.

Law in the UK

1. FGM is illegal unless it is a surgical operation on a girl or woman irrespective of her age:
    a. which is necessary for her physical or mental health; or
    b. she is in any stage of labour, or has just given birth, for purposes connected with the labour or birth.
2. It is illegal to arrange, or assist in arranging, for a UK national or UK resident to be taken overseas for the purpose of FGM.
3. It is an offence for those with parental responsibility to fail to protect a girl from the risk of FGM.

Antenatal care

Legal responsibility of the health professional once a woman with FGM is identified:

1. Mandatory Data Recording

- FGM and FGM type (if known or genital examination was performed) must be clearly documented in the medical records.
- Genital piercings should be classified as type 4 FGM in accordance with the WHO FGM classification.

- Use the FGM recording tool (Appendix 1) to record further details in accordance with the HSCIC FGM Enhanced Dataset. This information will be used by the reporting lead to report to the Department of Health.
- Explain to the woman that her personal data will be transmitted to the HSCIC for the purpose of FGM prevalence monitoring and that the data will be anonymised at the time of publication. Explicit patient consent is not required however FGM patient information leaflet MUST be given.

- If a patient raises an objection at time of discussion, the responsible clinician must inform the FGM team. This must be noted on the FGM recording tool.

- If the objection is not raised at this point, and the patient's information is submitted, the patient must be advised to contact HSCIC to raise an objection at the following website:

http://www.hscic.gov.uk/media/14700/Preventing-the-use-of-yourinformation-for-health-andor-social-care-purposes-other-than-directcare/pdf/Preventing_Use_of_Your_Information_Form.pdf

This will automatically remove her information from the dataset.

NB: Reporting to the Department of Health is mandatory with each encounter not only at first attendance.

2. Mandatory Reporting Duty

- If the woman is under 18, urgent referral to the police as soon as possible after a case is discovered. The best practice is to reports by the close of the next working day. A maximum timeframe of one month from when the discovery is made applies in cases where further advice from safeguarding team is required.
- Report by **calling 101**, the single non-emergency number. Explain that you are making a report under the FGM mandatory reporting duty
- The individual professional who becomes aware of the case MUST make the report; the responsibility CANNOT be transferred. The only exception to this is if you know that another individual from your profession has already made a report; there is no requirement to make a second.
- If the unborn child, or any other child in the family, is considered to be at risk of FGM then reporting to social services or the police must occur.

3. Refer to Miss Ablett ANC for review as may need booking for consultant care, FGM leaflet to be given at booking. If seen in different clinic please inform member of the FGM team or Miss Ablett's secretary for data collection locally and nationally.

- If the woman has achieved successful vaginal deliveries prior to this referral, she may not need consultant clinic review and can be contacted by Stephanie Dickens, Specialist Midwife to discuss issues.
- If primiparous - assess the extent of FGM (appendix 2) and document in the notes. If able to visualise the urethra, defibulation (reversal) is not required. If the FGM is more extensive than this, elective defibulation should be offered and with consent, be performed within the second trimester of pregnancy.
- If Type 2 or 3 manage as high obstetric risk (increased risk of haemorrhage, perineal trauma and caesarean section.
- Support and counselling must be provided concerning the law in this country / the effects of FGM within pregnancy and childbirth / health consequences of FGM / the woman's future after defibulation has been performed / child protection issues. Discuss and clearly document agreed plan of care in the green page.
- Offer screening for hepatitis C in addition to routine screening for hepatitis B, HIV and syphilis

4. Safeguarding

- It is the responsibility of the attending clinician to report to the police and/or social services (see above). All women should be referred to the Reading Multi Agency Safeguarding Hub or Children's Social Care Services in West Berkshire and Wokingham for further assessment regarding child protection. Please reassure the woman not to be alarmed by this.
- FGM safeguarding risk assessment form (appendix 3) must be completed at the clinic by the assessor or during telephone conversation by the midwife. A copy of this form together with Child protection referral form must be sent by secure fax or email to the local children's social care services.
- All women should be referred to Poppy team and Child protection midwife
- Letter to GP copied to Health visitor.
- Provide details about of NSPCC helpline, Health passport and support groups

Copies of Health passport can be obtained here:

https://www.gov.uk/government/publications/statement-opposing-female-genital-mutilation

- Ensure all women have FGM information leaflet

.

Intrapartum care

- If defibulation has been performed before or during pregnancy, treat as normal.

- If the woman remains infibulated, offer reversal early in the labour to aid vaginal examinations and catheterisation. This could be carried out by an appropriately trained midwife or registrar.
- If the woman prefers reversal in the 2nd stage of labour, perform as the fetal head distends the vulva.
- For defibulation, draw up 5-10mls of 1% Lidocaine using a syringe and orange needle and inject along the line of the fused labia. Once the Lidocaine is effective, place your fingers under the skin of the fused labia for guidance and use straight scissors to perform an anterior midline episiotomy (cut upwards), stopping the incision once the urethra is exposed. Use gauze to soak up blood and apply pressure. (An RML episiotomy does not need to be routinely performed).
- By British law, it is illegal to re-infibulate the woman. Thus, if the labial edges are bleeding, they may need suturing, but the edges should not be sutured together (re-infibulation). Any suturing performed must not impede future intercourse and childbirth and the urethra must be exposed.

Postnatal care

- Perineal care as normal, stressing the importance of personal hygiene to aid healing.
- Continued support and counselling of the effects of FGM, the physiological and psychological changes from defibulation and the future of the woman and her family.
- Effective communication between all health professionals in being aware of any child at risk of FGM.
- If identified postnatally – See above – legal responsibility of health professionals. Notify the designated child protection midwife or other member of the FGM team.
- **<u>If the sex of the neonate is female or has female sibling</u>**:
    - Fill in the FGM assessment form, If not filled during antenatal follow up.
    - Refer to Child Protection midwife for referral to Multi Agency Safeguarding Hub regardless of type of FGM or history of defibulation.
    - Enter FGM onto CMIS
    - Document maternal history of FGM in the personal child health record (‘Red Book’) prior to postnatal discharge
    - Share information in postnatal booklet SBAR tool
    - Provide details about of NSPCC helpline, Health passport and support groups

- Document FGM on discharge summary to HV and GP in postnatal booklet, state referral for Child protection.

See Child Protection Procedures for Berkshire Local Safeguarding Children Boards (http://berks.proceduresonline.com/index.htm)

References

1. House of Commons (2003) Female Genital Mutilation Bill: A Bill to restate and amend the law relating to female genital mutilation; and for connected purposes. 11th Dec: House of Commons: London
2. The Children's act (1989) section 47 (1).
3. Ministry of Justice, Home Office. Serious Crime Act 2015.
4. HM Government, Multi-Agency Practice Guidelines: Female genital Mutilation, 2014 Ch 6. Pg 32-34.
5. Royal College of Obstetricians and Gynaecologists (2015) Green-top Guideline No. 53 – Female Genital Mutilation and its Management
6. Royal College of Midwives (2011) Female Genital Mutilation, Guidance for Midwives.
7. 'Female Genital Mutilation Enhanced Dataset – Information Governance Statement', http://www.hscic.gov.uk/media/18125/FGM-Enhanced-Dataset-IGStatement/pdf/FGM_Enhanced_Dataset_IG_Statement.pdf
8. FGM Prevention Programme-DoH - Understanding the FGM Enhanced dataset – updated guidance and clarification to support implementation. Sept. 2015

   FGM Prevention Programme: requirement for NHS staff (PDF, 319kb)
9. DH Safeguarding against FGM Guidance for professionals. 2015

   https://www.gov.uk/government/publications/safeguarding-women-and-girls-at-riskof-fgm

Author/s: Marianne Flynn (Midwife), Jill Ablett (Consultant Obstetrician) 2004

Reviewed: October 2007 (Jill Ablett), November 2010, December 2012, February 2014, October 2014 (Leila Rushamba, Catherine Hiskett and Jill Ablett), October 2015 Leila Rushamba (SAS Obs & Gynae)

Review: November 2017

Author:	Leila Rushamba	Date:	November 2015
Job Title:	SAS Obstetrics and gynaecology	Review Date:	November 2017
Policy Lead:	Group Director Urgent Care	Version:	6.1 ratified 13th Nov 2015 Mat CG mtg
Location:	Policy hub/ Clinical/ Maternity / Medical conditions & complications / GL837		

FGM RECORDING TOOL

PATIENT DETAILS

(place sticker with full address please)

Date……

Country of birth			
Country of Origin & Region			
GP (Practice name)			
Department where patient was seen			
Referred from			
Is she Pregnant? Yes No EDD:……..	If yes, referral to Miss Ablett ANC	Yes	No
Is she under 18 years old? Yes No	If yes, referral to police	Yes	No
Any daughter/granddaughter under 18? Yes NO	If yes, Referral to Children social services (follow child protection procedures)	Yes	No

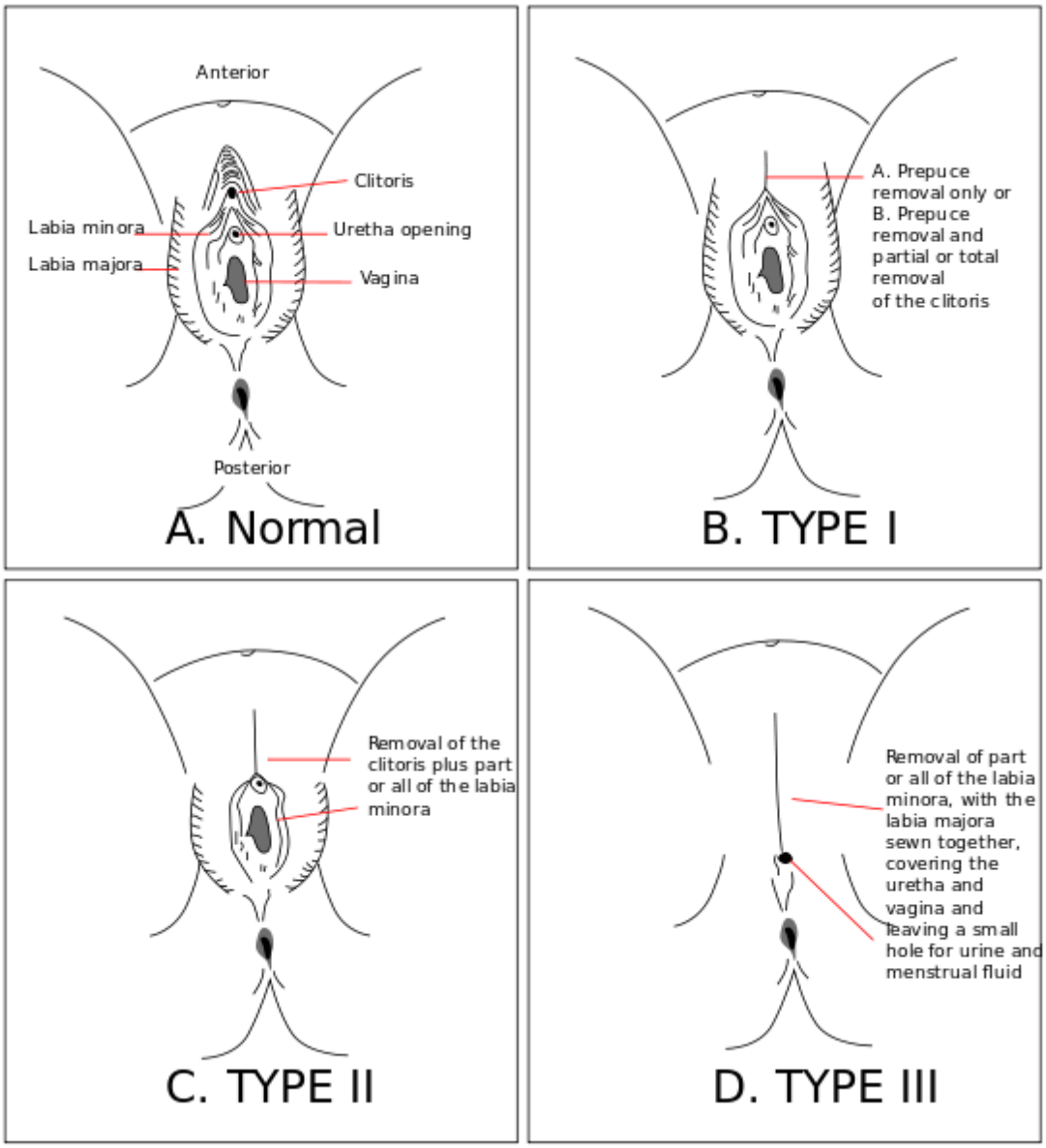
FGM Information

How was FGM identified		Self reported	
		During examination	
Type of FGM if known			
Age range when FGM was performed			
Country were FGM was undertaken			
Any other family members with FGM (list)			
Any Physical or Mental effect?		Yes	No
Advice given	Health implications of FGM?	Yes	No
	FGM specialist clinic	Yes	No
	Support groups	Yes	No
	Illegalities of FGM in the UK	Yes	No
	NSPCC helpline	Yes	No
	Child line	Yes	No
	Health Passport	Yes	No
Informed of the FGM enhanced dataset		Yes	No
Any objection to FGM enhanced dataset		Yes	No
Letter to GP		Yes	No
FGM PIL given		Yes	No

FGM team Informed : Yes Name of the FGM team: ..... Date:…..

Appendix 2 – Type classification of FGM

back to top



Appendix 3: Pregnant woman

(This is to help you make a decision as to whether the unborn child (or other female children in the family) are at risk of FGM or whether the woman herself is at risk of further harm in relation to her FGM).

Completed by:.....

Date:.....

Initial / on-going assessment *(please circle)*

Patient's details

Indicator	***Yes***	***No***	***Details***
CONSIDER RISK			
Woman comes from a community known to practice FGM			
Woman has undergone FGM herself			
Husband/partner comes from a community known to practice FGM			
A female family elder is involved/will be involved in care of children/unborn child or is influential in the family			
Woman/family has limited integration in UK community			
Woman and/or husband/partner have limited/ no understanding of harm of FGM or UK law			
Woman's nieces of siblings and/or in-laws have undergone FGM			
Woman has failed to attend follow-up appointment with an FGM clinic/FGM related appointment.			
Woman's husband/partner/other family member are very dominant in the family and have not been present during consultations with the woman			
Woman is reluctant to undergo genital examination			
SIGNIFICANT OR IMMEDIATE RISK			
Woman already has daughters have undergone FGM			
Woman requesting re-infibulation following childbirth			
Woman is considered to be a vulnerable adult and therefore issues of mental capacity and consent should be considered if she is found to have FGM			
Woman says that FGM is integral to cultural or religious identity			
Family are already known to social care services – if known, and you have identified FGM within a family, you must share this information with social services			

ACTION: *If the risk of harm is **imminent,** contact* Social Services/CAIT team/ Police - 999/MASH ***URGENTLY***.

Appendix 4 – Decision making & action flowchart for Maternity Staff

Royal Berkshire NHS
NHS Foundation Trust

Decision Making and Action Flowchart for Maternity Staff when the risk of FGM is identified

(place in front of buff on blue paper notes tick when action has been completed)

ANTENATAL

Referral made to specialist Consultant Jill Ablett

- ❑ **Refer to Reading Multi Agency Safeguarding Hub(MASH) or Childrens Social Care Services in West Berkshire and Wokingham**
- ❑ Refer to poppy team and Child protection midwife

- ❑ Document consultant plan on cons care green sheet.
- ❑ Fill in FGM assessment form
- ❑ Liaison letter to GP
- ❑ Copy to Child Protection midwife
- ❑ Inform named health visitor
- ❑ Provide information about health consequences and the UK law
- ❑ Give details of NSPCC helpline & support groups
- ❑ Discuss services for any psychological needs
- ❑ Give RBH FGM leaflet

INTRAPARTUM

Read and discuss with women Consultants plan of care in labour documented on green paper at front of buff notes

POSTNATAL

Sex of neonate

Male

- ❑ No further action required

Female

- ❑ Enter FGM status of mother onto CMIS

- ❑ **Refer to MASH or Local Childrens Social Care Services in West Berkshire and Workinham.**
- ❑ Refer to poppy team and CP midwife
- ❑ Enter FGM onto CMIS
- ❑ Share information in postnatal booklet SBAR tool
- ❑ Document FGM on discharge summary to HV and GP in postnatal booklet

J Ablett, L Rushamba, C Hiskett (Oct 2014)

Page 1 of 1

Job Title:	SAS Obstetrics and gynaecology	Review Date:	November 2017
Policy Lead:	Group Director Urgent Care	Version:	6.1 ratified 13th Nov 2015 Mat CG mtg
Location:	Policy hub/ Clinical/ Maternity / Medical conditions & complications / GL837		

Royal Berkshire NHS
NHS Foundation Trust

Guideline for the Management Female Genital Mutilation outside the Maternity Department
GL993

Approval and Authorisation

Approved by	Job Title	Date
Policy Approval Group	Chair, Policy Approval Group	January 2016

Change History

Version	Date	Author	Reason
Version 1.0	November 2015	Ann Gordon, Leila Rushamba	New Guidance.

Author:	Dr Gordon,Dr Leila Rushamba	Date:	January 2016
Job Title:	Named Doctor Child Protection,Speciality Dr in Obstetrics and Gynaecology	Review Date:	January 2018
Policy Lead:	Director of Nursing	Version:	Version 1.0
Location:	Corporate Governance shared drive – GL993		

Contents

1.0 Purpose ..... Page 3

2.0 The Function of the Policy ..... Page 3

3.0 Female Genital (FGM) Mutilation and UK Legislation ..... Page 4

4.0 Background to Female Genital Mutilation ..... Page 5

5.0 Types of FGM ..... Page 6

6.0 General Principles ..... Page 7

7.0 Identifying Women and Girls at Risk ..... Page 7

8.0 Notifying Cases of FGM ..... Page 8

9.0 Where to Find Things ..... Page 9

10.0 Actions to be taken in Different Scenarios ..... Page 11

11.0 References ..... Page 16

Appendix 1 Countries that Practice FGM ..... Page 17

Appendix 2 Traditional and Local Terms for FGM ..... Page 18

Appendix 3 Types of FGM ..... Page 19

Appendix 4 RBH Data Collection Tool ..... Page 20

Appendix 5 Pregnant Woman Risk Assessment ..... Page 21

Appendix 6 Non-Pregnant Woman Risk Assessment ..... Page 22

Appendix 7 Child /Young Adult at Risk of FGM Risk Assessment ..... Page 23

Appendix 8 Child/Young Adult has had FGM Risk Assessment ..... Page 25

1.0 Purpose

The purpose of this document is to provide advice on how to manage cases where Female Genital Mutilation is identified. It is applicable to all departments except Maternity who currently have their own guideline.

2.0 The Function of Policy

The function of the policy is to ensure that all departments manage cases of Female Genital Mutilation appropriately ensuring that the needs of the woman, any child protection issues and all legal requirements are addressed.

3.0 Female Genital Mutilation (FGM) and UK Legislation

FGM is illegal in the UK. Under the Female Genital mutilation Act 2003 and The Serious Crime Act 2015 it is an offence to

- Perform FGM in England, Wales or Northern Ireland.
- Assist a girl to carry out FGM on herself in England Wales or Northern Ireland
- UK nationals or ANY UK residents to carry out aid or abet counsel or procure the carrying out of FGM abroad. (this is intended to cover taking a girl abroad to be subjected to FGM).
- There is the offence of failing to protect a girl from FGM.
- Any person found guilty of an offence under the FGM Act 2003 is liable to a maximum penalty of 14 years imprisonment or a fine or both.

In addition FGM is CHILD ABUSE and should be dealt with as such under the Children Act 1989 and Child Protection Procedures for Berkshire Local Safeguarding Children Boards (http:/berks.proceduresonline.com/index.htm). The SAFETY OF THE CHILD IS PARAMOUNT and all professionals have a duty to SAFEGUARD girls at risk.

It is mandatory for the Royal Berkshire NHS Trust (RBHNHST) to submit data to the Department of Health FGM Enhanced Dataset hosted by HSCIC.

It is mandatory for health professionals to report all cases of FGM in those **under 18** to the Police – this should be done as soon as possible normally by the end of the next working day. The number to phone is 101 the police non-emergency crime number. It must be reported by the person identifying/ receiving the disclosure of FGM and **cannot be delegated**. Please discuss any cases with the Safeguarding Team.

4.0 Background to Female Genital Mutilation

Female Genital Mutilation (FGM) comprises all procedures involving partial or complete removal of the external female genitalia or other injury to the female genital organs for non medical reasons. It has no health benefits and harms girls and women in many ways. It involves removing and damaging healthy and normal female genital tissue, and hence interferes with the natural function of girls and women's bodies. The practice causes severe pain and has several immediate and long term consequences, including difficulties in child birth and also dangers to the child (see Appendix 1). **IT IS A FORM OF CHILD ABUSE.**

FGM is a deeply rooted tradition, widely practised mainly among specific ethnic populations in Africa and parts of the Middle East and Asia but has also been documented in communities in Iraq, Israel, Oman, the UAE, the Occupied Palestinian Territories, India, Indonesia, Malaysia and Pakistan. (**Appendix 1**).

FGM may be carried out in the newborn period, during childhood, adolescence, just before marriage or during first pregnancy. However it is thought that most cases occur between 5 and 8 years old and so girls in this age group are at higher risk.

FGM is often seen as a natural and beneficial practice carried out by a loving family who believe that it is in the girl's or woman's best interests and this may inhibit a girl in coming forward to discuss concerns or talk openly about FGM. It may be seen as a requirement for marriage in some communities and part of their cultural identity. Religion is sometimes given as a justification for FGM however FGM predates Christianity, Islam and Judaism and the Bible, Koran, Torah and other religious texts do not advocate or justify FGM. It is a form child abuse and violence against women and serves as a complex form of social control of women's sexual and reproductive rights.

FGM carries many short and long term health risks for girls and women; pain, bleeding, infection, urinary problems, chronic pelvic infections and pain, menstrual difficulties, pain during sex and loss of pleasurable sensation, infertility, complications during pregnancy and delivery of the baby and psychological and mental health issues.

FGM may be known by many different terms, including cutting, female genital cutting, circumcision, initiation. The names FGM or 'cut' are increasingly used at community level but may not always be understood by individuals in practising communities (**Appendix 2).**

5.0 Types of FGM

Four types of FGM are recognised and some in particular Type 4 may be difficult to recognise unless the practitioner is an expert in this area (**Appendix 3**)

- Type 1 – Clitoridectomy: partial or total removal of the clitoris or rarely the prepuce.

- Type 2 - Excision: partial or complete removal of the clitoris and labia minora with or without the removal of the labia majora.

- Type 3 – Infibulation: narrowing of the vaginal opening through the creation of a seal.

- Type 4 - Other: all other harmful procedures to the female genitalia for non-medical purposes, eg pricking, piercing, incising, scraping or cauterising. These cases should be reported to the FGM Enhanced data base as Type 4 FGM as per WHO definition.

6.0 General Principles

- FGM is child abuse and professionals have a duty to safeguard girls at risk. It should be seen as no different from any other kind of abuse and referred as such.
- Get accurate information about the urgency of the situation.
- Adult patients where there is **no risk** to female children have a right to confidentiality and no referrals should be made without their consent.
- The RBH must record data for the 'FGM Enhanced Data set' and we must inform the woman of this and give her the information leaflet 'More Information on FGM 2015'
- Talking about FGM should be non judgemental but clear on the illegality and health risks of the act but not blaming the girl/woman.
- Every effort should be made to provide a female professional to discuss FGM if a girl or woman would prefer this.
- Interpreters should not be a family member or someone known to the individual and should not be someone with influence in their community.
- Professionals should deal with FGM in a professional manner and avoid expressing horror or suggesting that an individual is 'abnormal' as a result of having undergone the procedure.
- Document all information clearly and contemporaneously.

7.0 Factors for Identifying Women and Girls at Risk

There are a range of potential indicators that suggest a child or young person may be at risk of FGM, which individually may not indicate risk but if there are two or more indicators are present this could signal a risk to the child or young person. It is believed that FGM happens to British girls in the UK as well as overseas.

Indicators of heightened risk

- The girl comes from a community where FGM is known to be practised.
- Any girl born to a woman who has been subjected to FGM also any other female children in the extended family.
- Any girl who has a sister who has already undergone FGM must be considered to be at risk of FGM also any female children in the extended family.
- Any girl who is withdrawn from PHSE at school may be at risk as a result of her parents wishing to keep her uninformed of her body and rights.

Indicators of Imminent Risk

- Families may practise FGM when an elderly female relative from the country of origin is visiting.
- A girl is heard talking about it.
- A girls is heard talking about a special procedure/attend a special occasion to become a woman
- A girl may request help.
- A girl is taken out of the country by a relative or parents for a prolonged period.
- A girl may talk of a long holiday to a country where FGM is prevalent.
- Parents seek to with draw their daughter from learning about FGM.

Indications that FGM may have already taken place

- Difficulty in walking/sitting/standing**.**
- A girl may spend longer in the toilet.
- A girl may have menstrual/urinary problems or urinary tract infections.
- There may be prolonged absences from school or college.
- A girl or woman may be particularly reluctant to undergo normal medical examination.
- A girl of woman may confide in a professional.

8.0 Notifying Cases of FGM

- The Royal Berkshire Hospital has a duty to notify all cases of FGM to the Health and Social Care Information Centre (HSCIC) to provide input to the Enhanced Data Set on FGM. This is mandatory.

- Women should be informed that their information will be submitted to the HSCIC and given the information that they can apply to have their data removed and how to go about doing this. The purpose of this data collection is to improve the NHS response to FGM and help in commissioning services to support women who have undergone the procedure. No personal details will be passed on to the police or social care from this and will not trigger individual criminal investigations.

- **All women MUST be given the patient information leaflet 'More Information about FGM' (2015) which gives full information about the data collection and how to have their data removed. Down load from** http://www.nhs.uk/NHSEngland/AboutNHSservices/sexual-health-services/Documents/2903740%20DH%20FGM%20Leaflet%20Acessible%20-%20English.pdf **.Giving the leaflet makes the RBH compliant with 'fair processing' and Data Protection. Hard copies are available in gynaecology emergency clinic, Paediatric ED and from the Safeguarding team.**

- All cases are referred by either Dr Leila Rushamba (obstetric and gynaecological cases) or Named Nurse for Child Protection Jo Horsburgh (all other cases). They must be informed of patient's details of all cases identified in any areas.

- The attending clinician is responsible for collecting the necessary information for the Enhanced Data Set. The Trust FGM recording tool (**appendix 4**) is available on the Trust FGM website and covers all required information.

- A girl/woman will only undergo a clinical examination if it is medically necessary for her care. **There is no place for examining a girl/woman simply to confirm FGM or its type for reporting purposes**.

- Cases should be reported **every time** contact is made with RBH not just on first presentation. It includes contacts which are not due to FGM related problems.

Contacts

- Dr Leila Rushamba (Speciality Doctor, Obsterics and Gynaecology) – for maternity and non pregnant gynaecology patients. Leila.Rushamba@royalberkshire.nhs.uk / bleep 612

- Joanne Horsburgh (Named Nurse for Child Protection) – for all other women and girls identified in other departments. Joanne.Horsburgh@royalberkshire.nhs.uk and 0118 322 8046

9.0 Where to find things

Document/Form	Found at
Information leaflet on FGM and enhanced data set 'More Information about FGM' (2015)	. http://www.nhs.uk/NHSEngland/AboutNHSservices/sexual-health-services/Documents/2903740%20DH%20FGM%20Leaflet%20Acessible%20-%20English.pdf
RBH FGM recording tool	RBH FGM website
Risk Assessment Form Non Pregnant Women	RBH FGM website
Risk Assessment Form Pregnant Women	RBH FGM website
Risk Assessment Forms Child Young Adult under 18	RBH FGM website
Female Genital Mutilation (circumcision) Guideline (GL837) for use in the Obsteric Department.	RBH Policy Hub
Generic Referral form to Children's Social Care	RBH Intranet Clinical Care under Child Protection page.
Multiple useful/interesting documents relating to FGM	RBH FGM website.

The RBH FGM website is found at RBH Intranet - Clinical Care - Child Protection
FGM is highlighted in a green bar which links through to the website.

http://nww.intranet.royalberkshire.nhs.uk/clinical_care/s/safeguarding.aspx

Useful Names and Numbers

Joanne Horsburgh	-	Named Nurse for Child Protection	0118 3228046
Elizabeth Porter	-	Lead Nurse Adult Safeguarding	01183227482
Catherine Hiskett	-	Named Midwife for child protection	07768752529
Jessica Higson	-	Senior Nurse for Children and Safeguarding	01183226998
Ann Gordon	-	Named Dr for Child Protection via switchboard mobile or page	

Social Care

Reading MASH	01189 373 641
West Berkshire CAAS	01635 503 090
Wokingham Triage	01189 088 002
Bracknell Forest Access and Assessment	01344 352 000
Emergency Duty Team (out of hours referrals)	01344786543

Police

Non-emergency referral line 101 (to refer new cases of FGM in girls under 18)

Support Service

NSPCC FGM helpline: 0800 028 3550 or fgmhelp@nspcc.org.uk

9.0 Actions to be taken in different scenarios

Pregnant Woman with FGM

Assess are there symptoms related to FGM which require urgent medical intervention?

YES carry it out/refer to Gynaecology/Obstetrics registrar as appropriate (bleep 602/555)

NO Is she already booked with the Obstetric team and known to the FGM Obstetric team?

YES - then further assessment and management will be in hand, check that she has an appointment and knows where to go. Collect information necessary for the dataset. Inform Dr Rushamba of her attendance for notification to Data Set.

NO - Refer to Miss Ablett in Antenatal Clinic where the FGM team (midwife or obstetrician) will make an individual risk assessment. Make the referral by ringing the Maternity Co-ordinator on delivery suite.
Any child considered at risk (unborn or other) will then be referred to social care. Ensure that the woman knows that she must attend antenatal clinic. Make sure that any need for an interpreter is indicated at the time of referral.

Inform the woman that FGM is illegal in this country and that it cannot be carried out on any female children that she may have.

Inform her that social care will be involved in assessing any risk to any female children already in the family and any future children if they are female.

Inform her that the RBH must notify her details to the FGM Enhanced Data set and give her the leaflet ‘More Information on FGM’ and ‘RBH – Maternity - FGM Patient information leaflet’ from intranet.

Collect Data for Data set and inform Dr Rushamba of her attendance for notification to data set.

Carry out risk assessment (**appendix 5**) and refer to social care.

Sign Post to Support Groups if wanted
NSPCC FGM Helpline (National) 0800 028 3550

Document all discussions, actions and referrals clearly in the notes. Inform the GP.

There is a Female Genital Mutilation (circumcision) Guideline (GL837) under Maternity on the RBH Hub to more fully cover this.

Action - Non Pregnant Female over 18 with FGM

Asess are there symptoms related to FGM or a gynaecological condition which require urgent intervention.

YES - carry it out/refer to Gynaecology registrar on call as appropriate (bleep 602).

If treatment requires admission then the actions below become the responsibility of the gynaecology consultant who may delegate as appropriate. If no admission is required the actions remain the responsibility of the referring team.

NO – Assess Family Circumstances

Are there children and if so how many, how old and what sex are they?

CHILDREN AT HOME
• Assess the risk of FGM in female children using the risk assessment tool. **(Appendix 6)**
• If risk is urgent involve the Named Doctor and Nurse urgently (in their absence the paediatric consultant on call) and make referral urgently to social care.
• Discuss/refer to social care as appropriate in other cases.
• Inform the woman of the involvement of social care and what they plan.

FOR ALL WOMEN
• Explain procedure is illegal in the UK and give information leaflet.
• If does not require immediate intervention, **respect patient wishes** / if wishes clinic appointment to discuss non urgent symptoms GP to refer to Gynaecology Outpatients for the attention of Dr. Leila Rushamba who will see and assess whether treatment locally or onward referral to a centre specialising in FGM is more appropriate.
• Sign Post to Support groups • NSPCC FGM Help Line 0800 328 0550
• Referral to Mental Health Team if needed Inpatient – PMS • Outpatient CPE on 0300 365 0300
• Inform woman that RBH must notify her details to national data set and give her the information leaflet. Collect Data for Data set and inform Named Nurse Jo Horsburgh for notification to data set.
• Document that she has had FGM in the medical notes.
• Document referrals made and information given. Inform GP by sending copy of assessment tool.

During working hours the Named Nurse/Dr may be able to come to assist in the assessment of risk and are available for advice.

Action - girl 16 or under identified with FGM (or Discloses FGM) while in the RBH

Assess are there symptoms related to FGM which require urgent medical intervention?

Yes – refer to the paediatric consultant on call (paediatric registrar if unavailable) gynaecology registrar (bleep 602) who will involve the gynaecology consultant. and to the paediatric consultant on call.

No - Refer to the paediatric consultant on call (as per Child Protection) who may wish to discuss with the Named Professionals during working hours.

Paediatric consultant to see parent and child together to obtain history and family details (as per child protection medical).

If the child has no current symptoms and has made a disclosure then there is no need to examine the genitalia as a forensic examination will be organised as part of the Child Protection investigation.

If the referral is made based on FGM being identified by another health professional and there is no disclosure from the child then the paediatric consultant needs to make a professional decision over whether to examine the genitalia either alone or with a colleague to rule out other medical conditions.
If an examination is to be carried out, arrange for an appropriate chaperone to attend.

Inform the parent/s and child that FGM is illegal in the UK and is managed as child abuse. You have a duty to refer any case to Social care and the police.

Refer to Children's Social Care as a **child protection referral**. Social care should then be able to organise an appropriate medical assessment at an appropriate time. This will be done via the Sexual Abuse Referral Centre (SARC).
Refer the case to the police using the non emergency number 101.

Inform child and parents of the referral to social care and the police.

Collect information for the Data Set and inform Named Nurse Jo Horsburgh of the case for submission of data to the data set. Give information leaflet - More Information on FGM (2015)

Consider referral to CAMHS/Psychologist if there are signs of emotional trauma.

Sign Post Parent and child to support groups
NSPCC 0800 028 3550 fgmhelp@nspcc.org.uk

Arrange follow up appointment to discuss any FGM related chronic health problems, and arrange referral to specialist centre for surgical reversal if required. The centre to refer to is currently under exploration. There is a NHS list of specialist centres on the FGM website.

Document all discussions, actions and referrals clearly in the notes. Inform the GP

Action - young woman 17- 18 identified with FGM or discloses FGM. (this group are defined a child for Social Care and Police)

Assess - Are there symptoms related to FGM which need urgent medical intervention?

Yes – refer to gynaecology registrar (bleep 602) who will involve the consultant.

The Gynaecology Consultant will then assume responsibility for all the actions listed below. They may wish to delegate this but ultimate responsibility for ensuring all are completed will rest with them. They may wish to discuss with the Named Professionals during working hours (or the paediatric consultant out of hours).

NO – If there are no acute symptoms related to FGM the responsible consultant will then assume responsibility for all the actions below. They may wish to delegate this but ultimate responsibility for ensuring all are completed will rest with them. They may wish to discuss with the Named Professionals during working hours (or the paediatric consultant out of hours).
The consultant or their delegate will see the young woman (with or without parent present) to obtain history, and family details. There is no need to examine the genitalia as a forensic examination will be organised as part of the Child Protection investigation.

If there aresymptoms related to FGM but no urgent intervention is required, advise the GP to refer to Gynaecology Outpatients for the attention of Dr. Leila Rushamba who will see and assess whether treatment locally or onward referral to a centre specialising in FGM is more appropriate.

If the referral is made based on FGM being identified by another health professional and there is no disclosure from the young woman then the responsible consultant needs to make a professional decision over whether to examine the woman's genitalia either alone or with a colleague to rule out other medical conditions.

If an examination is to be carried out then an appropriate chaperone should be in attendance.

Inform the young woman (parents if present) that FGM is illegal in the UK and is managed as child abuse. You have a duty to refer any case to social care and the police.

Refer to Children's Social Care as a **child protection referral**. Social care should then be able to organise an appropriate medical assessment at an appropriate time. This will be done via the SARC as there are currently no Paediatricians performing this work at the RBH.

Refer the case to the police using the non emergency number 101

Inform child and parents of the referral to social care and the police.

Collect information for the Data Set and inform Named Nurse Jo Horsburgh of the case for submission of data to the data set. Give the leaflet More Information on FGM (2015).

Consider referral to CAMHS/Psychologist if there are signs of emotional trauma.

Sign Post young woman to support groups
NSPCC 0800 028 3550 fgmhelp@nspcc.org.uk

Document that the girl has had FGM in the medical notes and document all other actions taken and referrals made. Share information with the GP.

Action - there are concerns identified at the RBH that a young person less than 18 years is at risk of FGM or has had FGM performed.

This may be an emergency if the child or young woman is about to be taken abroad for the procedure or have it performed in the UK imminently. The police and social care can use emergency protection procedures to prevent this.

Use the risk assessment tool to gather information to either support or reduce concern about risk. (**appendix 7/8**).

Discuss with Named Professionals in working hours. Discuss with Paediatric Consultant if child 16 years or less or supervising speciality consultant if young person 17-18 years and out of hours.

Discuss with girl/young woman/parents that FGM is illegal in UK and give 'More Information about FGM (2015)' leaflet.

Decide if **Significant** or **Immediate risk** requiring **urgent referral to social care** for the child's protection and **make referral if** required.

If no significant or immediate risk consider whether there is sufficient concern to merit referral or discussion with Social Care and who is best placed to do this. This is probably best done in working hours by a senior professional after discussion with the named professionals.

Sign Post girl/ young woman/parents to support group.
NSPCC 0800 028 3550 fgmhelp@nspcc.org.uk

Document all assessments, actions and discussions in the notes.

Share information of any identified risk with the Patient's GP.

10.0 References

- Female Genital Mutilation Risk and Safeguarding – Guidance for Professionals. DOH March 2015

- FGM Prevention Programme – Understanding the FGM Enhanced dataset-updated guidance and clarification to support implementation. DOH/hscic September 2015

- Mandatory Reporting of FGM A new professional duty. DOH/NHS England 2015

- Female Genital Mutilation The Facts, Home Office.

- More Information about FGM (2015) DOH

- Multi-Agency Practice Guidelines: Female Genital Mutilation, HM Government.

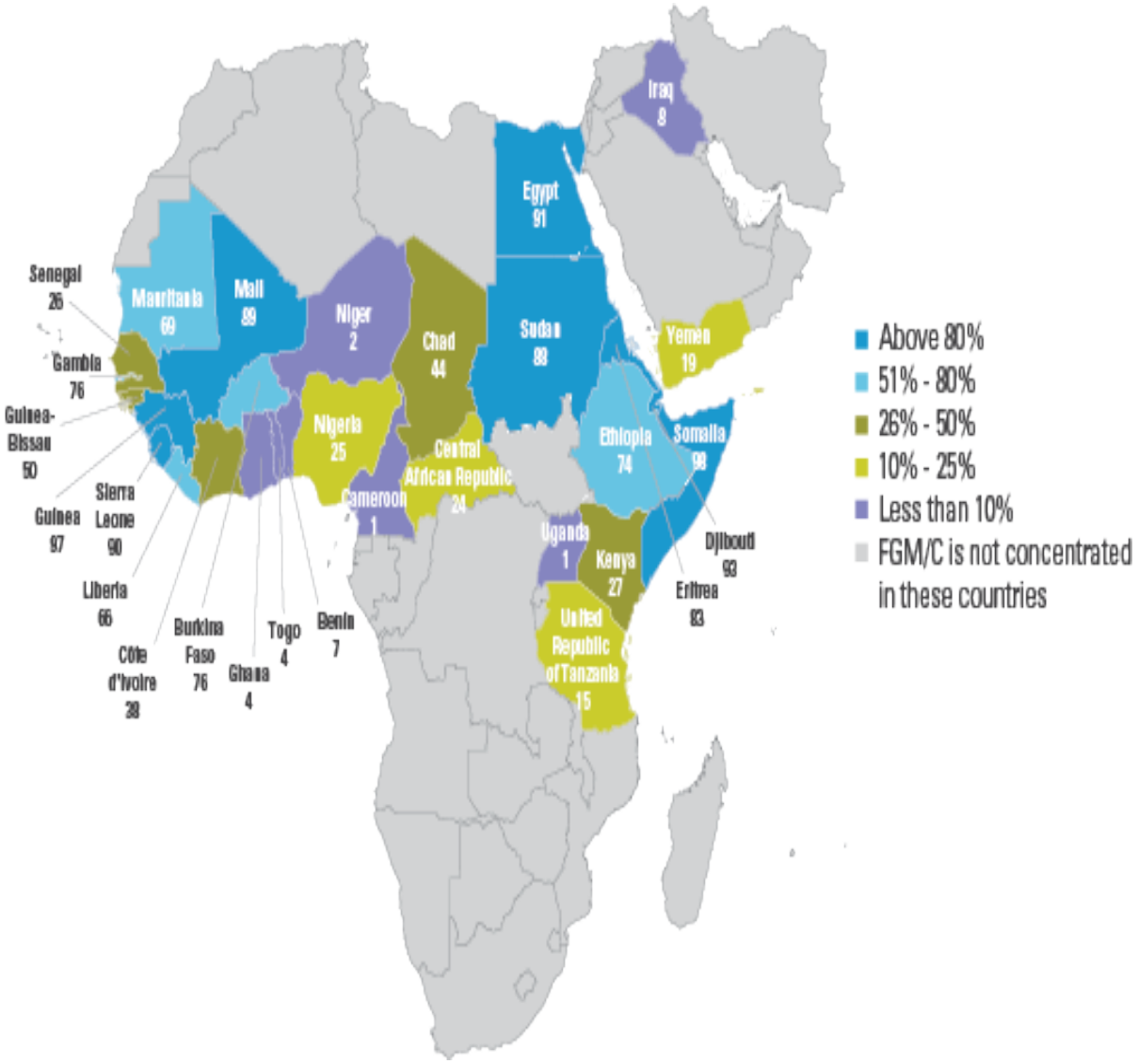
- Tackling FGM in the UK, Intercollegiate recommendations for identifying and reporting 2013.

- Working Together to Safeguard Children 2015

- Berkshire LSCB Child Protection Procedures 2.11 Female Genital Mutilation.

Most of the above are available on the RBH FGM website.
There is a RED Folder in Dr Gordon's office labelled FGM where there are hard copies for reference.

Appendix 1: Countries that practice FGM



FGM has also been documented in communities including: •Iraq •Israel •Oman •the United Arab Emirates •the Occupied Palestinian Territories •India •Indonesia •Malaysia •Pakistan

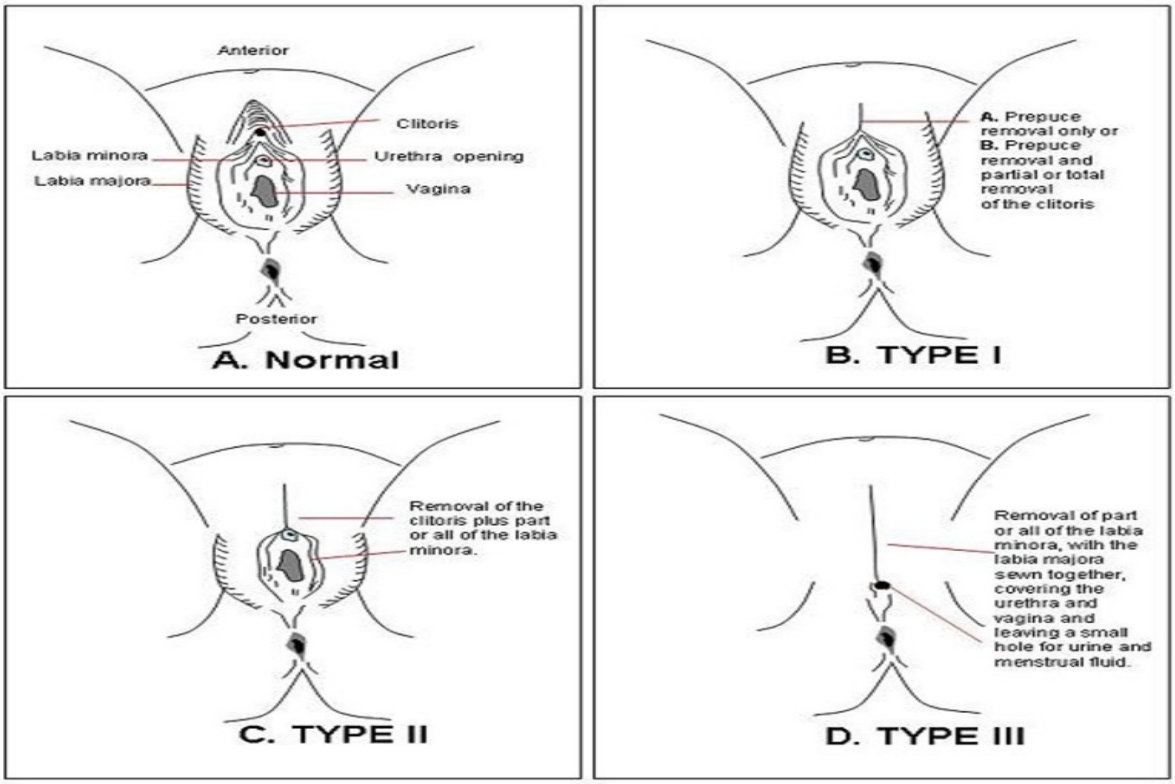
(Percentage of girls and women aged 15 to 49 years who have undergone FGM/C)

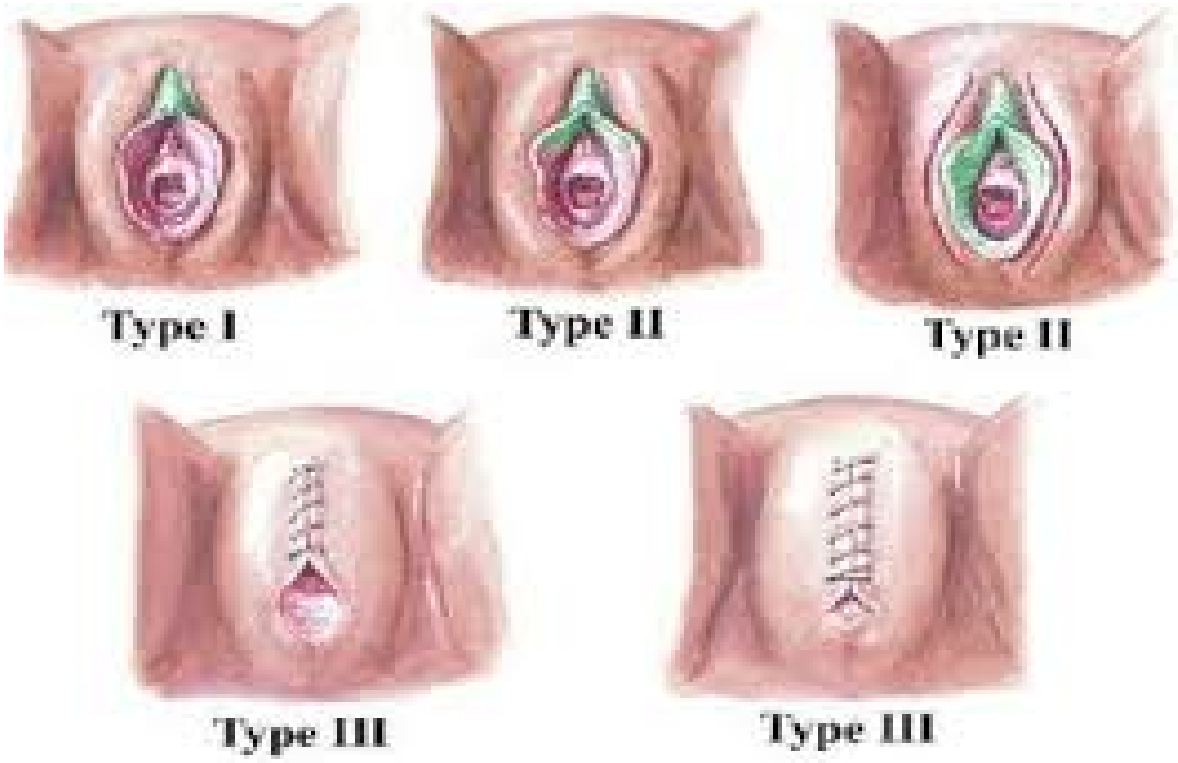
Source. http://www.data.unicef.org/child-protection/fgmc

Appendix 2: Traditional and local terms for FGM

Country	Term used for FGM	Language	Meaning
EGYPT	Thara	Arabic	Deriving from the Arabic word 'tahar' meaning to clean/purify
	Khitan	Arabic	Circumcision – used for both FGM and male circumcision
	Khifad	Arabic	Deriving from the Arabic word 'khafad' meaning to lower (rarely used in everyday language
ETHIOPIA	Megrez	Amharic	Circumcision/cutting
	Absum	Harrari	Name giving ritual
ERITREA	Mekhnishab	Tigregna	Circumcision/cutting
KENYA	Kutairi	Swahili	Circumcision – used for both FGM and male circumcision
	Kutairi wasichana	Swahili	Circumcision of girls
NIGERIA	Ibi/Ugwu	Igbo	The act of cutting – used for both FGM and male circumcision
	Sunna	Mandingo	Religious tradition/obligation – for Muslims
SIERRA LEONE	Sunna	Soussou	Religious tradition/obligation – for Muslim
	Bondo	Temenee/ Mandingo/Limba	Integral part of an initiation rite into adulthood – for non-Muslims
	Bondo/Sonde	Mendee	Integral part of an initiation rite into adulthood – for non-Muslims
SOMALIA	Gudiniin	Somali	Circumcision used for both FGM and male circumcision
	Halalays	Somali	Deriving from the Arabic word 'halal' ie. 'sanctioned' – implies purity. Used by Northern & Arabic speaking Somalis

Appendix 3 Types of FGM





Appendix 4; FGM Data Recording Tool

FGM RECORDING TOOL				
PATIENT DETAILS (place sticker with full address please) Date……				
Country of birth				
Country of Origin & Region				
GP				
Department where patient was seen				
Referred from				
Is she Pregnant? Yes No	If yes, referal to Miss Ablett ANC		Yes	No
Is she under 18 years old? Yes No	If yes, referral to police		Yes	No
Any daughter/ granddaughter under 18 ? Yes NO	If yes, Referral to Children social services (follow child protection procedures)		Yes	No
FGM Information				
How was FGM identified		Self reported		
		During examination		
Type of FGM if known				
Age range when FGM was performed				
Country were FGM was undertaken				
Any other family members with FGM (list)				
Any Physical or Mental effect?		Yes	No	
Advice given	Health implications of FGM?	Yes	No	
	FGM specialist clinic	Yes	No	
	Support groups	Yes	No	
	Illegalities of FGM in the UK	Yes	No	
	NSPCC helpline	Yes	No	
	Child line	Yes	No	
	Health Passport	Yes	No	
Informed of the FGM enhanced dataset		Yes	No	
Letter to GP		Yes	No	
More Information on FGM leaflet given.		Yes	No	

Appendix 5: Pregnant woman (This is to help the social services make a decision as to whether the unborn child (or other female children in the family) are at risk of FGM or whether the woman herself is at risk of further harm in relation to her FGM).

Patient's details

Date:..... Completed by:.....
Initial/on-going assessment

Indicator	*Yes*	*No*	*Details*
CONSIDER RISK			
Woman comes from a community known to practice FGM			
Woman has undergone FGM herself			
Husband/partner comes from a community known to practice FGM			
A female family elder is involved/will be involved in care of children/unborn child or is influential in the family			
Woman/family has limited integration in UK community			
Woman and/or husband/partner have limited/ no understanding of harm of FGM or UK law			
Woman's nieces of siblings and/or in-laws have undergone FGM			
Woman has failed to attend follow-up appointment with an FGM clinic/FGM related appointment.			
Woman's husband/partner/other family member are very dominant in the family and have not been present during consultations with the woman			
Woman is reluctant to undergo genital examination			
SIGNIFICANT OR IMMEDIATE RISK			
Woman already has daughters have undergone FGM			
Woman requesting reinfibulation following childbirth			
Woman is considered to be a vulnerable adult and therefore issues of mental capacity and consent should be considered if she is found to have FGM			
Woman says that FGM is integral to cultural or religious identity			
Family are already known to social care services – if known, and you have identified FGM within a family, you must share this information with social services			

ACTION: If unsure whether the level of risk requires referral at this point, discuss with your named/ designated safeguarding lead.
If the risk of harm is ***imminent,*** *contact* Social Services/CAIT team/ Police/MASH ***URGENTLY****.*
In all cases:– •Share information of any identified risk with the patient's GP •Document in notes •Discuss the health complications of FGM and the law in the UK

Author:	Dr Gordon,Dr Leila Rushamba	Date:	January 2016
Job Title:	Named Doctor Child Protection,Speciality Dr in Obstetrics and Gynaecology	Review Date:	January 2018
Policy Lead:	Director of Nursing	Version:	Version 1.0
Location:	Corporate Governance shared drive – GL993		

Appendix 6: Non-Pregnant woman (This is to help decide whether any female children are at risk of FGM, whether there are other children in the family for whom a risk assessment may be required or whether the woman herself is at risk of further harm in relation to her FGM).

Patient's details

Date:..... Completed by:.....

Initial/on-going assessment

Indicator	*Yes*	*No*	*Details*
CONSIDER RISK			
Woman already has daughters who have undergone FGM – who are over 18 years of age			
Husband/partner comes from a community known to practice FG			
Grandmother (maternal or paternal) is influential in family or female family elder is involved in care of children			
Woman and family have limited integration in UK community			
Woman's husband/partner/other family member may be very dominant in the family and have not been present during consultations with the woman			
Woman/family have limited/ no understanding of harm of FGM or UK law			
Woman's nieces (by sibling or in-laws) have undergone FGM Please note:– if they are under 18 years you have a professional duty of care to refer to social care			
Woman has failed to attend follow-up appointment with an FGM clinic/FGM related appointment			
Family are already known to social services – if known, and you have identified FGM within a family, you must share this information with social services			
SIGNIFICANT OR IMMEDIATE RISK			
Woman/family believe FGM is integral to cultural or religious identity			
Woman already has daughters who have undergone FGM – who are under 18 years of age			
Woman is considered to be a vulnerable adult and therefore issues of mental capacity and consent should be triggered if she is found to have FGM			

ACTION: If one or more indicators are identified, refer to Social Services/CAIT team/ Police/MASH, in accordance with your local safeguarding procedures. If unsure whether the level of risk requires referral at this point, discuss with your named/ designated safeguarding lead.

If the risk of harm is ***imminent,*** *contact* Social Services/CAIT team/ Police/MASH ***URGENTLY***

In all cases:– •Share information of any identified risk with the patient's GP •Document in notes •Discuss the health complications of FGM and the law in the UK

Author:	Dr Gordon,Dr Leila Rushamba	Date:	January 2016
Job Title:	Named Doctor Child Protection,Speciality Dr in Obstetrics and Gynaecology	Review Date:	January 2018
Policy Lead:	Director of Nursing	Version:	Version 1.0
Location:	Corporate Governance shared drive – GL993		

Appendix 7: CHILD/YOUNG ADULT (under 18 years old)

This is to help when considering whether a child is AT RISK of FGM, or whether there are other children in the family for whom a risk assessment may be required.

Patient's details

Date:..... Completed by:.....

Initial/on-going assessment

Indicator	***Yes***	***No***	***Details***
CONSIDER RISK			
Child's mother has undergone FGM			
Other female family members have had FG			
Father comes from a community known to practice FG			
A Family Elder such as Grandmother is very influential within the family and is/will be involved in the care of the girl			
Mother/Family have limited contact with people outside of her family			
Parents have poor access to information about FGM and do not know about the harmful effects of FGM or UK law			
Parents say that they or a relative will be taking the girl abroad for a prolonged period – this may not only be to a country with high prevalence, but this would more likely lead to a concern			
Girl has spoken about a long holiday to her country of origin/another country where the practice is prevalent			
Girl has attended a travel clinic or equivalent for vaccinations/anti-malarials			
FGM is referred to in conversation by the child, family or close friends of the child (see Appendix Three for traditional and local terms) – the context of the discussion will be important			
Sections missing from the Red book. Consider if the child has received immunisations, do they attend clinics etc			
Girl withdrawn from PHSE lessons or from learning about FGM - School Nurse should have conversation with child			
Girls presents symptoms that could be related to FGM – continue with questions in part 3			
Family not engaging with professionals (health, school, or other)			
Any other safeguarding alert already associated with the Always check whether family are already known to social care			

SIGNIFICANT OR IMMEDIATE RISK			
A child or sibling asks for help			
A parent or family member expresses concern that FGM may be carried out on the child			
Girl has confided in another that she is to have a 'special procedure' or to attend a 'special occasion'. Girl has talked about going away 'to become a woman' or 'to become like my mum and sister			
Girl has a sister or other female child relative who has already undergone FGM			
Family/child are already known to social services – if known, and you have identified FGM within a family, you must share this information with social services			

ACTION: If one or more indicators are identified, refer to Social Services/CAIT team/ Police/MASH, in accordance with your local safeguarding procedures. If unsure whether the level of risk requires referral at this point, discuss with your named/ designated safeguarding lead.
If the risk of harm is ***imminent,*** *contact* Social Services/CAIT team/ Police/MASH ***URGENTLY***
In all cases:– •Share information of any identified risk with the patient's GP •Document in notes •Discuss the health complications of FGM and the law in the UK

Appendix 8: CHILD/YOUNG ADULT (under 18 years old) (This is to help when considering whether a child HAS HAD FGM)

Patient's details

Date:..... Completed by:.....

Initial/on-going assessment

Indicator	***Yes***	***No***	***Details***
CONSIDER RISK			
CHILD/YOUNG ADULT (under 18 years old)			
Girl has difficulty walking, sitting or standing or looks uncomfortable			
Girl finds it hard to sit still for long periods of time, which was not a problem previously			
Girl presents to GP or A & E with frequent urine, menstrual or stomach problems			
Increased emotional and psychological needs eg withdrawal, depression, or significant change in behaviour			
Girl avoiding physical exercise or requiring to be excused from PE lessons without a GP's letter			
Girl has spoken about having been on a long holiday to her country of origin/another country where the practice is prevalent			
Girl spends a long time in the bathroom/toilet/long periods of time away from the classroom			
Girl talks about pain or discomfort between her legs			
SIGNIFICANT OR IMMEDIATE RISK			
Girl asks for help			
Girl confides in a professional that FGM has taken place			
Mother/family member discloses that female child has had FGM			
Family/child are already known to social services – if known, and you have identified FGM within a family, you must share this information with social service			

ACTION: If one or more indicators are identified, refer to Social Services/CAIT team/ Police/MASH, in accordance with your local safeguarding procedures. If unsure whether the level of risk requires referral at this point, discuss with your named/ designated safeguarding lead.

*If the risk of harm is **imminent,** contact* Social Services/CAIT team/ Police/MASH ***URGENTLY***

In all cases:– •Share information of any identified risk with the patient's GP •Document in notes •Discuss the health complications of FGM and the law in the UK

Author:	Dr Gordon,Dr Leila Rushamba	Date:	January 2016
Job Title:	Named Doctor Child Protection,Speciality Dr in Obstetrics and Gynaecology	Review Date:	January 2018
Policy Lead:	Director of Nursing	Version:	Version 1.0
Location:	Corporate Governance shared drive – GL993		

Royal Berkshire NHS
NHS Foundation Trust

Safeguarding Children

Information Sharing Guidance: Child Sexual Exploitation (CSE)

This document has been developed to provide guidance to RBH frontline professionals involved in information sharing discussions at multi agency locality CSE operational meetings.

The guidance aims to provide:

- confidence that CSE cases continue to be dealt with in line with established child protection procedures
- a consistent approach to information sharing
- clarity for front line staff

Introduction

In order to ensure safeguarding, information sharing is an important part of frontline practitioners' job when working with children and young people. This guidance gives a practical overview of sharing information relating to Child Sexual Exploitation, to enable practitioners to feel confident in sharing information whilst also building and maintaining therapeutic relationships.

Professor Munro's[1] review of child protection recommended greater trust in, and responsibility on, skilled practitioners at the frontline. It emphasized the move away from a less central prescription and interference. Lord Laming[2] highlighted that the safety and welfare of children is paramount and practitioners should feel confident about how to deal with the complexities of information sharing.

In relation to children being sexually exploited, practitioners need to adopt an open and inquiring mind to any reasons for a change in behaviour for all children. If practitioners have a concern about a child's welfare, or believe they are at risk of harm, that information should be shared with the Local Authority, considering the security of sharing and being proportionate (Refer to Child Protection Protocol CG074).

[1] Munro. E. (2011) The Munro Review of Child Protection: final report. Accessed at https://www.gov.uk/government/uploads/system/uploads/attachment_data/file/175391/Munro-Review.pdf 7/8/15

[2] The Lord Laming (2009) The Protection of Children in England. https://www.gov.uk/government/uploads/system/uploads/attachment_data/file/328117/The_Protection_of_Children_in_England.pdf accessed 7/8/15

Many cases of CSE will pass a threshold for intervention under Section 17 or 47 of the Children's Act 1989 which makes information sharing straightforward. However, some cases fall short of the threshold. These cases are no less important because there still may be identified risk. In these cases, information may be shared in the public interest, to protect children and potentially prevent and detect crime.

This guidance is provided to ensure that practitioners feel confident about when and how to share information.

Consent/Informing Young People about Sharing Information

In line with Child Protection guidance, wherever possible, the young person will be informed that information will be shared.

In practice, however, for most cases consent will not be sought from the young person. However, it is still possible to share personal information without consent in order to protect an individual from significant risk or if the child/ young person is suffering or likely to suffer significant harm.

Key message: a young person deemed to be at risk of child sexual exploitation is a child / young person at risk of significant harm.

When to share information

1. Is there a clear and legitimate purpose for sharing information?
   - Yes – see next question
   - No – do not share
2. Does the information enable an individual to be identified?
   - Yes – see next question
   - No – you can share but should consider how
3. Is the information confidential?
   - Yes – see next question
   - No – you can share but should consider how
4. Do you have consent?
   - Yes – you can share but should consider how
   - No – see next question
5. Is there another reason to share information such as to fulfil a public function or to protect the vital interests of the information subject?
   - Yes – you can share but should consider how
   - No – do not share

In considering the questions above, it is important to note that the CSE operational groups have a "clear and legitimate purpose for information sharing" i.e. to safeguard and protect young people.

The flow chart in Appendix 1 identifies when and how to share information.

RBFT information sharing recommendations (in line with Appendix 1)

Guidance	Agreement
Identify how much information to share	The key consideration is proportionality. If the child / young person is known to be on Child Protection plan, is a Looked After Child, or is known to be a level 1, 2 or 3 CSE risk the following information is likely to be proportionate: 1) Known / not known to service 2) Engaged / not engaged with sexual health services 3) Admissions/attendances for "high risk" indicators such as drug and alcohol use and self harm. 4) Confirmation that the RBFT Trust Sexual Health CSE safeguarding indicator tool has been completed and outcome: • No risk identified – no further action • Risk identified - CP referral made following established CP procedures **NB – if information is sought over that set out above, the requester should be asked to justify that request, setting out what further information is required and why.** **Further sensitive information will then be shared with the allocated social worker.** <u>Points for consideration in relation to proportionate sharing</u> - Does the encounter with Health Services at the RBFT add to a bigger picture about the child / young person? - Does the requester have any further information about risk that would justify further disclosure? - Could sharing information about the child / young person compromise their engagement with services and/or potentially lead to increased risk? If there is any doubt about the level of information to be shared or whether sharing will increase the risk to the child, discuss with departmental senior staff, safeguarding and legal team to confirm detail to be shared.

Distinguish fact from opinion	As per CP guidance
Ensure you are giving the right information to the right individual	As per CP guidance
Ensure information is shared securely	• No paper copies of meeting notes to be carried to operational meetings • NHS.net used for all correspondence • Confidentiality at all ops meetings acknowledged
Inform the individual that info has been shared unless it will create or increase risk	As per CP guidance

Recording the information sharing decision

The information sharing decision should be recorded in the medical records of the service user. The record should detail:

- The origin and basis for the information request
- The information shared and the reasons behind it
- Any outcome of the information sharing
- Whether the service user's consent was sought

The service user (and potentially their parents) will be entitled to access the medical records. Following such a request, consideration should be given as to whether the entries relating to CSE information sharing should be redacted on the basis that they may cause harm to the service user or others (or whether any other exemption applies to subject access). This decision should be made in line with the principles which govern whether the consent of the patient was sought at the time of information sharing.

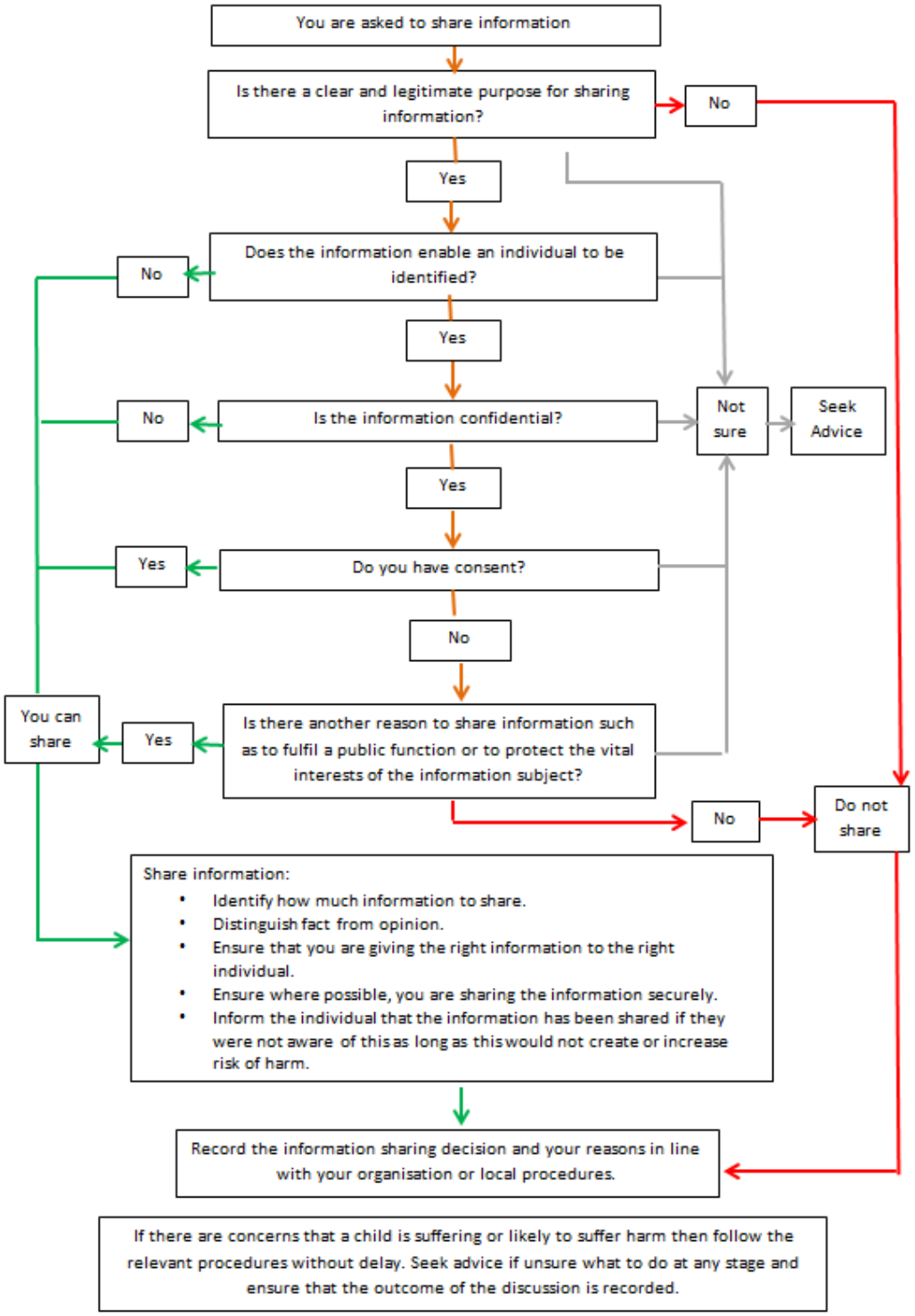
Persons of Interest

In the event that, following CSE information sharing, the Police request information in relation to a Person of Interest, they should be asked to make this request through the formal Trust procedures. This can be made through the RBFT legal team.

Information sharing in response to audit requests

Area profile audits - percentages to be supplied rather than comment made on individual cases.

Appendix 1: Flowchart of when and how to share information relating to Child Sexual Exploitation



READING BOROUGH COUNCIL

REPORT BY DIRECTOR OF ADULT CARE & HEALTH SERVICES

TO: Health & Wellbeing Board

DATE: 24th March 2017 **AGENDA ITEM: 8**

TITLE: The Berkshire Suicide Prevention Strategy 2017-2020

LEAD COUNCILLOR: Cllr Hoskin **PORTFOLIO:** Health

SERVICE: Wellbeing **WARDS:** All

LEAD OFFICER: Jo Hawthorne **TEL:** 0118 9373623

JOB TITLE: Head of Wellbeing, Commissioning & Improvement

EMAIL: Jo.hawthorne@reading.gov.uk

1. PURPOSE OF REPORT AND EXECUTIVE SUMMARY

1.1 The NHS Five Year Forward View for Mental Health sets a target on all NHS agencies and partners to reduce the current level of suicide by 10% by 2020. To achieve this, the Department of Health has recommended, in its 3rd Progress Report on the National Suicide Prevention Strategy, that all top tier local authorities produce suicide prevention actions plans.

1.2 In Berkshire, this has been coordinated by a multi-agency suicide prevention group which has overseen the preparation of a strategy including a Berkshire-wide action plan, and local action plans responding to the unique needs and circumstances of each of the six local authorities in Berkshire.

1.3 The action plans are reliant on multi-agency working, and partners across the health and public sectors are in the process of endorsing the strategy.

1.4 Appendices

- The Draft Berkshire Suicide Prevention Strategy 2017-2020
- A copy of the presentation to the Health and Wellbeing Board to be given at the meeting is attached.

2. RECOMMENDED ACTION

That the Health & Wellbeing Board notes the report and:

i) Endorses the Berkshire Suicide Prevention Strategy; and

ii) Agrees the action plan for the Reading Borough contained within the strategy.

3. POLICY CONTEXT

3.1 A cross-Government National Suicide Prevention Strategy for England was published in 2012. This included commitments to tackling suicide in six key areas:

- Reducing the risk of suicide in high risk groups;
- Tailoring approaches to improve mental health in specific groups;
- Reducing access to means of suicide;
- Providing better information and support to those bereaved or affected by suicide;
- Supporting the media in delivering sensitive approaches to suicide and suicidal behaviour; and
- Supporting research, data collection and monitoring.

3.2 In 2016, an independent Mental Health Taskforce presented a report - The Five Year Forward View for Mental Health - to the NHS in England. The Taskforce recommended setting a national ambition to reduce the suicide rate in England by 10 per cent by 2020-21, and that every local area should have in place a multi-agency suicide prevention plan. These local plans are expected to align with local Crisis Care Concordat action plans, and to reflect local ambitions for prevention planning.

3.3 The 3rd Progress Report on Preventing suicide in England (published in January 2017) contains further guidance on local suicide prevention plans. Local plans should be in place by 2017, set out targeted actions in line with the national Suicide Prevention Strategy and new evidence around suicide, and include a strong focus on primary care, alcohol and drug misuse. Each plan should demonstrate how areas will implement evidence-based preventative interventions that target high-risk locations and support high-risk groups within their population.

3.4 Suicide prevention work is part of promoting good mental health more broadly, and there is an increasing focus on mental health as a vital part of overall wellbeing. This was illustrated at a national level by the Prime Minister's Charity Commission lecture on 9th January 2017. More locally, on 16th January 2017, the Brighter Berkshire (Year of Mental Health) campaign was launched. This is aimed at reducing stigma and improving access to support networks.

3.5 Reading's Health and Wellbeing Strategy 2017-20 includes 'reducing deaths by suicide' as one of its eight priorities, with a further two priorities complementing this very closely:

- Promoting positive mental health and wellbeing in children and young people
- Reducing loneliness and social isolation

4. THE PROPOSAL

4.1 Current Position:

Berkshire Authorities had not published a suicide prevention action plan at the time of the 2015 All Party Parliamentary Group inquiry into local suicide prevention plans in England. Action plans were a recommendation of the England Suicide Prevention Strategy published in 2012. Since 2015, a high-level multi-agency steering group has met in Berkshire to plan a local audit of suicides and provide a vehicle for partners to work together on a strategy and action plans for each locality. The draft strategy annexed to this report is the result of this work, and a recommendation of the strategy is that all six local health and wellbeing boards endorse the strategy and their local action plans.

4.2 Options Proposed

Endorse the Strategy and Action Plan for Reading.
This is the recommended option. Members of the Health and Wellbeing Board can make a difference in preventing suicides through the provision and commissioning of evidence-based services and through showing the leadership to achieve this important public health outcome.

4.3 Other Options Considered

Do nothing.
This is not recommended. Councils are expected to have a suicide prevention action plan and the Secretary of State for Health has recently reiterated this desire.

5. CONTRIBUTION TO STRATEGIC AIMS

5.1 Reading's Health and Wellbeing Strategy 2017-20 (adopted by the Health and Wellbeing Board on 27 January 2017) includes 'reducing deaths by suicide' as one of its eight priorities. Adopting the Berkshire Suicide Prevention Strategy would reinforce the Board's commitment to this priority, and set local plans in the context of partnership working across Berkshire.

5.2 Adopting the Berkshire Suicide Prevention Strategy and accompanying Action Plans would also support the Council's Corporate Plan priority to 'safeguard and protect those that are most vulnerable.' Similarly, this would support the Reading Clinical Commission Groups' aim per the Berkshire West Strategic Plan 2014-19 to 'give mental health parity of esteem with physical health through the commissioning of high quality evidence-based mental health services which reflect the national mental health strategy and other key guidance'.

5.3 The Berkshire Suicide Prevention Strategy is an important public health strategy which seeks to save lives lost to suicide through its prevention, and to improve the health and wellbeing of those bereaved by suicide. It also includes more general whole-population actions aimed at improving mental health and wellbeing as contributing factors that prevent suicide. The strategy highlights and action plans prioritise certain population groups which have greater risk factors for suicide, and thus contributes to narrowing inequalities.

6. COMMUNITY ENGAGEMENT AND INFORMATION

6.1 The Berkshire-wide steering group is made up of stakeholders from across the area representing all sectors. They have consulted their organisations, some of whom will endorse the strategy formally. This is the first iteration of the strategy and it would be expected that with each new iteration, further organisations will be able to formally endorse it.

6.2 During a public consultation on Reading's draft Health and Wellbeing strategy for 2017-20, local residents commented that 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. It was in direct response to this feedback that suicide reduction was added as a priority in the final (adopted) version of the strategy, and the final strategy made more explicit that the priority on reducing loneliness and social isolation incorporates developing personal resilience.

7. EQUALITY IMPACT ASSESSMENT

7.1 The Berkshire Suicide Prevention Strategy follows national guidance which includes due consideration of equalities issues and assesses these in relation to the evidence base regarding the risk of suicide. Some groups with 'protected characteristics' as defined in the Equality Act are at increased risks of suicide, such as lesbian gay, bisexual and transgender people, and targeted approaches are proposed in relation to groups facing higher risks. Adopting the Strategy is therefore intended to have a differential impact on some protected groups, but this would be a positive rather than a negative differential impact. A full Equalities Impact Assessment is not therefore required.

8. LEGAL IMPLICATIONS

8.1 The council has the power enshrined in the 2012 Health and Social Care Act to undertake necessary action as required to discharge its new public health duties, to improve health and protect the health of the local population.

8.2 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. Some groups of residents identified in the draft Suicide Prevention Strategy as facing a higher suicide risk will be in possession of 'protected characteristics' as set out in the Equality Act, and the Strategy and Action Plans therefore have the potential to be vehicles for promoting equality of opportunity.

9. FINANCIAL IMPLICATIONS

9.1 No specific new funds are required. The local action plan will be delivered through local partners and co-ordinated by the Council's Wellbeing Team working within the constraints of existing budgets.

9.2 Value for Money (VFM) - The economic and social cost of a suicide is substantial. The average cost of suicide in someone of working age in England is estimated to be £1.67 million.
This includes direct costs of care, indirect costs relating to loss of productivity and earnings, and the intangible costs associated with pain, grief and suffering of those bereaved or affected by suicide. For every person who dies by suicide at least 10 people are directly affected.

10. APPENDICES

Appendix 1: Draft Berkshire Suicide Prevention Strategy 2017-2020. Public Health Services for Berkshire. 2017.

11. BACKGROUND PAPERS

Office for National Statistics. Suicides in the UK in 2014. London: Office for National Statistics; 2016.

HM Government. Preventing suicide in England: A cross government strategy to save lives. London: Department of Health; 2012.

NHS England Mental Health Taskforce. The five year forward view for mental health. NHS England; 2016.

All-Party Parliamentary Group on Suicide and Self-Harm Prevention. Inquiry into local suicide prevention plans in England. All-Party Parliamentary Group on Suicide and Self-Harm Prevention; 2015.

HM Government. Preventing suicide in England: Third progress report of the cross-government outcomes strategy to save lives. London: Department of Health; 2017.

Public Health England (PHE). Local Suicide Prevention Planning, A Practical Resource. Public Health England; 2016.

Public Health Services for Berkshire

Berkshire Suicide Prevention Strategy 2017-2020

High Level Version

DRAFT V1

Darrell Gale FFPH

Consultant in Public Health

Mental Health Lead Consultant for Berkshire

NB: All comments in red are instructions to help guide the final drafting and formatting.

Logos to be added as follows:

Bracknell Forest Council	Reading Borough Council	Royal Borough of Windsor & Maidenhead	Slough Borough Council	West Berkshire Council	Wokingham Borough Council

Bracknell & Ascot NHS CCG	Newbury & District NHS CCG	North and West Reading NHS CCG	Slough NHS CCG	South Reading NHS CCG	Windsor Ascot & Maidenhead NHS CCG	Wokingham NHS CCG

Berkshire Healthcare NHS Foundation Trust	Frimley Health NHS Foundation Trust	Royal Berkshire NHS Foundation Trust

Brighter Berkshire Year of Mental Health

Contents

		Notes for final editing
2	Acknowledgements	
3	Executive Summary	
4	Recommendations	*To be formatted to use as a standalone page*
6	10 Things Everyone Needs To Know About Suicide Prevention	*Should be formatted to use as a stand-alone page maybe with infographics*
7	Berkshire-Wide Action Plan 2017-18	*To be formatted to use as a standalone page(s)*

Acknowledgements

Acknowledgements are due to a wide range of partners and colleagues whose work; encouragement and commitment to suicide prevention has enabled the development of this strategy and its action plans. In particular, we acknowledge the following:

Rutuja Kulkarni and the public health officers from Berkshire local authorities who undertook the Suicide Audit, and who did much to build the foundations upon which this strategy has developed;

The suicide prevention and mental health leads from the Berkshire local authorities for preparing the local action plans;

Network Rail and British Transport Police for their support with work on railway suicides;

Helena Fahie at Public Health England South East Centre for encouragement; advice and going the extra mile;

David Colchester at the Local Criminal Justice Board for the Thames Valley and Thames Valley Police for their input on real-time surveillance;

The NHS Provider trusts in Berkshire for their input and continued support;

The seven Clinical Commissioning Groups in Berkshire for their strong partnership working;

and of course all past and present members of the Berkshire Suicide Prevention Steering Group.

Executive Summary

The NHS Five Year Forward View for Mental Health sets a target on all NHS agencies and partners to reduce the current level of suicide by 10% by 2020. This is a laudable and hopefully readily achievable aim. However as discussions across the range of organisations which have contributed to this strategy have progressed, it appears to many, that this aim is not challenging enough. Zero Suicide should be our aim; as it is in the gift of the combined efforts of these organisations, and of society at large, to put in place the policies and services which protect people from mental distress, and to ease the factors which cause that distress. This strategy therefore forges ahead with a stretch target to reduce suicide by at least 25% by 2020, thus ensuring that this becomes a shared priority across organisations and areas.

We recognise that a Berkshire without suicide is the true aim we work towards.

This document is a high-level summary of the full Berkshire-wide strategy which seeks to save lives lost to suicide through its prevention, and to improve the health and wellbeing of those bereaved by suicide. It also includes more general whole-population actions aimed at improving mental health and wellbeing as contributing factors that prevent suicide. The strategy highlights, and action plans prioritise, certain population groups which have greater risk factors for suicide, and thus contributes to narrowing health inequalities.

It goes without saying, but we should remind ourselves, that suicides are tragedies for all involved. For every person who dies by suicide at least 10 people are directly affected. Support for those bereaved, including the professionals who deal with the suicide, is vitally important. The social and economic cost of a suicide is substantial. The average cost of suicide in someone of working age in England is estimated to be £1.67 million. This includes direct costs of care, indirect costs relating to loss of productivity and earnings, and the intangible costs associated with pain, grief and suffering of those bereaved or affected by suicide.

Many stakeholders have contributed to this strategy and it should now be adopted as a joint strategy by each of the CCGs, Local Authorities, and the Health and Wellbeing Boards in Berkshire. It should also be referenced and reflected in other plans and strategies when they are drafted or re-written, to ensure suicide prevention becomes a pursuit common to all agencies and professions. It is an important and happy coincidence that this strategy will be formally launched, once it has been endorsed by all health and wellbeing boards in Berkshire, during Brighter Berkshire, the Year of Mental Health. This community led initiative aims to help increase the opportunities and support for our Berkshire population who need help with their mental health, when they need it and to build a stronger happier Berkshire population. The aims of this strategy fit well with these broader aims.

Dr Lise Llewellyn
Strategic Director of Public Health for Berkshire April 2017

Recommendations

The following recommendations are the principle strategic objectives for Berkshire as a whole. These link through into more detailed action plans for Berkshire-wide work and for local authority areas. In line with the national suicide prevention strategy, the main outcomes of this strategy are to reduce suicides in Berkshire by 25% by 2020, and to provide better support for those bereaved or affected by suicide. The national strategy has identified six priority areas and the recommendations linked to these are outlined below, following those relating to the overarching aims.

Over-arching Recommendations

RECOMMENDATION
That this Steering Group revisit their terms of reference and membership and become known as the "Berkshire Suicide Prevention Steering Group", with the aim of providing the governance to this strategy and its action plans.

RECOMMENDATION
That organisations represented on the Berkshire Suicide Prevention Steering Group consider nominating a suicide prevention champion from within their membership.

RECOMMENDATION
That all agencies represented on the Steering Group commit to an annual Action Plan of their own which can then be brought together to create a Berkshire-wide Action Plan for each year of the Strategy.

RECOMMENDATION
Sign off / endorsement of this strategy by all Health & Wellbeing Boards in Berkshire.

RECOMMENDATION
Launch this strategy at a multi-agency suicide prevention summit, by October 2017.

RECOMMENDATION
Ensure strategic fit with the action plans of the Berkshire Crisis Care Concordat.

Priority Areas

1. Reduce the risk of suicide in key high-risk groups;

RECOMMENDATION
Implement the NICE guidelines on self-harm, specifically ensuring that people who present to Emergency Departments following self-harm receive a psychosocial assessment.

RECOMMENDATION
Evaluate the Berkshire CALMzone and recommission targeted suicide prevention work for younger men and middle aged men.

2. Tailor approaches to improve mental health in specific groups;

RECOMMENDATION
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.

3. Reduce access to the means of suicide;

RECOMMENDATION
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.

RECOMMENDATION
That the Steering Group seek a named Highways England officer to act as a liaison link and group member, and to share real-time intelligence of highways network incidents.

RECOMMENDATION
That local authority public health teams work with other council departments such as car parks and open space services to identify local actions to prevent suicide including staff awareness training.

4. Provide better information and support to those bereaved or affected by suicide;

RECOMMENDATION
Ensure bereavement information and access to support is available to those bereaved by suicide, including professionals involved in the case.

5. Support the media in delivering sensitive approaches to suicide and suicidal behaviour;

RECOMMENDATION
Liaise with local media to encourage reference to and use of guidelines for the reporting of suicide through a summit with local press and media organisations, and to provide information to professionals on the sensitive reporting of suicide. By 20 July 2017

6. Support research, data collection and monitoring.

RECOMMENDATION
Develop working relationships between individual coroners and local public health teams ensure local plans are evidence based and responsive. Coroners can be invited to become formal members of any local suicide prevention groups or networks

Coroners can also inform the local authority or Director of Public Health if they identify particular areas of concern, e.g. locations used for suicide, possible clusters of suicide, increase in a particular method or new and emerging method of suicide.

Refresh the Berkshire-wide Suicide Audit for deaths in the period 2014-16 to include new categories based on best practice.

10 Things Everyone Needs To Know About Suicide Prevention

1 Suicides take a high toll

There were 4,882 deaths from suicide registered in England in 2014 and for every person who dies at least 10 people are directly affected.

2 There are specific groups of people at higher risk of suicide

Three in four deaths by suicide are by men. The highest suicide rate in England is among men aged 45-49. People in the lowest socio-economic group and living in the most deprived geographical areas are 10 times more at risk of suicide than those in the highest socio-economic group living in the most affluent areas.

3 There are specific factors that increase the risk of suicide

The strongest identified predictor of suicide is previous episodes of self-harm. Mental ill-health and substance misuse also contribute to many suicides. Suicide prevention strategies must consider and link to programmes of early identification and effective management of self-harm, mental ill-health and substance misuse.

4 Preventing suicide is achievable

The delivery of a comprehensive strategy is effective in reducing deaths by suicide through combining a range of integrated interventions that build community resilience and target groups of people at heightened risk of suicide. Directors of public health and health and wellbeing boards have a central role. Their involvement is crucial in coordinating local suicide prevention efforts and making sure every area has a strategy in place.

5 Suicide is everybody's business

A whole system approach is required, with local government, primary care, health and criminal justice services, voluntary organisations and local people affected by suicide having a role to play. Suicide prevention can also be part of work addressing the wider determinants of health and wellbeing.

6 Restricting access to the means for suicide works

This is one of the most evidenced aspects of suicide prevention and can include physical restrictions, as well as improving opportunities for intervention.

7 Supporting people bereaved by suicide is an important component of suicide prevention strategies

Compared with people bereaved through other causes, individuals bereaved by suicide have an increased risk of suicide and suicidal ideation, depression, psychiatric admission as well as poor social functioning.

8 Responsible media reporting is critical

Research shows that inappropriate reporting of suicide may lead to imitative or 'copycat' behaviour.

9 The cost of suicide justifies investment in suicide prevention work

The economic cost of each death by suicide of someone of working age is estimated to be £1.67 million. This covers the direct costs of care, indirect costs relating to loss of productivity and earnings, and the intangible costs associated with pain, grief and suffering.

10 Local suicide prevention strategies must be informed by evidence

Local government should consider the national evidence alongside local data and information to ensure local needs are addressed.

Berkshire-Wide Action Plan 2017-18

Areas for Action	Specific Risk Groups	Action in 2017-18	Timescale by:	Delivery Lead
Overarching Aims		Sign off / endorsement of this Berkshire Suicide Prevention Strategy by all Health & Wellbeing Boards in Berkshire.	1 April 2017	Lead Consultant Mental Health
		All other local governance completed thus enabling this strategy to be owned by the Local Authorities and their partners.	1 April 2017	Local PH Mental Health Leads
		Launch of strategy at multi-agency suicide prevention summit.	15 Oct. 2017	Strategic DPH
		Identify Suicide Prevention Champions to promote the Berkshire Strategy; and to work within the Local Authorities and partner agencies.	15 Oct. 2017	Local PH Mental Health Leads
		Develop Berkshire-wide information sharing protocols to best utilise real time surveillance of suicides and near misses, in order to respond promptly to local trends and risks to reduce risk of clusters, and inform future service delivery.	30 July 2017	Lead Consultant Mental Health
		The Steering Group revisit their terms of reference and membership and become known as the "Berkshire Suicide Prevention Steering Group", with the aim of providing the governance to this strategy and its action plans.	1 April 2017	Steering Group Members
		Ensure strategic fit with the action plans of the Berkshire Crisis Care Concordat.	1 April 2017	Lead Consultant Mental Health
National Strategy				
1. Reduce the risk of suicide in key high-risk groups	Men	Evaluate the Berkshire-Wide CALMzone initiative and agree Berkshire-wide commissioning of specific support services for men for future years. To include future commissioning of CALMzone for younger men; and services for middle aged men and older men.	15 Oct. 2017	Lead Consultant Mental Health
	People who self-harm	Ensure agencies have plans to Implement the NICE guidelines on self-harm	15 Oct. 2017	Lead Consultant Mental Health
	People who misuse substances	Ensure local strategies and contracts for DAAT services include suicide prevention objectives.	Ongoing work	Local PH Mental Health Leads

	People in mental health care	Support BHFT in its Zero Suicide Approach and support local prevention work across the care system.	Ongoing work	Steering Group Members
	People in contact with the criminal justice system	Identify local actions to prevent suicide in those in contact with the criminal justice system, recognising increased incidence of self-harm in the prison population.	30 July 2017	Local PH Mental Health Leads
	Occupational groups	Ensure local health trusts and providers can demonstrate actions to prevent suicide and promote metal wellbeing amongst their staff.	30 July 2017	Steering Group Members
		Identify particular local action plans for those in agricultural / land-based industries.	30 July 2017	Local PH Mental Health Leads
2. Tailor approaches to improve mental health in specific groups	Community based approaches	For the Steering Group to assess community-based interventions which may be best delivered at scale across the county.	Ongoing work	Steering Group Members
	Suicide prevention training	Coordinate a database on evidence based suicide prevention training programmes and providers across the county.	Ongoing work	Steering Group Members
	People vulnerable due to economic circumstances	For the Steering Group to solicit data from each LA on key indicators that may highlight risk: e.g. number of homelessness presentations.	Ongoing work	Steering Group Members
	Pregnant women and those who have given birth in last year	To undertake a needs assessment of this group in relation to suicide prevention.	30 July 2017	Local PH Mental Health Leads
	Children and young people	Through LSCBs, identify local actions to prevent suicide in children and young people.	30 July 2017	Local PH Mental Health Leads
3. Reduce access to the means of suicide		Support Network Rail, British Transport police and The Samaritans with local escalation process locations and general suicide prevention work.	Ongoing work	Steering Group Members
		Investigate suicides on council owned land and properties, and agree a local action plan.	15 Oct. 2017	Local PH Mental Health Leads
		Analyse local data gathered from the suicide audit and/or real-time surveillance to identify trends and clusters and take appropriate action(s) e.g. work with local media.	Ongoing work	Local PH Mental Health Leads

		The Steering Group seek a named Highways England officer to act as a liaison link and group member, and to share real-time intelligence of highways network incidents.	1 April 2017	Lead Consultant Mental Health
4. Provide better information and support to those bereaved or affected by suicide		Promote resources for people bereaved and affected by suicide (e.g. Help is at Hand and National Suicide Prevention Alliance resources) and support services such as SOBS (Survivors of Bereavement by Suicide).	Ongoing work	Steering Group Members
5. Support the media in delivering sensitive approaches to suicide and suicidal behaviour		Convene a Berkshire-wide Summit on journalism and reporting standards with local press and media organisations, to develop and agree standards for reporting. Agree a local action plan with the local communications team to support this aim. Identify a lead officer to monitor internet and both local and social media. Challenge stigma: Media campaign to support world suicide prevention day Update council and stakeholder webpages to ensure effective signposting for those bereaved by suicide	20 July 2017 20 July 2017 Ongoing work 1 Sept 2017 1 April 2017	Lead Consultant Mental Health Local PH Mental Health Leads Local PH Mental Health Leads Local PH Mental Health Leads Local PH Mental Health Leads
6. Support research, data collection and monitoring		Refresh Berkshire-wide suicide audit to include deaths during 2014-2016 to include data on GP consultations. To update data on the JSNA summary on suicide.	30 July 2017 As per JSNA timetable	Local PH Mental Health Leads Local PH Mental Health Leads

Back Cover to be designed and add contact details of Shared Team etc.

URL of Strategy

Public Health Services for Berkshire

Berkshire Suicide Prevention Strategy 2017-2020

Full Version with Audit & Action Plans

DRAFT V7

Darrell Gale FFPH

Consultant in Public Health

Mental Health Lead Consultant for Berkshire

NB: All comments in red are instructions to help guide the final drafting and formatting.

Logos to be added as follows:

Bracknell Forest Council	Reading Borough Council	Royal Borough of Windsor & Maidenhead	Slough Borough Council	West Berkshire Council	Wokingham Borough Council

Bracknell & Ascot NHS CCG	Newbury & District NHS CCG	North and West Reading NHS CCG	Slough NHS CCG	South Reading NHS CCG	Windsor Ascot & Maidenhead NHS CCG	Wokingham NHS CCG

Berkshire Healthcare NHS Foundation Trust	Frimley Health NHS Foundation Trust	Royal Berkshire NHS Foundation Trust

Brighter Berkshire Year of Mental Health

Contents

To be finalised at end of editing process		Notes for final editing
3	Acknowledgments	*Update if required*
4	Executive Summary	*Introduction required by LL and final edit required*
5	Recommendations	*To be formatted to use as a standalone page*
7	Background	
8	10 Things Everyone Needs To Know About Suicide Prevention	*Should be formatted to use as a stand-alone page maybe with infographics*
9	Strategy Aims	
10	National Context	
14	Strategic Context	
15	Evidence Base in Suicide Prevention	
16	National Best Practice in Suicide Prevention	
18	Local Context	
18	Local Suicide Audit Results	
26	Local Governance Structures	
29	Local Best Practice in Suicide Prevention	
32	Areas of High Frequency	
34	Crisis Care Concordat	
35	Gap Analysis and Emergent Berkshire-Wide Concerns	
39	Berkshire-Wide Action Plan 2017-18	*To be formatted to use as a standalone page(s)*
42	References	*Will need checking and hyperlinks added*
Appendices		
43	Appendix 1 Resources available	*Will need suggestions, checking and hyperlinks added*
44	Appendix 2 Bracknell Forest Action Plan 2017-18	
46	Appendix 3 RBWM Action Plan 2017-18	
50	Appendix 4 Slough Action Plan 2017-18	
54	Appendix 5 Reading Action Plan 2017-18	
56	Appendix 6 West Berkshire Action Plan 2017-18	
58	Appendix 7 Wokingham Action Plan 2017-18	
61	Appendix 8 Membership of the Berkshire Suicide Prevention Steering Group	*Needs to be updated according to membership*

Acknowledgements

Acknowledgements are due to a wide range of partners and colleagues whose work; encouragement and commitment to suicide prevention has enabled the development of this strategy and its action plans. In particular, we acknowledge the following:

Rutuja Kulkarni and the public health officers from Berkshire local authorities who undertook the Suicide Audit, and who did much to build the foundations upon which this strategy has developed;

The suicide prevention and mental health leads from the Berkshire local authorities for preparing the local action plans;

Network Rail and British Transport Police for their support with work on railway suicides;

Helena Fahie at Public Health England South East Centre for encouragement; advice and going the extra mile;

David Colchester at the Local Criminal Justice Board for the Thames Valley and Thames Valley Police for their input on real-time surveillance;

The NHS Provider trusts in Berkshire for their input and continued support;

The seven Clinical Commissioning Groups in Berkshire for their strong partnership working;

and of course all past and present members of the Berkshire Suicide Prevention Steering Group.

Executive Summary

The NHS Five Year Forward View for Mental Health sets a target on all NHS agencies and partners to reduce the current level of suicide by 10% by 2020. This is a laudable and hopefully readily achievable aim. However as discussions across the range of organisations which have contributed to this strategy have progressed, it appears to many, that this aim is not challenging enough. Zero Suicide should be our aim; as it is in the gift of the combined efforts of these organisations, and of society at large, to put in place the policies and services which protect people from mental distress, and to ease the factors which cause that distress. This strategy therefore forges ahead with a stretch target to reduce suicide by at least 25% by 2020, thus ensuring that this becomes a shared priority across organisations and areas.

We recognise that a Berkshire without suicide is the true aim we work towards.

This strategy is an important public health strategy which seeks to save lives lost to suicide through its prevention, and to improve the health and wellbeing of those bereaved by suicide. It also includes more general whole-population actions aimed at improving mental health and wellbeing as contributing factors that prevent suicide. The strategy highlights, and action plans prioritise, certain population groups which have greater risk factors for suicide, and thus contributes to narrowing health inequalities.

It goes without saying, but we should remind ourselves, that suicides are tragedies for all involved. For every person who dies by suicide at least 10 people are directly affected. Support for those bereaved, including the professionals who deal with the suicide, is vitally important. The social and economic cost of a suicide is substantial. The average cost of suicide in someone of working age in England is estimated to be £1.67 million. This includes direct costs of care, indirect costs relating to loss of productivity and earnings, and the intangible costs associated with pain, grief and suffering of those bereaved or affected by suicide.

Many stakeholders have contributed to this strategy and it should now be adopted as a joint strategy by each of the CCGs, Local Authorities, and the Health and Wellbeing Boards in Berkshire. It should also be referenced and reflected in other plans and strategies when they are drafted or re-written, to ensure suicide prevention becomes a pursuit common to all agencies and professions. It is an important and happy coincidence that this strategy will be formally launched, once it has been endorsed by all health and wellbeing boards in Berkshire, during Brighter Berkshire, the Year of Mental Health. This community led initiative aims to help increase the opportunities and support for our Berkshire population who need help with their mental health, when they need it and to build a stronger happier Berkshire population. The aims of this strategy fit well with these broader aims.

Dr Lise Llewellyn
Strategic Director of Public Health for Berkshire April 2017

RECOMMENDATION
Launch this strategy at a multi-agency suicide prevention summit, by October 2017.

Recommendations

The following recommendations are the principle strategic objectives for Berkshire as a whole. These link through into more detailed action plans for Berkshire-wide work and for local authority areas. In line with the national suicide prevention strategy, the main outcomes of this strategy are to reduce suicides in Berkshire by 25% by 2020, and to provide better support for those bereaved or affected by suicide. The national strategy has identified six priority areas and the recommendations linked to these are outlined below, following those relating to the overarching aims.

Over-arching Recommendations

RECOMMENDATION
That this Steering Group revisit their terms of reference and membership and become known as the "Berkshire Suicide Prevention Steering Group", with the aim of providing the governance to this strategy and its action plans.

RECOMMENDATION
That organisations represented on the Berkshire Suicide Prevention Steering Group consider nominating a suicide prevention champion from within their membership.

RECOMMENDATION
That all agencies represented on the Steering Group commit to an annual Action Plan of their own which can then be brought together to create a Berkshire-wide Action Plan for each year of the Strategy.

RECOMMENDATION
Sign off / endorsement of this strategy by all Health & Wellbeing Boards in Berkshire.

RECOMMENDATION
Launch this strategy at a multi-agency suicide prevention summit, by October 2017.

RECOMMENDATION
Ensure strategic fit with the action plans of the Berkshire Crisis Care Concordat.

Priority Areas

1. Reduce the risk of suicide in key high-risk groups;

RECOMMENDATION
Implement the NICE guidelines on self-harm, specifically ensuring that people who present to Emergency Departments following self-harm receive a psychosocial assessment.

RECOMMENDATION
Evaluate the Berkshire CALMzone and recommission targeted suicide prevention work for younger men and middle aged men.

2. Tailor approaches to improve mental health in specific groups;

RECOMMENDATION
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.

3. Reduce access to the means of suicide;

RECOMMENDATION
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.

RECOMMENDATION
That the Steering Group seek a named Highways England officer to act as a liaison link and group member, and to share real-time intelligence of highways network incidents.

RECOMMENDATION
That local authority public health teams work with other council departments such as car parks and open space services to identify local actions to prevent suicide including staff awareness training.

4. Provide better information and support to those bereaved or affected by suicide;

RECOMMENDATION
Ensure bereavement information and access to support is available to those bereaved by suicide, including professionals involved in the case.

5. Support the media in delivering sensitive approaches to suicide and suicidal behaviour;

RECOMMENDATION
Liaise with local media to encourage reference to and use of guidelines for the reporting of suicide through a summit with local press and media organisations, and to provide information to professionals on the sensitive reporting of suicide. By 20 July 2017

6. Support research, data collection and monitoring.

RECOMMENDATION
Develop working relationships between individual coroners and local public health teams ensure local plans are evidence based and responsive. Coroners can be invited to become formal members of any local suicide prevention groups or networks

Coroners can also inform the local authority or Director of Public Health if they identify particular areas of concern, e.g. locations used for suicide, possible clusters of suicide, increase in a particular method or new and emerging method of suicide.

Refresh the Berkshire-wide Suicide Audit for deaths in the period 2014-16 to include new categories based on best practice.

Background

Suicide is a devastating event. It is an individual tragedy, a life-altering crisis for those bereaved, and a traumatic event for communities and services. The impacts are immediately and profoundly distressing. We thus need to be sure that in the Clinical Commissioning Groups (CCGs) and Local Authorities in Berkshire, an alliance of stakeholders takes preventive and ongoing action covering the main risks. The 2012 national strategy ('Preventing Suicide in England') sets us two major objectives: reducing the suicide rate in England, and giving better support to people bereaved or affected by suicide. Those objectives are thus given priority in this strategy.

Suicide is not inevitable. Preventing suicides is a complex and challenging issue, but there are effective solutions for many of the individual factors which contribute towards the risk of suicide. Suicide Prevention work is cost-effective when conducted in accordance with evidence of effectiveness, and by working in partnership. Local Government, statutory services, the third sector, local communities and families each have a role to play.

Whilst suicide causes a vast negative wellbeing impact on family, friends, colleagues, and wider contacts, they also have a huge economic impact. The average cost of a single completed suicide of a working age individual in England was estimated in 2012 to be more than £1.5 million. This includes intangible costs (loss of life to the individual and the pain and suffering of relatives), as well as waged and unwaged lost output, public service time and funeral costs. Non-fatal self-harm also has major – potentially avoidable - cost implications for public services, particularly A&E and acute inpatient services and psychiatric follow-up.

Suicides are not inevitable and are a major issue for society as well as being a leading cause of years of life lost. There are many ways in which services, communities, individuals and society as a whole can help to prevent suicides. Government and statutory services have a role to play in building individual and community resilience. Vulnerable people in the care of health and care services can be supported and kept safe from preventable harm. Interventions can be provided quickly when someone is in distress or in crisis and for vulnerable people in the wider community, practical measure such as debt advice services can make all the difference.

Public Health England (PHE) has recently published a guide to local suicide prevention planning (2016). In it, they identify ten things that everyone needs to know about suicide prevention. These are re-produced here in full, and with kind permission of PHE. Simple to follow and understand, these form the basis of raising awareness of suicide prevention across Berkshire services and populations.

10 Things Everyone Needs To Know About Suicide Prevention

1 Suicides take a high toll

There were 4,882 deaths from suicide registered in England in 2014 and for every person who dies at least 10 people are directly affected.

2 There are specific groups of people at higher risk of suicide

Three in four deaths by suicide are by men. The highest suicide rate in England is among men aged 45-49. People in the lowest socio-economic group and living in the most deprived geographical areas are 10 times more at risk of suicide than those in the highest socio-economic group living in the most affluent areas.

3 There are specific factors that increase the risk of suicide

The strongest identified predictor of suicide is previous episodes of self-harm. Mental ill-health and substance misuse also contribute to many suicides. Suicide prevention strategies must consider and link to programmes of early identification and effective management of self-harm, mental ill-health and substance misuse.

4 Preventing suicide is achievable

The delivery of a comprehensive strategy is effective in reducing deaths by suicide through combining a range of integrated interventions that build community resilience and target groups of people at heightened risk of suicide. Directors of public health and health and wellbeing boards have a central role. Their involvement is crucial in coordinating local suicide prevention efforts and making sure every area has a strategy in place.

5 Suicide is everybody's business

A whole system approach is required, with local government, primary care, health and criminal justice services, voluntary organisations and local people affected by suicide having a role to play. Suicide prevention can also be part of work addressing the wider determinants of health and wellbeing.

6 Restricting access to the means for suicide works

This is one of the most evidenced aspects of suicide prevention and can include physical restrictions, as well as improving opportunities for intervention.

7 Supporting people bereaved by suicide is an important component of suicide prevention strategies

Compared with people bereaved through other causes, individuals bereaved by suicide have an increased risk of suicide and suicidal ideation, depression, psychiatric admission as well as poor social functioning.

8 Responsible media reporting is critical

Research shows that inappropriate reporting of suicide may lead to imitative or 'copycat' behaviour.

9 The cost of suicide justifies investment in suicide prevention work

The economic cost of each death by suicide of someone of working age is estimated to be £1.67 million. This covers the direct costs of care, indirect costs relating to loss of productivity and earnings, and the intangible costs associated with pain, grief and suffering.

10 Local suicide prevention strategies must be informed by evidence

Local government should consider the national evidence alongside local data and information to ensure local needs are addressed.

Strategy Aims

In 2014, the seven Berkshire CCGs and six local authority public health teams across Berkshire began work to refresh the suicide audits previously undertaken and to recommend from this a strategy for reducing suicide risk across Berkshire. This strategy is the result of a study of national research and recommendations plus recommendations of many local stakeholders from a range of organisations.

This strategy proposes co-ordinated prevention across all the elements influencing suicide, from the wider determinants of distress and escalating desperation, and poor mental health, through coordinated local preventive action spanning local authority and voluntary services, and primary and secondary care.

The overall aim of this strategy is:

- To outline how partners across the county will work to prevent suicide in Berkshire.
- To outline the governance structure for Suicide Prevention work in Berkshire.
- To make clear how the public, partners and other stakeholders can deliver the actions outlined herein.

The objectives and six priority areas to meet this aim are also drawn from the National Suicide Prevention Strategy – "Preventing Suicide in England" (DH, 2012), and are intended to be met through coordinated multi-agency actions, under the governance of the Berkshire Suicide Prevention Steering Group.

The objectives of this strategy developed from the national strategy are:

- To reduce suicides in Berkshire by 25% by 2020;
- To ensure better support is provided for those bereaved or affected by suicide.

The priority areas of this strategy drawn from the national strategy are:

1. Reduce the risk of suicide in key high-risk groups;
2. Tailor approaches to improve mental health in specific groups;
3. Reduce access to the means of suicide;
4. Provide better information and support to those bereaved or affected by suicide;
5. Support the media in delivering sensitive approaches to suicide and suicidal behaviour;
6. Support research, data collection and monitoring.

These six priority areas have become the golden thread which runs through this strategy and the action plans which support it. These action plans are for the year 2017/18, whilst the strategy is for the years 2017-2020, taking this to the year when the overarching aim to reduce suicide by 10%, as stated in the Five Year Forward View on Mental Health and incorporated into the Sustainability and Transformation Plans produced by groups of CCGs. There are other recommendations around process and which address the overarching aims and/or a combination of the priority areas.

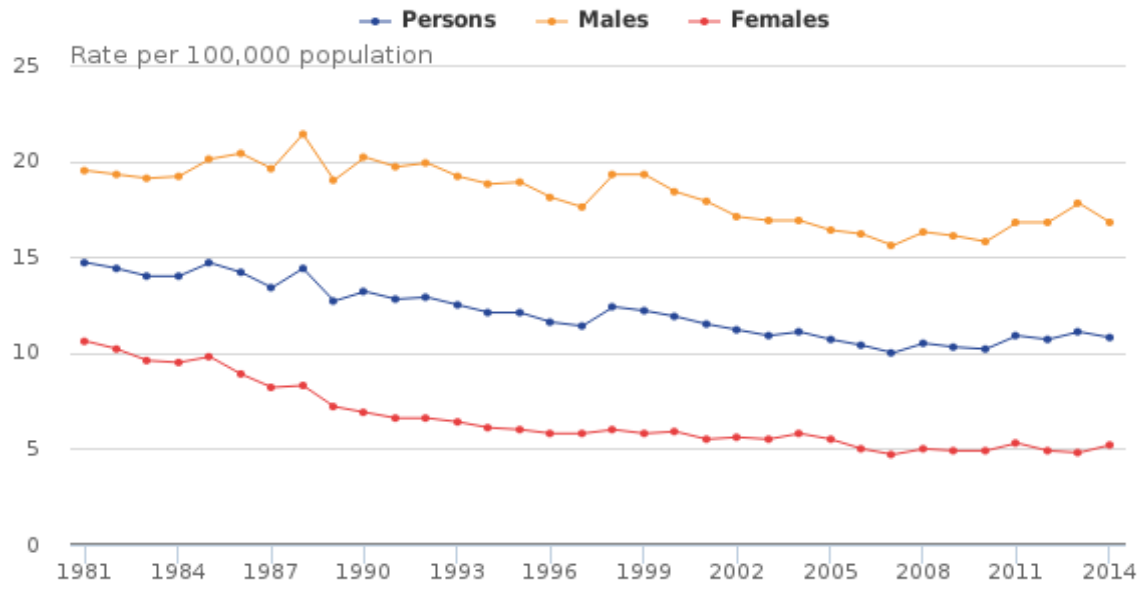
National Context

Nationally available data on suicides can help place local information on suicides in context. From the national references which include rates, trends, risk factors, suicide methods and evidence of what works to prevent suicides, a local approach for suicide prevention can be developed. This section presents the national data on suicides and is intended to be used as a guide to draw comparisons with local data and information from the Berkshire Audit.

The Office for National Statistics (ONS) provides figures on deaths by suicide, available publicly on its website at: www.ons.gov.uk. Data can be downloaded which shows numbers and rates of death by suicide per 100,000 population. Rates are important as they account for the age and size of populations, so it is more reliable when comparing suicide across age groups and areas.

Suicide is defined in England and Wales as a death with an underlying cause of intentional self-Harm and/or an injury/poisoning of undetermined intent (ICD10 codes X60-X84 - all ages and Y10-Y34 – for ages over 15 years). There is an assumption that most injuries or poisonings of undetermined intent are self-inflicted and where there is insufficient evidence to prove that the person intended to kill themselves. This assumption however is not applied to children due to the possibility that these deaths were caused by other situations – such as abuse or neglect. For this reason, data on suicides in England only include persons aged 15 years and over for deaths from injury of undetermined intent and may therefore lead to an under-reporting of deaths as a result of suicide in children.

Figure 1: Age-standardised suicide rates by sex, deaths registered between 1981 and 2014, United Kingdom



Source: Office for National Statistics, National Records of Scotland, Northern Ireland Statistics and Research Agency. 2016.

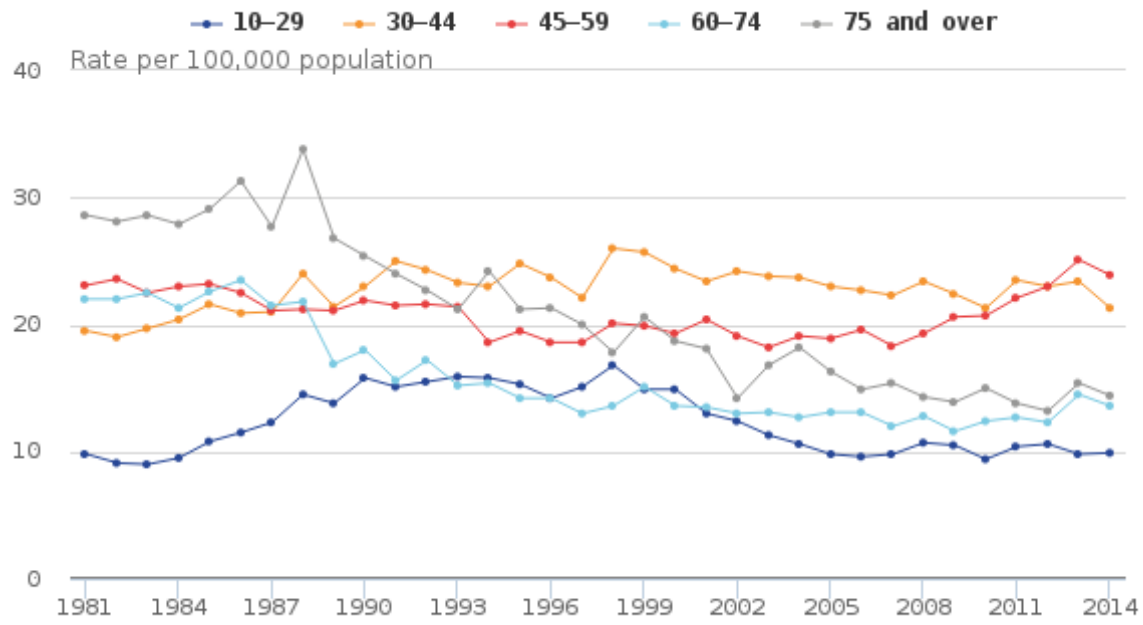
Figure 1 above shows the age standardised suicide rates for the UK since 1981. A generally downward trend in suicide rates was observed between 1981 and 2007, with a decrease from 15.6 to 10.6 deaths per 100,000 population (see figure 1). There has been a slight overall increase in suicide rates since 2007, to 10.8 per 100,000, which is part of an upward trend since 2007 for both sexes.

Suicide continues to be more than three times as common in males. The male suicide rate in 2013 was the highest since 2001. The lowest male rate since the beginning of the data series, at 16.6 per 100,000, was in 2007.

The highest suicide rate in the UK in 2014 was among men aged 45 to 59, at 23.9 deaths per 100,000, slightly lower than the record high seen in 2013. This age group also had the highest rate among women, at 7.3 deaths per 100,000 population.

Men aged 45 to 59 had the highest suicide rate in 2014 for the second year in a row with a rate of 23.9 deaths per 100,000 population. Between 2000 and 2011, the rate in this age group was the second highest, behind men aged 30 to 44. Since 2007, the rate in the 45 to 59 age group has been increasing.

Figure 2: Age-specific suicide rate, males, deaths registered between 1981 and 2014, United Kingdom

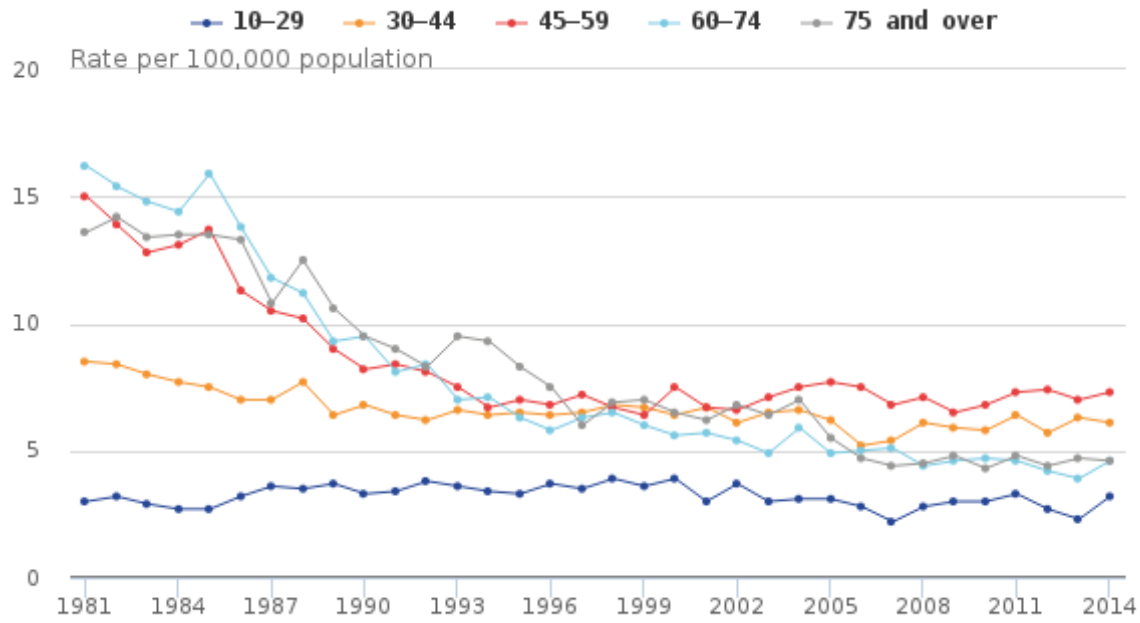


Source: Office for National Statistics, National Records of Scotland, Northern Ireland Statistics and Research Agency. 2016.

Female rates have stayed relatively constant since 2007. In 2014, the age group with the highest suicide rate for females was 45- to 59-year-olds, with a rate of 7.3 deaths per 100,000 population (see Figure 3). This has been the case since 2003. Analysing this data by 5 year age group shows that females aged 50 to 54 have the highest suicide rate at 8.0 per 100,000 population. Between 1981 and 1994, female suicide rates decreased across all broad age groups apart from 10 to 29 year-olds. Suicide rates for

women under 60 have remained relatively constant since 2008, and for women aged 60 and over continue to show a broadly decreasing trend,showing the biggest reduction since 1981.

Figure 3: Age-specific suicide rate, females, deaths registered between 1981 and 2014, United Kingdom



Source: Office for National Statistics, National Records of Scotland, Northern Ireland Statistics and Research Agency. 2016.

A time trend analysis in England suggested that the recent recession in the UK could be an influencing factor in the increase in suicides. The study found that local areas with greater rises in unemployment had also experienced higher rises in male suicides (Barr et al 2012). A review by the Samaritans (2012) emphasised that middle-aged men in lower socioeconomic groups are at particularly high risk of suicide. They pointed to evidence that suicidal behaviour results from the interaction of complex factors such as unemployment and economic hardship, lack of close social and family relationships, the influence of a historical culture of masculinity, personal crises such as divorce, as well as a general 'dip' in subjective wellbeing among people in their midyears, compared to both younger and older people (Office for National Statistics, 2014).

Suicide by mental health in-patients continues to fall, most clearly in England where the decrease has been around 60% during 2004-14. This fall began with the removal of ligature points to prevent deaths by hanging, but has been seen in suicides on and off the ward and by all methods. Despite this success, there were 76 suicides by in-patients in the UK in 2014, including 62 in England. The 2016 National Confidential Inquiry into Suicide and Homicide by People with Mental Illness found that: many people who died by suicide had a history of drug or alcohol misuse, but few were in contact with specialist substance misuse services; more patients who died by suicide were reported as having economic problems, including homelessness, unemployment and debt; and there has

been a rise in the number of suicides by recent UK residents, i.e. those who had been in the UK for less than 5 years, including those who were seeking permission to stay. There are twice as many suicides under crisis resolution / home treatment compared to in-patients.

Hanging, strangulation and suffocation account for the largest number of suicides in males, at 60% of the total. In females hanging and drug related poisoning are the joint most frequent methods, at 38%.

Strategic Context

Local suicide prevention planning is the responsibility of local authority public health teams to deliver with clinical commissioning groups (CCGs), health and wellbeing boards and a wider network of partners. Very recent guidance to inform this strategy has been developed by Public Health England (2016) in partnership with the National Suicide Prevention Alliance.

The need to develop suicide prevention strategies and action plans at a local level and which engage with a wide network of stakeholders in reducing suicide is set out in the government's national strategy for England, Preventing Suicide in England, a cross government strategy to save lives (HM Government, 2012). It is also reinforced by the Mental Health Taskforce's report to NHS England, *The Five Year Forward View for Mental Health* (NHS England, 2016).

Two key objectives are laid out in the national suicide prevention strategy:

- to reduce the suicide rate in the general population, and
- to provide better support for those bereaved or affected by suicide.

This national strategy in turn set out six key areas for action:

1 Reduce the risk of suicide in key high-risk groups
2 Tailor approaches to improve mental health in specific groups
3 Reduce access to the means of suicide
4 Provide better information and support to those bereaved or affected by suicide
5 Support the media in delivering sensitive approaches to suicide and suicidal behaviour
6 Support research, data collection and monitoring

Responsibility for suicide prevention action plans and strategy lies with local government through health and wellbeing boards. Local authorities report on the quality and success of initiatives to improve the health and wellbeing of their populations, using national indicators set out in the Public Health Outcomes Framework. Indicators relevant to suicide prevention include suicide rate, self-harm and excess mortality in adults aged under 75 years with serious mental illness

Around half of people who die by suicide have a history of self-harm, and self-harm is a sign of serious emotional distress in its own right. Mental health promotion, prevention and early intervention are essential to help reduce self-harm in the community that does not present to health services. The effective assessment and management of self-harm by NHS services where people do present with self-harm, particularly in Emergency Departments, represents a huge opportunity to reduce repetition of self-harm and future suicide risk. In June 2013, NICE published a new quality standard to improve the quality of care and support for people who self-harm. The Spending Review (2013) committed to every Emergency Department having constant access to mental health professionals and Public Health Outcomes Framework published in (2013) includes the definition of the new indicator on self-harm. This makes clear the priority given to the prevention and management of self-harm across local authority and NHS services.

Evidence Base in Suicide Prevention

The Government published its review of the suicide strategy, *"Preventing suicide in England: Two years on Second annual report on the cross-government outcomes strategy to save lives"* (Department of Health, 2015). This section summaries this, the latest evidence and best practice as identified within the report.

Men and Economic Crisis

A recent study found that men in different age brackets had different suicide risks during the recent recession. Those aged between 35-44 years old experienced increased suicide rates corresponding to economic decline. The study also found the halt in the downward trend in suicide rates amongst men aged 16-34 may have begun before the 2008 economic recession (Coope, et al, 2014).

Self-Harm and Alcohol

There was a higher rate of alcohol-related deaths for those presenting at emergency departments with self-harm for both males and females. Local areas need to ensure that those presenting to hospital with self-harm should be assessed for alcohol problems to identify issues early and get treatment (Bergen, et al, 2014). This is in line with NICE guidelines. In the year following self-harm the risk of suicide is raised 49-fold in the year, this increases with age at initial self-harm (Hawton, et al).

Crisis Resolution

Crisis resolution home treatment services have a key role to play in suicide prevention. Approximately 180 suicides each are patients who are under crisis resolution home treatment services, with approximately 80 among in-patients (Hunt, et al; NCISH 2014).

Primary Care Patients

Both frequent attendance and non-attendance at GP surgeries is linked to increased risk of suicide. For young men, non-attendance is a particular risk factor (NCISH 2002-20012).

Discharge Processes

The first 3 months following discharge from a mental health inpatient episode remains a high risk, with the highest risk at 2 weeks discharge. Community Care reforms which recommend a 7 day follow up have shown positive results although progress has stalled recently (Psychiatry Online).

Self-harm in Prisons

There is an association between self-harm and suicide within the prison setting. Prevention and treatment of self-harm should be part of the suicide prevention efforts within prisons (Hawton, et al, 2014).

National Best Practice in Suicide Prevention

These case studies were reported in, *"Preventing suicide in England: Two years on Second annual report on the cross-government outcomes strategy to save lives"* (Department of Health, 2015).

U Can Cope

The U Can Cope film and online resources were designed for people in distress and those trying to support them, to instil hope, promote appropriate self-help and inform people regarding useful strategies and how they can access help and support. They have been endorsed by the International Association of Suicide Prevention: www.connectingwithpeople.org/ucancope

Social Media

Emerging findings from the research study on Understanding the role of social media in the aftermath of youth suicides (COSMOS), commissioned in support of the suicide prevention strategy, are that:

- Suicidal tweeters show a high degree of reciprocal connectivity (i.e. they follow each other), when compared with other studies of the connectivity of Twitter users, suggesting a community of interest.
- A retweet graph shows that users who post suicidal statements are connected to users who are not, suggesting a potential for information cascade and possibly contagion of suicidal statements.
- The reaction on Twitter to the Hayley Cropper Coronation Street suicide storyline was mostly information/support and debate about the morality of assisted dying, rather than statements of suicidal feelings.
- Tweets about actual youth suicide cases are far more numerous than newspaper reports and far more numerous than tweets about young people dying in road traffic accidents. This suggests that suicide is especially newsworthy in social media. In newspapers there is no significant difference between the two types of death, in terms of number of reports per case.

Nottinghamshire Healthcare NHS Trust and Connecting with People

Nottinghamshire Healthcare NHS Trust is implementing an innovative approach to suicide prevention to improve both patient care and clinical governance. The Trust has developed a team of in-house trainers to deliver suicide and self-harm awareness and response training across the Trust. They are also piloting a web-based App to help to consistently record individual assessments. The App is integrated securely within the NHS system and is based on peer-reviewed clinical tools.

Other Trusts are also involved in the pilot of the App in partnership with the social enterprise *Connecting with People*. The approach being taken:

- Is evidence based and uses peer reviewed clinical tools. It combines compassion with sound clinical governance.

- Is proactive, emphasising safe triage and the co-creation of immediate safety plans for all patients with suicidal thoughts, irrespective of risk. It documents evidence on level of risk and actions agreed to mitigate the risks.
- Has been developed by healthcare practitioners, third sector organisations and service users, for delivery to health and social care practitioners in primary and secondary care and in third sector organisations.

It is an example of how the third sector can work effectively in partnership with the NHS to improve patient care in specialist areas, forming part of the RCPsych OnSite training.

Safety Collaboratives in Mental Health

The South West of England has had a safety collaborative in Mental Health since 2010. This work spread across the South of England in 2013. It involves the majority of Mental Health Trusts in the region. Work streams include getting medicines right, improving physical health care and delivering safe and reliable care. This includes reducing absence without leave from inpatient units and reducing suicides.

North Essex Partnership University NHS Foundation Trust and Samaritans

Three Samaritans branches together with the North Essex Partnership University Foundation Trust have signed a partnership agreement to develop a range of opportunities for patients and staff to benefit from the knowledge, experience and complementary services offered by Samaritans in support of emotional wellbeing and suicide prevention. This will include:

- NHS staff organising for a patient (with their consent) to receive a call from Samaritans.
- Training for non-clinical NHS staff on handling challenging contacts, suicide awareness and emotional well-being.
- Establishing referral pathways between Samaritans and GPs in the area.
- Samaritans presence in Emergency Departments.

This partnership is an example of how the voluntary sector and NHS can deliver better support to people by working together more closely.

Healthtalk Online for parents whose child is self-harming

Drawing on research with families, this website enables parents to see and hear parents and other family members of young people who self-harm share their personal stories on film. The films cover issues such as why young people self-harm, discovering that a young person is self-harming, how they helped their young person, living with self-harm, support and treatment, and what helped them cope. www.healthtalk.org/peoples-experiences/mental-health/self-harm-parents-experiences/topics

Staying safe if you're not sure life's worth living

A new online resource developed by the Royal College of Psychiatrists, Connecting with People, Samaritans, Grassroots Suicide Prevention, State of Mind, leading academics, people with lived experience and their carers.

Staying safe if you're not sure life's worth living includes practical, compassionate advice and many useful links for people in distress:

www.connectingwithpeople.org/StayingSafe .

Local Context

In Berkshire, the trends in suicides broadly reflect the national trends, and the results from the most recent local suicide audit, carried out in 2015, are shown below.

Of note:

- more males completed suicide than females
- 70% of the deaths recorded between 2007-2014 were in age brackets 30-44 and 45-59 years
- The percentage of deaths among the unemployed rose from 13% in 2007 to 38% in 2014
- The most common method for suicide was hanging/strangulation.

Local Suicide Audit Results

During 2015, Public Health Teams in Berkshire undertook an audit of suicide and undetermined deaths during the 2012-2014 period. This audit provides an analysis of the most recent audit and includes comparative data from previous audits. The audit defined suicide as a death where the coroner has given a verdict of suicide (based on evidence that the intent was to cause death or take own life) or where an open verdict was reached in a death from injury or poisoning. The definition comprises suicides and open verdicts coded as ICD10 X60-X84 and Y10-YY34.

Data for the audit was collected from Berkshire Coroner Office case notes for people who died from suicide or undetermined injuries during 2012-2014. The audit only includes Berkshire residents who died in the County. It is important to note that there can be a substantial delay between the date of death and the date of registration for suspected suicides, so it is likely that not all deaths from 2014 were included in this audit.

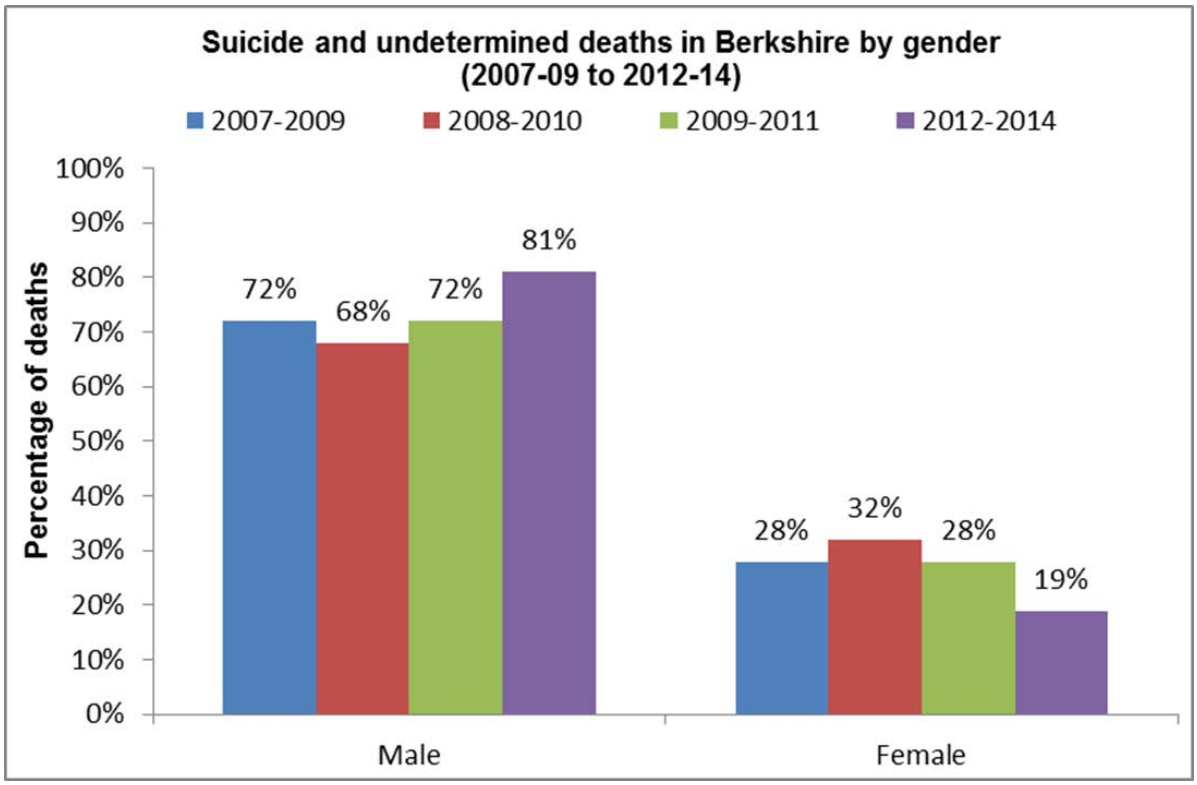
The analysis of suicide data is based on small numbers and is likely to show differences over time or between different groups that are due to random occurrence. However, the analysis of this data can give some indication as to local patterns in suicide deaths. Data from the audit is presented as averages over a three year period to reduce some of the random variations that occur when analysing small numbers. For confidentiality reasons, figures under 5% have been supressed and data is shown at a Berkshire level, rather than by individual local authorities.

120 deaths were included in the Berkshire suicide audit for 2012-14. 70% of these were classified as suicide by the coroner and the other 30% were undetermined deaths / open verdicts.

Gender

Data from all recent audits show that males have a higher suicide rate compared to women in Berkshire. This is consistent with national figures.

Figure 4: Suicide and undetermined deaths in Berkshire by gender (2007-09 to 2012-14)



Age

70% of the deaths recorded in 2012-14 were for people aged 30-59.

Age group	2012-2014
10-29	
30-44	
45-59	
60-74	
75 and over	

Ethnicity

The majority of people dying from suicide or an undetermined death in Berkshire are White-British. This is largely representative of Berkshire's population. In 2011, 73% of Berkshire's population were from a White-British background, ranging from 35% in Slough to 80% in West Berkshire. The majority of deaths from other ethnic groups (Asian/Asian-British and White-Other) were Slough residents and this also reflects the Borough's population profile. It is important to note that 15% of the cases included in the 2015 audit did not have an ethnic origin recorded in the audit. This is a higher proportion than the previous audit and will therefore have affected the validity of the analysis for 2012-2014 data.

Ethnicity	2007-2009	2008-2010	2009-2011	2012-2014
White-British	77%	75%	77%	61%
White-Other	10%	15%	13%	13%
Asian/Asian-British	<5%	<5%	<5%	12%
Black/Black-British	<5%	<5%	<5%	0%
Not Known	<5%	<5%	<5%	15%

Diurnal and Seasonal Variation

The following tables illustrate the day of the week and seasons in which deaths from suicide occurred in Berkshire during 2007-2011 and 2012-2014.

Day of the week	2007-2009	2008-2010	2009-2011	2012-2014
Monday	19%	21%	21%	20%
Tuesday	16%	17%	17%	13%
Wednesday	16%	11%	10%	9%
Thursday	10%	10%	15%	16%
Friday	8%	9%	7%	14%
Saturday	19%	14%	15%	13%
Sunday	14%	17%	15%	13%

The data shows a relatively even spread across the whole week, with no particularly 'common' day.

Season	2007-2009	2008-2010	2009-2011	2012-2014
Winter (Dec-Feb)	24%	23%	27%	28%
Spring (Mar-May)	29%	30%	27%	31%
Summer (Jun-Aug)	25%	21%	21%	21%
Autumn (Sept-Nov)	21%	26%	28%	18%

Figure 5: Suicide and undetermined deaths in Berkshire by day of week (2007-09 to 2012-14)

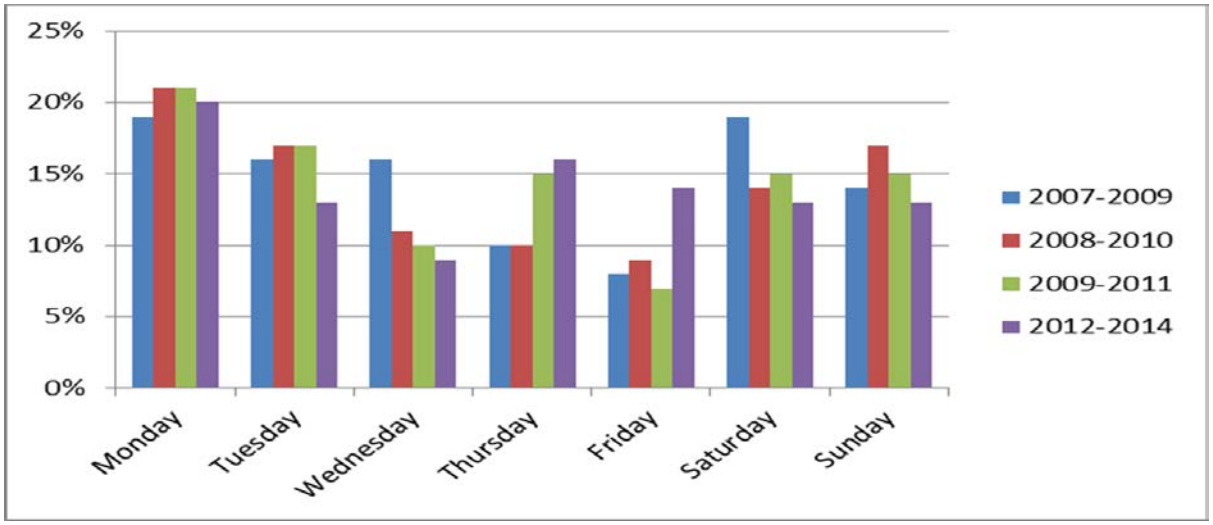
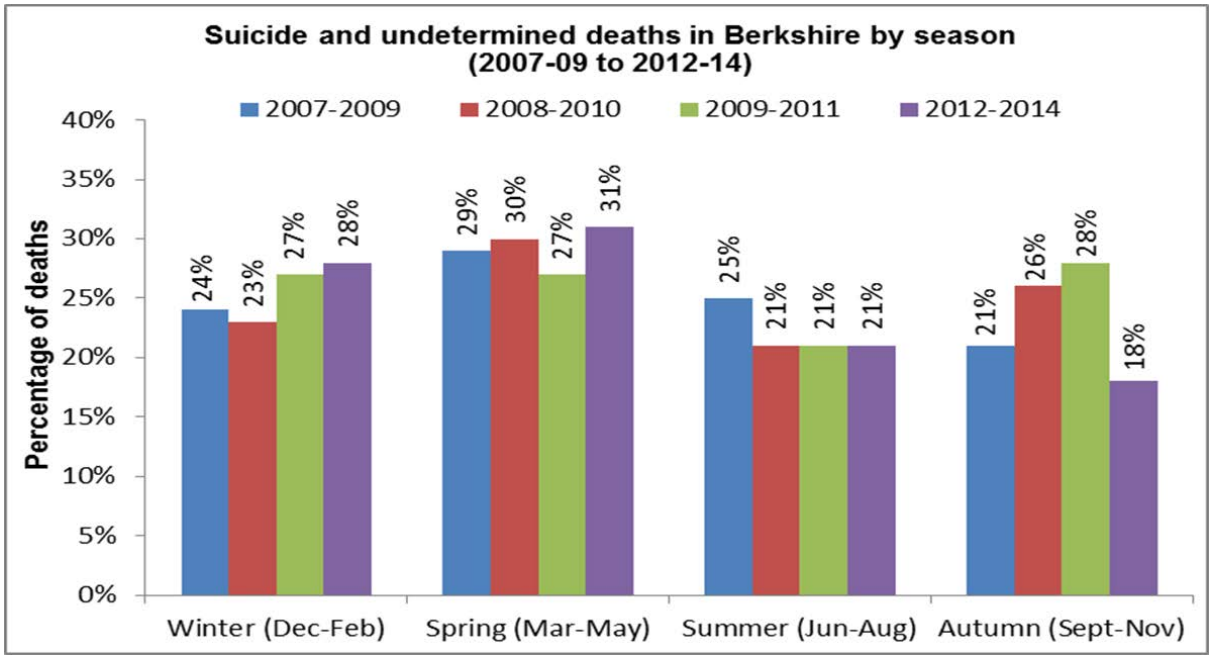


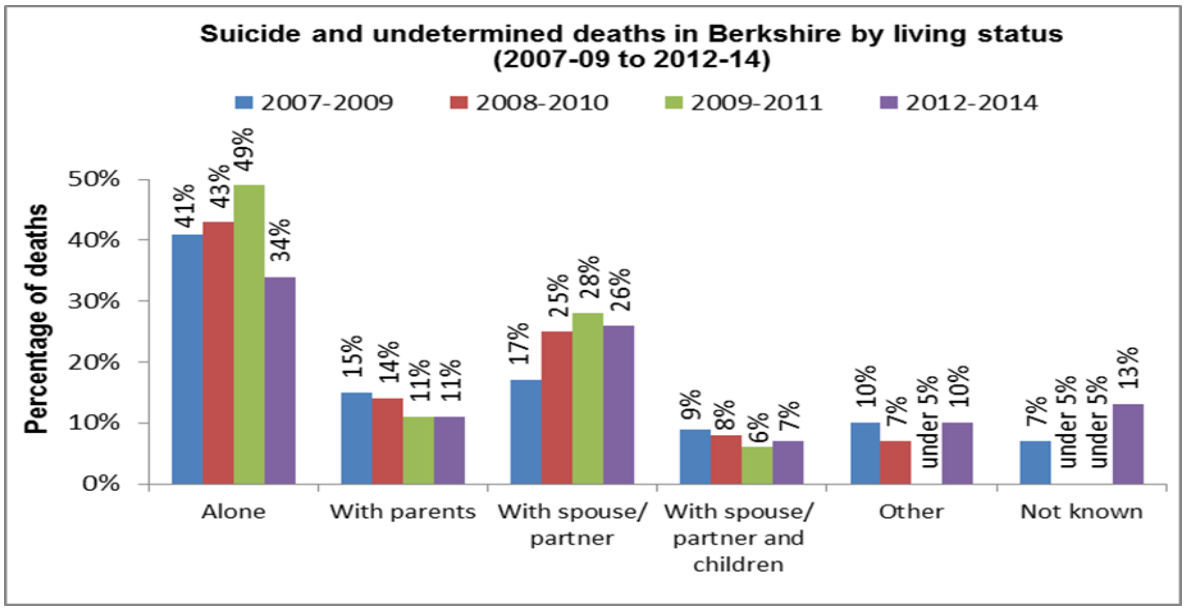
Figure 6: Suicide and undetermined deaths in Berkshire by season (2007-09 to 2012-14)



Marital and Living Status

Recent data from the Office for National Statistics shows that 13% of usual residents in England and Wales were living on their own in 2011. The table below indicates that those living alone in Berkshire are therefore over-represented in suicide deaths. This percentage has reduced from 49% in 2009-2011 to 34% in 2012-2014, however it is still the main living status recorded. It is important to note that the number of people with a living status not recorded or not known is higher in 2012-2014 (13%), which makes comparisons of data difficult.

Figure 7: Suicide and undetermined deaths in Berkshire by living status (2007-09 to 2012-14)



The table below shows that there were more deaths from single people in the two audit periods, ranging from 39% to 45%.

Marital status	2007-2009	2008-2010	2009-2011	2012-2014
Single	45%	39%	39%	40%
Married	23%	29%	30%	29%
Divorced	14%	13%	13%	8%
Separated	10%	7%	7%	<5%
Widowed	4%	6%	7%	<5%
Co-habiting	<5%	<5%	5%	10%
Not stated	<5%	<5%	<5%	6%

Employment Status

Some studies have indicated that there is a strong independent association between suicide and individuals who are unemployed (Lewis and Sloggert, 1998). Unemployment in the Thames Valley is low, although there has been some fluctuation between 2007 and 2014. The lowest level of unemployment during this time was 3.4% in Jul-07 to Jun-08, with the highest rate of 6.1% in Apr-09 to Mar-10.

Data from the 2012-2014 Berkshire audit shows that 38% of people dying from suicide and undetermined deaths were unemployed. This is an over-representation of the population, considering that only 4-5% of people were unemployed during that time period. This is also a notable increase on the figures from 2007-2011, which ranged from 11%-14%. This change may be down to a random occurrence, due to small numbers.

Employment status	2007-2009	2008-2010	2009-2011	2012-2014
Full Time	46%	51%	55%	36%
Part Time	5%	<5%	<5%	<5%
Unemployed	13%	11%	14%	38%
Student	6%	6%	<5%	<5%
Retired	18%	17%	17%	11%
Long-term illness/ disability benefits	<5%	<5%	<5%	<5%
Housewife/husband	<5%	<5%	<5%	<5%
Not known	8%	5%	<5%	12%

Suicide Note

The table below shows the proportion of deaths where a suicide note was left.

Left a suicide note?	2007-2009	2008-2010	2009-2011	2012-2014
Yes	29%	32%	40%	36%
No	71%	68%	60%	54%
Not known	0%	0%	0%	10%

Housing Status

A large number of the cases included in the 2012-2014 audit did not capture the housing status for people, which means that the data cannot be presented in this analysis.

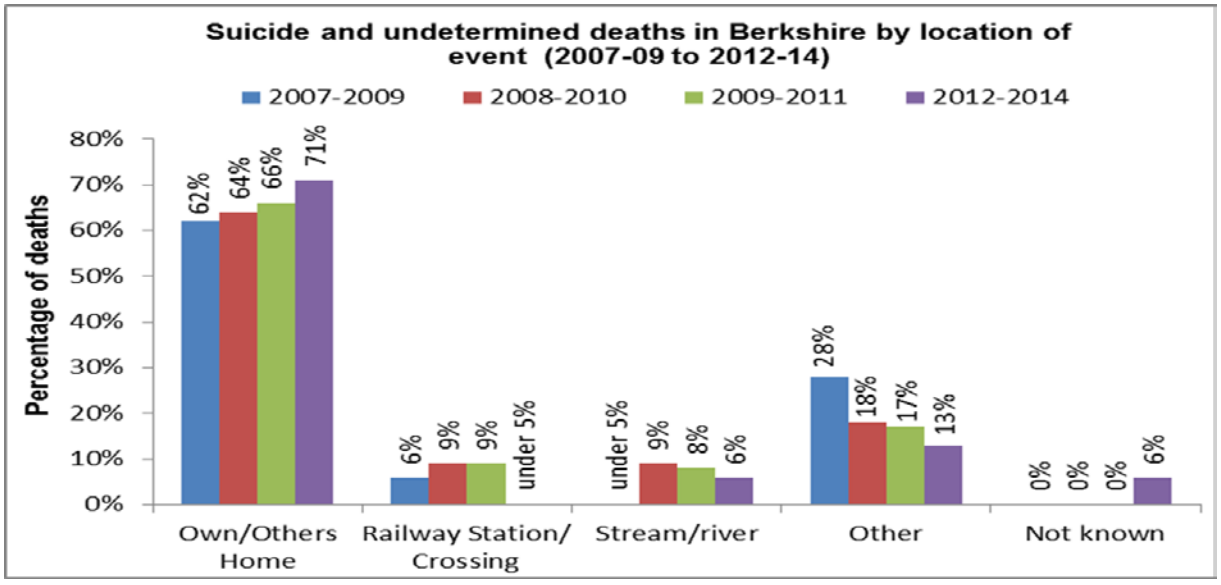
Housing status	2007-2009	2008-2010	2009-2011	2012-2014
Owner/Occupier	46%	46%	52%	35% of these cases did not have a housing status recorded and therefore this data cannot be presented
Privately Renting	41%	33%	25%	
Council House/ Housing Association	5%	9%	11%	
With Parents	<5%	<5%	<5%	
Supervised Hostel	<5%	<5%	<5%	
Unsupervised Hostel	<5%	<5%	<5%	
Other	<5%	<5%	<5%	
Not Known	<5%	<5%	<5%	

Location of event

The majority of deaths identified in the local audits took place in the person's own home or another person's home. This proportion has continued to increase from 62% in 2007-2009 to 71% in 2012-2014.

Location of event	2007-2009	2008-2010	2009-2011	2012-2014
Own/Others Home	62%	64%	66%	71%
Railway Station/ Crossing	6%	9%	9%	<5%
Stream/river	<5%	9%	8%	6%
Other	28%	18%	17%	13%
Not known	0%	0%	0%	6%

Figure 8: Suicide and undetermined deaths in Berkshire by location of event (2007-09 to 2012-14)



Methods Used

Suicide methods can be classified as either 'active' or 'passive'. Active methods are quick and effective allowing little time for reconsideration. Such methods are hanging, shooting, jumping in front of a train or from a height. Among the general population hanging, strangulation and suffocation has been identified as the most common cause of suicide for men. Passive methods are less violent and allow some time for reconsideration or intervention (e.g. self-poisoning, carbon monoxide). Hanging/strangulation has been the most common cause of death over 2007-2014.

Methods used	**2007-2009**	**2008-2010**	**2009-2011**	**2012-2014**
Hanging / Strangulation	54%	47%	48%	49%
Carbon Monoxide Poisoning	8%	<5%	<5%	<5%
Jumping / laying before a train	6%	9%	9%	<5%
Jumping from a height	11%	11%	8%	<5%
Self-Poisoning	10%	9%	12%	0%
Drowning	<5%	7%	7%	6%
Other	7%	12%	14%	38%
Not known	0%	0%	0%	<5%

Alcohol and drugs taken at time of death

The audit of people dying from suicide and undetermined deaths during 2012-14 identified whether alcohol or prescribed drugs were detectable in the deceased. This data was not collected in the previous audit. The tables below show that at least 36% of people who died in 2012-14 had taken alcohol prior to their death and at least 42% had taken prescribed drugs, and outlines those drugs that were implicated in suicide deaths.

Alcohol present?	**2012-2014**	
At intoxicating level	23%	
At non-intoxicating level	13%	
No alcohol detected	54%	
Not known	11%	
Prescribed drugs present?	**2012-2014**	
At fatal level	14%	
At intoxicating level	8%	
At therapeutic level	20%	
No prescribed drugs detected	43%	
Not known	16%	
Drugs implicated	**Male**	**Female**
Antidepressants	✓	✓
Paracetamol	✓	
Coproxomal or similar	✓	✓
Benzodiazepine	✓	
Other hypnotic		
Anti-psychotic	✓	✓

Other substances implicated in suicide deaths in 2012-14 were:

Other substances	Male	Female
Amphetamines	✓	✓
Ecstasy	✓	
Crack/Cocaine	✓	
Ketamine	✓	
Heroin	✓	✓
Opiates	✓	
Methadone	✓	✓

Personal, Social and Health Factors associated with deaths from suicide

The following factors were identified from records at the Coroner's Office as being associated with suicide:

Factor identified	2007-2009	2008-2010	2009-2011	2012-2014
Relationship problems	14%	6%	<5%	29%
Financial problems	9%	6%	<5%	24%
Depression	25%	42%	51%	67%
Low self esteem	<5%	<5%	<5%	Not collected
Other Mental health Issues	8%	8%	<5%	Not collected
Pending Police Investigation	<5%	<5%	<5%	12%
Family bereavement	<5%	<5%	<5%	12%
Physical Health	8%	<5%	<5%	33%
Job related	<5%	<5%	<5%	17%
Not Stated	15%	13%	20%	-

2015 Data Update

The most recent raw data on the number of suicides in Berkshire was released in December 2016 by the Office for National Statistics for the year 2015. This shows an increase across Berkshire as a whole rather than a small decrease as seen in England and the South East. Caution should be employed as these raw data do not give the detail required to indicate trends or draw conclusions.

	2014	2015	Difference
Bracknell Forest	5	10	+ 5 (+ 100%)
RBWM	11	11	0
Slough	15	9	- 6 (- 40%)
Reading	12	18	+ 6 (+ 50%)
West Berkshire	5	6	+ 1 (+ 20%)
Wokingham Action	6	14	+ 8 (+ 233%)
Berkshire Total	54	68	+ 14 (+126%)
SE England Total	794	756	- 5%
England Total	4882	4820	- 1%

Local Governance Structures

In order to facilitate the production of this strategy and to steer the Berkshire-wide audit of suicides, a strategic group was convened with representatives from organisations across county. This worked under the identity of the Berkshire Suicide Risk & Self Harm Reduction / Prevention Steering Group. During 2015/16 as key staff changed, the group has lost some of its membership and had become less strategic. The original terms of reference state that the group:

> "*will provide public health leadership and advice to support a joint approach to achieve real change in the prevention of suicides and self- harm through actions taken by member organisations. It will facilitate the bringing together of clinicians, professionals and organisations, with the patient's voice, to deliver surveillance data to support projects / programmes to prevent suicides and offer support to those who are bereaved*."

Public Health England (2016) suggests that the membership of suicide prevention partnerships is made up of representative working with adults, children and young people. The following diagram suggests the range of partners who may be included.

The Berkshire Steering Group will need to own this strategy, and the membership should be updated to ensure a closer fit with the groups suggested above. The membership of the current group as at December 2016 is detailed in Appendix 8.

RECOMMENDATION

That the Berkshire Steering Group re-visits their terms of reference and membership and become known as the "Berkshire Suicide Prevention Steering Group", with the aim of providing the governance to this strategy and its action plans.

There are other groups for whom this strategy and its action plans are an important issue, and these include commissioning boards in the East Berkshire and West Berkshire Confederations of CCGs; Health and Wellbeing Boards; Health Overview and Scrutiny Committees; Adult Safeguarding Boards; and Community Safety Partnerships. In order to get full endorsement of this strategy and for organisations to commit to their action plans, the terms of reference should ensure that the links to these other structures are robust and transparent.

Members of the Steering Group could be asked to act as suicide prevention champions. These are individuals who get involved in specific pieces of suicide prevention work – and might include people who have been bereaved by suicide or those with a special interest or expertise. They can be pivotal in raising issues regarding suicide awareness locally, and drive forward the action plans of their agencies. A specific initiative to engage the elected members of councils as Mental Health Champions may provide an opportunity for them to also speak out on suicide prevention. Details of this initiative are available here: http://www.mentalhealthchallenge.org.uk/the-challenge/

RECOMMENDATION
That organisations represented on the Berkshire Suicide Prevention Steering Group consider nominating a suicide prevention champion from within their membership.

Monitoring & Evaluation and Progress

This is a pan-Berkshire and multi-agency Strategy and the action plans for this strategy which are overseen by the Berkshire Suicide Prevention Steering Group are set out below.

Individual Borough action plans for each of the six Berkshire Unitary Authorities are also included and are set out in appendices 2-7. These give a more local set of priorities and respond to the particular geographical issues, population structures and general health needs of the Authorities.

Other agencies which are part of the Steering Group may have their own action plans and an objective of this strategy is to bring these into one combined action plan as far as possible and to share openly the actions plans of all agencies in order to learn from one another; to avoid un-necessary duplication of effort or resources; and to encourage co-production of outcomes.

Links to Other Local Strategies

This is the first comprehensive Berkshire-Wide Suicide Prevention Strategy and action plans have been produced for the year 2017-18. One of the objectives is to ensure that this strategy, its aims and objectives are shared and upheld in the strategies, action plans and objectives of all those groups across Berkshire who are committed to improving health outcomes, promoting wellbeing, removing the stigma associated with mental health and preventing suicides.

Local Joint Health and Wellbeing Strategies and their action plans should endorse this Strategy and Health and Wellbeing Boards are key to the governance of this Strategy and the Steering Group. Through tightly-knit joined up thinking, organisations, individual and communities across Berkshire can come together to make the progress necessary to reduce suicides in our populations.

RECOMMENDATION

That all agencies represented on the Steering Group commit to an annual Action Plan of their own which can then be brought together to create a Berkshire-wide Action Plan for each year of the Strategy.

Local Best Practice in Suicide Prevention

Thames Valley Suicide Prevention and Intervention Network (SPIN) CALMzone

The Campaign Against Living Miserably (CALM) was originally a Department of Health helpline project on suicide prevention particularly targeting younger men using marketing methodology and images to specifically engage with this audience on issues surrounding mental distress and social alienation. The resources produced directed men to a special helpline, and latterly to web-based resources. In 2000, a partnership of six areas in the North-west of England commissioned this work for young men in Merseyside, which continued when CALM transferred into a national charity. There is a local CALMzone Coordinator who promotes CALM across Merseyside in collaboration with the local community – pubs and clubs, venues and universities, sports teams and clubs – to encourage them to join and promote the campaign.

In 2015, the local authorities across the Thames Valley through SPIN funded a Thames Valley CALMzone, and employed a coordinator undertaking similar promotions as in Merseyside. CALM have provided local commissioners with anonymised reports on numbers and trends of calls and web chats across the Thames Valley. As well as providing funding to support the helpline, the commissioners ensure CALM has an up-to-date local database of agencies which local callers can be referred to. Berkshire local authorities have continued to fund the helpline until June 2017, although the local coordinator post is no longer funded.

RECOMMENDATION
Evaluate the Berkshire CALMzone and recommission targeted suicide prevention work for younger men and middle aged men.

Real Time Suicide (and near fatal self-harm) Surveillance

It is important to have a real time overview of self-inflicted deaths/suspected suicides and near fatal self-harm in order to provide timely support for those bereaved and affected, pick up community risks of contagion or suicide clusters and identify public places where suicides/incidents of near fatal self-harm appear to occur with increasing frequency. All of these activities contribute to suicide reduction and prevention in line with national and local strategy. Thames Valley Police (TVP) and the Thames Valley Suicide Prevention and Intervention Network (SPIN), supported by funding from the Thames Valley Strategic Clinical Network are collaborating to build on the supportive signposting for people bereaved by suicide work and develop a robust real time surveillance process.

In simple terms this process is as follows:

- TVP identifies and collates suspected suicides on the Gen 19 sudden death form.
- Coroner's officers send Gen 19s of suspected suicides to a central TVP email for monitoring.
- Details of the incidents in real time are thereby collated and are available for analysis, reporting and provide the ability to respond.

- Details of families who consent to 'Supportive Signposting' are sent to a central NHS England suicide bereavement address.
- Supportive literature and referral signposting links to organisations and charities are provided to relatives.

RECOMMENDATION
Ensure bereavement information and access to support is available to those bereaved by suicide, including professionals involved in the case.

Further data is being collated from the following sources;

- NHS England monitor the strategic executive information system database for suspected suicides and near fatal self-harm.
- Links are being established with British Transport Police to monitor suspected suicides and near fatal attempts on the railways
- Links are being established with prisons to monitor prison suspected suicides and near fatal attempts.
- Links are to be established with the general hospital psychiatric liaison services to monitor incidents of near fatal self-harm.

All of this information will be reviewed by the TVP and SPIN leads and figures and concerns will be communicated to local public health suicide prevention leads for consideration within the local multi-agency suicide prevention action groups. A hub of SPIN comprising TVP, public health, NHS and the University of Oxford Department of Psychiatry Centre for Suicide Research has been established to maintain oversight of the regional prevalence of suicide with the aim of collaborating where indicated, in order to respond to issues that concern the whole geography, for example contagion and clusters.

Berkshire Healthcare Foundation NHS Trust (BHFT) Zero Suicide Programme

Berkshire Health Care Foundation NHS Trust have been inspired by the pioneering zero suicide approach within the Henry Ford Hospital System (USA). The Henry Ford Hospital System managed to implement a philosophy and practice of 'perfect depression care' which led within four years to a 75% drop in suicides, and eventually to years without a single suicide. For BHFT Zero suicide means using the ambitious target of zero to help focus on this quality improvement issue. Thinking in this way encourages tracking of best practices and formally incorporating them into how service users are treated. Most importantly, it encourages Trust staff to work with in collaboration with service users, carers and primary care colleagues to focus on genuine service user engagement and identification of need.

Based on their analysis of research and Trust data showing key patterns and risk points for suicide, BHFT have set key priority areas for their zero suicide campaign.

1. Optimise systems to enable staff to focus on engagement and collaborative approaches to risk assessment and management with service users and carers at the centre.

2. Training and supervision to equip staff with skills and competence to practice recovery focussed approaches to suicide risk and enable positive risk management and safety planning.
3. Development of a BHFT suicide surveillance dashboard – real time information on service gaps and analysis of patterns to inform practice and training.
4. Collaborating with colleagues, service users and carers as part of a wider suicide awareness campaign beyond secondary mental health care.

Areas of High Frequency

Due to their geography, design or operational use, there are places which present easier access to the means of suicide than others. This could be as a result of their isolation from staff operating their functions; because they are more generally isolated from crowds and the general public: or because life-threatening hazards exist which are generally mitigated by normal operation. They may have become known as places where suicides have occurred previously, either via media reports, or word of mouth.

The Railway Network

The railway network, mostly operated by Network Rail, is in places associated with higher frequencies of suicides, injurious attempts at suicide and suicide attempts and other incidents of people in hazardous positions which do not cause physical injury. The rail network in Berkshire includes a section of the main Great Western Railway routes from London to Wales and the South West, as well as sections of suburban rail lines and minor branch lines. The Great Western lines feature high-speed trains, and is presently being electrified by means of overhead cables. Most of the suburban rail lines are electrified using a third rail system. As well as a high volume of passenger trains, most local lines also feature freight trains operating throughout the day and night.

On average there are 255 suicides on the network per annum. Rail staff particularly drivers, are likely to be severely traumatised by these events and some may never return to work and therefore might need to access support services because of that. Network Rail operates a comprehensive programme of suicide prevention, working to reduce the potential for suicides to occur on the rail network and the industry sees its potential as going beyond that by seeking to do all it can to prevent suicides in its neighbouring communities. In 2015 Network Rail, together with British Transport Police, and The Samaritans agreed a process whereby any location that experienced three suspected suicide or injurious attempt incidents (or a combination of the two) would be subject of an escalation process. This would mean that enhanced working would be taken by all three parties in order to prevent further incidents at that that location. In Berkshire, there are locations where this process has been enacted. Actions taken at these locations include engineering solutions, such as the replacement of crossing with overbridges; or the fencing off of platforms on non-stopping fast lines; and the placement of Samaritans posters across the location.

RECOMMENDATION
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.

The Motorway and Roads Network

Most motorways and trunk roads (the strategic road network) are the operational responsibility of Highways England, with most other roads being the responsibility of local authorities, whilst some roads and byways are in private ownership. In Berkshire, the main London to South Wales Motorway, the M4 passes through the length of the county through all of the six unitary authorities and is managed by Highways England,

whilst the adjoining A329(M) motorway is the responsibility of Wokingham Borough Council. The speed of traffic on these roads and other major roads together with their overbridges provide places which can give access to the means of suicide. In 2013, the Highways Agency Traffic Officer Service attended 293 of 652 suicide/attempted suicide incidents on the strategic road network. Between April 2013 and December 2014, there were over 1,500 incidents which were brought to the attention of a Traffic Officer (Sutherland, 2015). Definitions in this area are not clear, but this does seem to indicate an increase in the reporting of road network incidents, if not in the number of incidents themselves.

RECOMMENDATION
That the Steering Group seek a named Highways England officer to act as a liaison link and group member, and to share real-time intelligence of highways network incidents.

Car Parks and Tall Buildings

Berkshire towns feature a number of multi-storey car parks of which some in the management or ownership of the Local Authorities. There are also many other tall buildings both residential and commercial, and together these locations can sometimes provide an access route to a means of jumping from a height.

The Horsham branch of The Samaritans is working with a local shopping centre and car park where suicides have occurred. They offer sessions for the car park attendants who are generally the first on the scene. They also have an arrangement with the shopping centre to call Samaritans if there is an incident, either to support the staff involved or to support shoppers/shop workers more generally if the incident was widely witnessed. (Sutherland, 2015). This is a simple intervention in which suicide prevention training could be incorporated.

Local Authority Settings

Local authorities may be responsible as owners, operators or managers of other facilities and locations where suicides may take place. This may be because of their isolation or due to their inclusion of specific means of suicide within them. Generally the local authorities in Berkshire look after many hectares of open space; parkland; and woodland, some of which may be managed as part of the highways network; but with most likely to be part of an open spaces portfolio. There is also significant waterside public realm managed or owned by the authorities. The risks at these sites include strong, tall trees as a means of hanging; access to water features such as lakes, rivers and canals which pose a risk of drowning; and dense undergrowth which could allow a person to die through neglect and exposure. Council staff and contractors may have an enhanced role to play in identifying suicide risks and in supporting people who appear to be in distress

RECOMMENDATION
That local authority public health teams work with other council departments such as car parks and open space services to identify local actions to prevent suicide including staff awareness training.

Mental Health Crisis Care Concordat

The Mental Health Crisis Care Concordat is a national agreement between 22 national agencies involved in the care and support of people in crisis and includes health, policing, social care, housing, local government and the third sector. It sets out how these agencies will work together better to make sure that people get the help they need when they are having a mental health crisis. Local areas have submitted declarations and developed action plans for the improvement of local mental health crisis care for their areas.

The Concordat focuses on four main areas:

- Access to support before crisis point – making sure people with mental health problems can access help 24 hours a day and are taken seriously.
- Urgent and emergency access to crisis care – making sure that a mental health crisis is treated with the same urgency as a physical health emergency.
- Quality of treatment and care when in crisis – people are treated with dignity and respect, in a therapeutic environment.
- Recovery and staying well – preventing future crises by ensuring that people are referred to appropriate services.

Although the Crisis Care Concordat focuses on the responses to acute mental health crises, it also includes a section on prevention and intervention. This strategy includes and reflects some of the key messages and recommendations from the concordat, aiming to reinforce a commitment by partners to work together in preventing and managing crises.

The local Crisis Care Concordat has, common to this strategy, been set at Berkshire-wide level, and has a comprehensive action plan, and certain actions include specific suicide prevention actions. These relate to the work of British Transport Police and the escalation process and staff training issues. They are more detailed than the recommendations and actions set out in this strategy, but there is strategic fit. There is a need to ensure full reference to this strategy in the Crisis Care Concordat action plans, and for further synergies to be explored.

RECOMMENDATION
Ensure strategic fit with the action plans of the Berkshire Crisis Care Concordat.

Gap Analysis and Emergent Berkshire-Wide Concerns

A gap analysis was undertaken by members of the Steering Group to identify the areas of the National Strategy which were not seen to be adequately addressed across Berkshire, taking into account the results of the local Suicide audit and the demography of the six unitary authorities. Some emergent concerns have also been captured which reflect discussion on the audit findings.

High Risk Groups

This strategy recognises that individuals may fall into two or more high-risk groups. Conversely, not all individuals in the group will be vulnerable to suicide. Other risk factors, such as loneliness, social circumstances and physical illness, must also be considered within the wider context or risk (Preventing suicide in England, Department of Health, 2012).

Berkshire is home to the University of Reading and other higher and further education establishments. Although the risk of suicide in the student population locally has not been established, recent ONS data (ONS, 2012) has shown a substantial increase nationally in both male and female suicides in the student population from 2007-2011.

Carers and people with long-term conditions have been highlighted as a local population at particular risk and this has been reinforced by the investigations into domestic homicides where a partner had subsequently taken their own life or attempted to. Adult Social Care and Public Health Outcomes Frameworks record measures of carer social interaction and that of people receiving care which give an insight into the vulnerabilities of these groups, and these are highlighted in the PHE Suicide Prevention Profiles. Not all people with a long-term health condition will be captured within these data, however; and the impact of symptoms such as chronic pain and reduced mobility, and access to certain medicines make this a group with heightened risk and access to means of suicide.

Berkshire no longer contains a prison. People in the criminal justice system will be imprisoned in neighbouring counties, which could make access visits more difficult for family and friends leading to increased isolation for the imprisoned.

Self-Harm continues to be an important risk factor for suicide and growing evidence to support using self-harm as an outcome measure for suicide prevention work with evidence showing that hospital presentation following self-harm is a clear risk factor for suicide (Hawton et al. 2012). There are around 200,000 episodes of self-harm that present to hospital services each year in England, although the true scale of the problem is not known as many people who self-harm do not attend A&E, or seek help from health or other services. Around 50% of people who die by suicide had a history of self-harm, in many cases with an episode shortly before their death, and around 15% of those who die by suicide have carried out an act of self-harm leading to presentation at hospital in the year before their death (PHE 2016).

The table below shows the rates of self-harm and suicide in the six authorities in Berkshire from the PHE Suicide Prevention Profiles (PHE, 2016A). All authorities have lower rates than England, although there is quite some variation across the authorities. It is important to ensure implementation of the NICE standards and pathways CG16 and CG133 for managing patients who self-harm.

Indicator	Period	England	SE England	Bracknell Forest	Reading	Slough	West Berkshire	Windsor & Maidenhead	Wokingham
Hospital stays for Self-Harm	2014-15	191.4	193.1	118.3	130.0	162.2	127.0	150.6	91.1
Suicide Rate persons	2013-15	10.1	10.2	8.1	11.0	8.8	7.0	7.1	6.0
Suicide rate (male)	2013-15	15.8	15.9	*	19.0	14.8	*	*	*
Suicide rate (female)	2013-15	4.7	4.8	*	*	*	*	*	*

Source: PHE Prevention Profiles. 2016

RECOMMENDATION
Implement the NICE guidelines on self-harm, specifically ensuring that people who present to Emergency Departments following self-harm receive a psychosocial assessment.

Tailor approaches to improve mental health in specific groups

Work on detailed Mental Health Strategies is underway across the Berkshire East and Berkshire West health systems. It will be important to ensure a good strategic fit between this strategy and those that are developed. Mental health and wellbeing promotion will remain important objectives of both strategies.

RECOMMENDATION
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.

Support research, data collection and monitoring

With real-time surveillance giving information on suicides and many near fatal self-harm events, there is concern that not all events will be recorded, for instance those attempted suicides which occur on the highways network.

There is further analysis of Coroner's case notes that is recommended as good practice, such as the last contact with a GP which have not been captured in the last local audit. A new audit should be run with this new category for deaths in the period 2014-16, beginning as soon as practicable. This can then be appraised alongside data received through real-time surveillance; gaps identified and protocols and policies put in place to

ensure that data can be confidentially shared for the purposes of identifying trends and clusters in order to take appropriate preventative actions.

RECOMMENDATION

Develop working relationships between individual coroners and local public health teams ensure local plans are evidence based and responsive. Coroners can be invited to become formal members of any local suicide prevention groups or networks

Coroners can also inform the local authority or Director of Public Health if they identify particular areas of concern, e.g. locations used for suicide, possible clusters of suicide, increase in a particular method or new and emerging method of suicide.

Refresh the Berkshire-wide Suicide Audit for deaths in the period 2014-16 to include new categories based on best practice.

Domestic Homicide Reviews

Domestic Homicide Reviews (DHRs) are part of the Domestic Violence, Crime and Victims Act 2004 and became law as of the 13th of April 2011. They do not replace but are in addition to an inquest or any other form of inquiry.

DHRs are one way to improve responses to domestic violence and aim to prevent the avoidable death of a member of the community. The review helps to ensure that public bodies including health, local authorities, police and other community based organisations understand the factors surrounding the death and identify where responses to the situation could have been improved. From this, the agencies involved are in a stronger position to learn appropriate lessons, including those involving joint working. A DHR does not seek to lay blame but to consider what happened and what could have been done differently. It also recommends actions to improve responses to domestic violence situations in the future.

DHRs are commissioned by Community Safety Partnerships where a death of a resident has occurred in accordance with the criteria set out in the Home Office Multi Agency guidance;

> ‘Domestic homicide review means a review of the circumstances in which the death of a person aged 16 or over has, or appears to have, resulted from violence, abuse or neglect by:
> (a) A person to whom he was related or with whom he was or had been in an (a) intimate personal relationship, or
> (b) A member of the same household as himself, held with a view to identifying the lessons to be learnt from the death.’

Updated DHR guidance was published in December 2016 and the DHR process is also now available to cover historic victims of domestic abuse:

> “Where a victim took their own life (suicide) and the circumstances give rise to concern, for example it emerges that there was coercive controlling behaviour in

the relationship, a review should be undertaken, even if a suspect is not charged with an offence or they are tried and acquitted. Reviews are not about who is culpable."

Such circumstances are likely to be rare; however the duty to undertake a DHR if required may place additional burden on those implementing suicide prevention locally. However, this must be balanced with the likelihood of new learning, which should be fed back into the Berkshire Suicide audit process.

Berkshire-Wide Action Plan 2017-18

Areas for Action	Specific Risk Groups	Action in 2017-18	Timescale by:	Delivery Lead
Overarching Aims		Sign off / endorsement of this Berkshire Suicide Prevention Strategy by all Health & Wellbeing Boards in Berkshire.	1 April 2017	Lead Consultant Mental Health
		All other local governance completed thus enabling this strategy to be owned by the Local Authorities and their partners.	1 April 2017	Local PH Mental Health Leads
		Launch of strategy at multi-agency suicide prevention summit.	15 Oct. 2017	Strategic DPH
		Identify Suicide Prevention Champions to promote the Berkshire Strategy; and to work within the Local Authorities and partner agencies.	15 Oct. 2017	Local PH Mental Health Leads
		Develop Berkshire-wide information sharing protocols to best utilise real time surveillance of suicides and near misses, in order to respond promptly to local trends and risks to reduce risk of clusters, and inform future service delivery.	30 July 2017	Lead Consultant Mental Health
		The Steering Group revisit their terms of reference and membership and become known as the "Berkshire Suicide Prevention Steering Group", with the aim of providing the governance to this strategy and its action plans.	1 April 2017	Steering Group Members
		Ensure strategic fit with the action plans of the Berkshire Crisis Care Concordat.	1 April 2017	Lead Consultant Mental Health
National Strategy				
1. Reduce the risk of suicide in key high-risk groups	Men	Evaluate the Berkshire-Wide CALMzone initiative and agree Berkshire-wide commissioning of specific support services for men for future years. To include future commissioning of CALMzone for younger men; and services for middle aged men and older men.	15 Oct. 2017	Lead Consultant Mental Health
	People who self-harm	Ensure agencies have plans to Implement the NICE guidelines on self-harm	15 Oct. 2017	Lead Consultant Mental Health
	People who misuse substances	Ensure local strategies and contracts for DAAT services include suicide prevention objectives.	Ongoing work	Local PH Mental Health Leads

	People in mental health care	Support BHFT in its Zero Suicide Approach, and support local prevention work across the care system.	Ongoing work	Steering Group Members
	People in contact with the criminal justice system	Identify local actions to prevent suicide in those in contact with the criminal justice system, recognising increased incidence of self-harm in the prison population.	30 July 2017	Local PH Mental Health Leads
	Occupational groups	Ensure local health trusts and providers can demonstrate actions to prevent suicide and promote metal wellbeing amongst their staff.	30 July 2017	Steering Group Members
		Identify particular local action plans for those in agricultural / land-based industries.	30 July 2017	Local PH Mental Health Leads
2. Tailor approaches to improve mental health in specific groups	Community based approaches	For the Steering Group to assess community-based interventions which may be best delivered at scale across the county.	Ongoing work	Steering Group Members
	Suicide prevention training	Coordinate a database on evidence based suicide prevention training programmes and providers across the county.	Ongoing work	Steering Group Members
	People vulnerable due to economic circumstances	For the Steering Group to solicit data from each LA on key indicators that may highlight risk: e.g. number of homelessness presentations.	Ongoing work	Steering Group Members
	Pregnant women and those who have given birth in last year	To undertake a needs assessment of this group in relation to suicide prevention.	30 July 2017	Local PH Mental Health Leads
	Children and young people	Through LSCBs, identify local actions to prevent suicide in children and young people.	30 July 2017	Local PH Mental Health Leads
3. Reduce access to the means of suicide		Support Network Rail, British Transport police and The Samaritans with local escalation process locations and general suicide prevention work.	Ongoing work	Steering Group Members
		Investigate suicides on council owned land and properties, and agree a local action plan.	15 Oct. 2017	Local PH Mental Health Leads
		Analyse local data gathered from the suicide audit and/or real-time surveillance to identify trends and clusters and take appropriate action(s) e.g. work with local media.	Ongoing work	Local PH Mental Health Leads

		The Steering Group seek a named Highways England officer to act as a liaison link and group member, and to share real-time intelligence of highways network incidents.	1 April 2017	Lead Consultant Mental Health
4. Provide better information and support to those bereaved or affected by suicide		Promote resources for people bereaved and affected by suicide (e.g. Help is at Hand and National Suicide Prevention Alliance resources), and support services such as SOBS (Survivors of Bereavement by Suicide).	Ongoing work	Steering Group Members
5. Support the media in delivering sensitive approaches to suicide and suicidal behaviour		Convene a Berkshire-wide Summit on journalism and reporting standards with local press and media organisations, to develop and agree standards for reporting. Agree a local action plan with the local communications team to support this aim. Identify a lead officer to monitor internet and both local and social media. Challenge stigma: Media campaign to support world suicide prevention day Update council and stakeholder webpages to ensure effective signposting for those bereaved by suicide	20 July 2017 20 July 2017 Ongoing work 1 Sept 2017 1 April 2017	Lead Consultant Mental Health Local PH Mental Health Leads Local PH Mental Health Leads Local PH Mental Health Leads Local PH Mental Health Leads
6. Support research, data collection and monitoring		Refresh Berkshire-wide suicide audit to include deaths during 2014-2016 to include data on GP consultations. To update data on the JSNA summary on suicide.	30 July 2017 As per JSNA timetable	Local PH Mental Health Leads Local PH Mental Health Leads

References

To be checked and formatted

All-Party Parliamentary Group on Suicide and Self-Harm Prevention. Inquiry into local suicide prevention plans in England. All-Party Parliamentary Group on Suicide and Self-Harm Prevention; 2015.

Barr, et al. Suicides associated with the 2008-10 economic recession in England: time trend analysis. BMJ 2012; 345:e5142 doi: 10.1136/bmj.e5142 (Published 14 August 2012).

Hawton K, Bergen H, Cooper J, Turnbull P, Waters K, Ness J, et al. Suicide following self-harm: findings from the multicentre study of self- harm in England: 2000-2012. J Affect Disord. 2015 Apr 1;175:147-51.

HM Government. Preventing suicide in England: A cross government strategy to save lives. London: Department of Health; 2012.

HM Government. Preventing suicide in England: Third progress report of the cross-government outcomes strategy to save lives. London: Department of Health; 2017.

Home Office. Multi-agency Statutory Guidance for the Conduct of Domestic Homicide Reviews. London: Home Office; 2016.

Making Mental Health Care Safer. The National Confidential Inquiry into Suicide and Homicide by People with Mental Illness. Annual Report and 20-year Review. University of Manchester; 2016.

NHS England Mental Health Taskforce. The five year forward view for mental health. NHS England; 2016.

Office for National Statistics. Suicides in students http://www.ons.gov.uk/ons/about-ons/what-we-do/publication-scheme/published-ad-hoc-data/health-and-social-care/november-2012/index.html ; 2012. [Accessed November 2016].

Office for National Statistics. Suicides in the UK in 2014. London: Office for National Statistics; 2015.

Office for National Statistics. Suicides in the UK in 2015. London: Office for National Statistics; 2016.

Public Health England (PHE). Local Suicide Prevention Planning, A Practical Resource. Public Health England; 2016.

Samaritans. Men, Suicide and Society: Why disadvantaged men in mid-life die by suicide. Ewell; The Samaritans; 2012.

Sutherlands, R. PACTS: 26th Westminster Lecture for Samaritans on 'Working together to reduce suicide in transport'. 2015.

Appendix 1: Resources available

These need checking and additions

Factsheet on managing suicide risk in Primary Care
http://www.connectingwithpeople.org/sites/default/files/SuicideMitigationInPrimaryCareFactsheet_0612.pdf

A free booklet on debt advice is available from:
http://www.moneysavingexpert.com/credit-cards/mental-health-guide#collect

Guide for health and social care workers to support people with debt and mental health problems written by the Royal College of Psychiatrists and Rethink Mental Illness:
http://www.rcpsych.ac.uk/pdf/FinalDemandcf.pdf

Primary Care Guidance on Debt and Mental Health from the Royal College of GPs and Royal College of Psychiatrists, due to be updated shortly:
http://www.rcgp.org.uk/clinical/clinical-resources/~/media/Files/CIRC/Mental%20health%20forum/Mental%20Health%20Page%20Sept%202013/PCMHF-Guidance-Debt-Mental-Health-Factsheet-2009.ashx

Leeds Bereavement Forum has produced a short document with details of local and national support services available.
http://www.leeds.gov.uk/docs/Bereavement%20leaflet%202013.pdf

Grassroots Suicide Prevention Brighton & Hove Suicide Prevention Strategy Group provides an excellent website full of practical suicide prevention expertise.
http://prevent-suicide.org.uk/suicide_safer_brighton_and_hove.html

RAID service saves money as well as improving the health and well-being of its patients.
http://www.bsmhft.nhs.uk/our-services/rapid-assessment-interface-and-discharge-raid/

NHS Cornwall and Isles of Scilly, in partnership with Outlook South West
http://www.outlooksw.co.uk/suicide-liaison-service

Children and Young People's Mental Health Coalition Resilience and Results:
http://www.cypmhc.org.uk/resources/resilience_results/

State of Mind is a Rugby League mental health and wellbeing initiative which aims to raise awareness and tackle stigma. The organisation aims to reach men who may not normally contact health and social care services, and signpost them to where support is available. A round of Rugby League fixtures is dedicated to State of Mind, which maximises the publicity. The focus is on promoting player welfare and resilience in local communities. Super League players act as ambassadors reaching fans and amateur players through presentations, meetings and social networking, with positive messages being specially commissioned and tweeted. Films with specific themes are available at www.stateofmindrugby.com

Samaritans Media Reporting Guidance:
http://www.samaritans.org/media-centre/media-guidelines-reporting-suicide

Appendix 2: Bracknell Forest Action Plan 2017-18

Areas for Action	Specific Risk Groups	Action in 2017-18	Timescale
Overarching Aims		Sign off / endorsement of this Berkshire Suicide Prevention Strategy by all Health & Wellbeing Boards in Berkshire. All other local governance completed thus enabling this strategy to be owned by the Local Authorities and their partners. Launch of strategy at multi-agency suicide prevention summit. Identify Suicide Prevention Champions to promote the Berkshire Strategy; and to work within the Local Authorities and partner agencies.	1 April 2017 1 April 2017 15 Oct. 2017 15 Oct. 2017
National Strategy			
1. Reduce the risk of suicide in key high-risk groups	Men People in mental health care Occupational Groups Carers (including young carers) Socially isolated	Promotion of CALM to a wider audience Support BHFT in its Zero Suicide Approach Work with local Carers' support groups to highlight Mental Wellbeing issues and risk factors Multi agencies approach to identify individuals and sign posting for support/ local befriending service/ other services Increase local befriender 's awareness of Mental Wellbeing issues and Risk factors	1 June 2017 Ongoing work
2. Tailor approaches to improve mental health in specific groups	Community based approaches People vulnerable due to economic circumstances	Work with local Domestic Abuse Forum and Executive Group to provide support and information on suicide prevention To share local Suicide Prevention strategy/action plans/supporting materials with IAPT/Job Centre and other employment support agencies Increase agencies awareness of Mental Wellbeing issues and Risk factors	

3. Reduce access to the means of suicide		Support Network Rail, British Transport police and The Samaritans with local escalation process locations and general suicide prevention work. Investigate suicides on council owned land and properties, and agree a local action plan. Analyse local data gathered from the suicide audit and/or real-time surveillance to identify trends and clusters and take appropriate action(s) e.g. work with local media.	Ongoing work 15 Oct. 2017 Ongoing work
4. Provide better information and support to those bereaved or affected by suicide		Promote resources for people bereaved and affected by suicide (e.g. Help is at Hand and National Suicide Prevention Alliance resources).	Ongoing work
5. Support the media in delivering sensitive approaches to suicide and suicidal behaviour		Convene a Berkshire-wide Summit on journalism and reporting standards with local press and media organisations, to develop and agree standards for reporting. Agree a local action plan with the local communications team to support this aim. Identify a lead officer to monitor internet and both local and social media. Challenge stigma: Media campaign to support world suicide prevention day Update council and stakeholder webpages to ensure effective signposting for those bereaved by suicide.	20 July 2017 20 July 2017 Ongoing work 10 Sept. 2017 1 April 2017
6. Support research, data collection and monitoring		To update data on the JSNA summary on suicide.	As per JSNA timetable

Appendix 3: Royal Borough of Windsor and Maidenhead Action Plan 2017-18

Formatting error means table begins ion next page

Areas for Action	Specific Risk Groups	Action in 2017-18	Timescale/lead	Delivery Lead
Overarching Aims		Establish a multi-agency steering group: terms of reference to be agreed. Group will also be responsible for reviewing communication between primary and secondary care including risk assessment and escalation protocols	Locally determined	To be locally determined
National Strategy				
1. Reduce the risk of suicide in key high-risk groups	Priority groups for 17/18: men; carers; unemployed; those who misuse substances; and those with mental health diagnoses.	Build on existing local voluntary and community group programmes e.g. men in sheds. Training for gatekeepers relating to priority at-risk groups (Warwickshire). Support BHFT in its Zero Suicide Approach Ensure adequate arrangements are in place for follow-up after discharge from secondary care Consider strengths and issues arising from the Berkshire crisis concordat relating to the Royal Borough of Windsor and Maidenhead.	Ongoing work Locally determined Ongoing work Ongoing work Ongoing work	To be locally determined
2. Tailor approaches to improve mental health in specific groups	Suicide prevention training	Map evidence of coverage by sector/organisation of self-harm and suicide prevention training.	Ongoing work	To be locally determined
3. Reduce access to the means of suicide		Support Network Rail, British Transport police and The Samaritans with local escalation process locations and general suicide prevention work. Investigate suicides on council owned land and properties, and agree a local action plan. Analyse local data gathered from the suicide audit and/or real-time surveillance to identify trends and clusters and	Ongoing work 15 Oct. 2017 Ongoing work	To be locally determined

		take appropriate action(s) e.g. work with local media.		
4. Provide better information and support to those bereaved or affected by suicide		Promote resources for people bereaved and affected by suicide (e.g. Help is at Hand and National Suicide Prevention Alliance resources). Update council and stakeholder webpages to ensure effective signposting for those bereaved by suicide. Map existing bereavement support and pathways.	Ongoing work Locally determined Ongoing work	
5. Support the media in delivering sensitive approaches to suicide and suicidal behaviour		Convene a Berkshire-wide Summit on journalism and reporting standards with local press and media organisations, to develop and agree standards for reporting. Agree a local action plan with the local communications team to support this aim. Identify a lead officer to monitor internet and both local and social media. Challenge stigma: Media campaign to support world suicide prevention day Update council and stakeholder webpages to ensure effective signposting for those bereaved by suicide.	20 July 2017 20 July 2017 Ongoing work 10 Sept. 2017 1 April 2017	

6. Support research, data collection and monitoring		To update data on the JSNA summary on suicide. Develop a suicide audit database (based on Bromley model) and continue to update relevant local data from sources which include: Office for National Statistics, Coroner's records, Thames Valley Police Work with steering group members to review data about current levels of population need and service provision Work with steering group members to map areas of high risk through information on locations of deaths and attempts. Take action to reduce suicide enablers (e.g. install signage, barriers) in line with evidence base Undertake mapping relating to local suicide prevention and self-harm services.	As per JSNA timetable Locally determined Locally determined Locally determined Locally determined	

Appendix 4: Slough Action Plan 2017-18

Areas for Action	Specific Risk Groups	Action in 2017-18	Timescale by:
Overarching Aims		Sign off / endorsement of this Berkshire Suicide Prevention Strategy by all Health & Wellbeing Boards in Berkshire. All other local governance completed thus enabling this strategy to be owned by the Local Authorities and their partners. Launch of strategy at multi-agency suicide prevention summit. Identify Suicide Prevention Champions to promote the Berkshire Strategy; and to work within the Local Authorities and partner agencies.	1 April 2017 1 April 2017 15 Oct. 2017 15 Oct. 2017
National Strategy			
1. Reduce the risk of suicide in key high-risk groups	Men People who misuse substances People in	Promotion of CALM to a wider audience To partner with the drugs and alcohol team on reviewing the referral pathway for dual diagnosis. To continue to ensure that information on how to access DAAT services and seek help are readily available for young men. Support BHFT in its Zero Suicide	Locally determined

	mental health care Occupational Groups	Approach To support SME business on the Slough Trading Estate on incorporating mental health and wellbeing in their policies and advise on how to improve staff well-being; i.e.; promote resilience training	Ongoing work
2. Tailor approaches to improve mental health in specific groups	Community based approaches Suicide prevention training People vulnerable due to economic circumstances Children and young people	To work with the community development team – to continue to build community cohesion, etc. To identify and work with Housing and unemployment teams on MHFA training for staff To deliver MHFA training to managers of SME businesses in Slough To partner with NEET young people's team and train staff on MHFA To design a service information leaflet for new migrant arrivals and to ensure that all frontline services have an access to the leaflet. To partner with young people service to design an intergenerational programme addressing loneliness and social isolation	

3. Reduce access to the means of suicide		Support Network Rail, British Transport police and The Samaritans with local escalation process locations and general suicide prevention work. Investigate suicides on council owned land and properties, and agree a local action plan. Analyse local data gathered from the suicide audit and/or real-time surveillance to identify trends and clusters and take appropriate action(s) e.g. work with local media.	Ongoing work 15 Oct. 2017 Ongoing work
4. Provide better information and support to those bereaved or affected by suicide		Promote resources for people bereaved and affected by suicide (e.g. Help is at Hand and National Suicide Prevention Alliance resources) To conduct a mapping of services available for those that have been bereaved by suicide Contact Samaritans SBCCG in order to identify Slough residents assessing the service and where they refer them to Contact the community mental health team to ensure all frontline staff have the information required to signpost patients to bereavement services	Ongoing work Locally determined

		To identify other local stakeholders and provide better information and support to those bereaved or affected by suicide	
5. Support the media in delivering sensitive approaches to suicide and suicidal behaviour		Convene a Berkshire-wide Summit on journalism and reporting standards with local press and media organisations, to develop and agree standards for reporting. Agree a local action plan with the local communications team to support this aim. Challenge stigma: Media campaign to support world suicide prevention day Update council and stakeholder webpages to ensure effective signposting for those bereaved by suicide	20 July 2017 20 July 2017 10 Sept. 2017 1 April 2017
6. Support research, data collection and monitoring		To update data on the JSNA summary on suicide.	As per JSNA timetable

Appendix 5: Reading Action Plan 2017-18

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 Strategy Group)	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	
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 Reading Recovery College	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
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 implementation of the Reading Domestic Abuse Strategy - Raise awareness of support available to	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	See Action Plan for Priority 4 for details.

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			community based interventions will be informed by a review of impact	
- 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	

Appendix 6: West Berkshire Action Plan 2017-18

Areas for Action	Specific Risk Groups	Action in 2017-18	Timescale by:
Overarching Aims		Sign off / endorsement of this Berkshire Suicide Prevention Strategy by all Health & Wellbeing Boards in Berkshire. All other local governance completed thus enabling this strategy to be owned by the Local Authorities and their partners. Launch of strategy at multi-agency suicide prevention summit. Identify Suicide Prevention Champions to promote the Berkshire Strategy; and to work within the Local Authorities and partner agencies. Set up local quarterly meetings to review the action plan	1 April 2017 1 April 2017 15 October 2017 15 October 2017 Quarterly interval
National Strategy			
1. Reduce the risk of suicide in key high-risk groups	Men People who self-harm People who misuse substances People in mental health care	Further development of "Pie and a pint" interventions Promotion of CALM to a wider audience Monitor levels of self-harm Liaising with local substance misuse services Support BHFT in its Zero Suicide Approach	Ongoing work Ongoing work Ongoing work
2. Tailor approaches to improve mental health in specific groups	Community based approaches Suicide prevention training Children and young people	Improve public awareness of suicide Link with West Berkshire Emotional Health Academy Delivery of Adult Mental Health First Aid Training Delivery of Youth Mental Health First Aid Training and MHFA Schools Training	

3. Reduce access to the means of suicide		Support Network Rail, British Transport police and The Samaritans with local escalation process locations and general suicide prevention work. Investigate suicides on council owned land and properties, and agree a local action plan. Analyse local data gathered from the suicide audit and/or real-time surveillance to identify trends and clusters and take appropriate action(s) e.g. work with local media.	Ongoing work 15 October 2017 Ongoing work
4. Provide better information and support to those bereaved or affected by suicide		Promote resources for people bereaved and affected by suicide (e.g. Help is at Hand and National Suicide Prevention Alliance resources) Seek views of those with lived experience on draft action plan Promotion of Newbury SOBs group	Ongoing work Locally determined Ongoing work
5. Support the media in delivering sensitive approaches to suicide and suicidal behaviour		Convene a Berkshire-wide Summit on journalism and reporting standards with local press and media organisations, to develop and agree standards for reporting. Agree a local action plan with the local communications team to support this aim. Identify a lead officer to monitor internet and both local and social media. Challenge stigma: Media campaign to support world suicide prevention day Update council and stakeholder webpages to ensure effective signposting for those bereaved by suicide	20 July 2017 20 July 2017 Ongoing work 10 Sept. 2017 1 April 2017
6. Support research, data collection and monitoring		To update data on the JSNA summary on suicide. Develop infographics to share with public. Link to W Berks mental health strategy Link to W Berks health and wellbeing strategy	As per JSNA timetable Locally determined

Appendix 7: Wokingham Action Plan 2017-18

Areas for Action	Specific Risk Groups	Action in 2017-18	Timescale by:	Outcome Measure
Overarching Aims		Sign off / endorsement of this Berkshire Suicide Prevention Strategy by all Health & Wellbeing Boards in Berkshire.	1 April 2017	Signed copy of Strategy
		All other local governance completed thus enabling this strategy to be owned by the Local Authorities and their partners.	1 April 2017	Strategy implemented and agreed across the borough
		Launch of strategy at multi-agency suicide prevention summit.	15 Oct. 2017	High profile launch of strategy
		Identify Suicide Prevention Champions to promote the Berkshire Strategy; and to work within the Local Authorities and partner agencies.	15 Oct. 2017	Number of champions identified and trained across the partnership
National Strategy				
1. Reduce the risk of suicide in key high-risk groups	Men	Promotion of CALM to a wider audience	1 June 2017	Widespread awareness of CALM and increase in numbers of men accessing the service
	People in mental health care	Support BHFT in its Zero Suicide Approach	Ongoing work	Evidence of joint working and shared actions
	Occupational Groups	Awareness raising and training for local businesses on identifying early signs and how to respond.		Number of training sessions run
	LGBT groups	Working with local services such as TVPS.		Evidence of joint working and shared actions
	Carers (including young	Work with local carer groups to raise awareness of Mental Health risks and prevention,		Training provided. Information on readily

	carers) and People with LTC People who misuse substances	promote local befriending and support groups. Work with the local treatment provider to ensure that risk of suicide and mental health are part of the assessment.		available from carer groups and networks Suicide risk and mental health area included in standard assessment
2. Tailor approaches to improve mental health in specific groups	Community based approaches Suicide prevention training	Engage with local groups such as faith groups and befriending services. Wellbeing work with tenants services Plan and prioritise a programme of suicide prevention training and integrate into MECC work stream.		Evidence of joint working and shared actions Evidence of joint working and shared actions. Information readily available to staff. Training plan in place.
3. Reduce access to the means of suicide		Support Network Rail, British Transport police and The Samaritans with local escalation process locations and general suicide prevention work. Investigate suicides on council owned land and properties, and agree a local action plan. Analyse local data gathered from the suicide audit and/or real-time surveillance to identify trends and clusters and take appropriate action(s) e.g. work with local media.	Ongoing work 15 Oct. 2017 Ongoing work	Robust prevention measures and escalation procedures are in place and all partners are aware of these Case review process established and evidence of reports and actions taken Data shared with partners
4. Provide better information and support to		Promote resources for people bereaved and affected by suicide (e.g. Help is at Hand	Ongoing work	Proportion of people referred to bereavement

those bereaved or affected by suicide		and National Suicide Prevention Alliance resources). Review the availability of support for families and communities bereaved by suicide and affected by near misses. Promote the local Wokingham SOBS group, working with them to identify gaps.	 Locally determined Ongoing work	services Needs assessment carried out Evidence of promotional work and partnership working
5. Support the media in delivering sensitive approaches to suicide and suicidal behaviour		Convene a Berkshire-wide Summit on journalism and reporting standards with local press and media organisations, to develop and agree standards for reporting. Agree a local action plan with the local communications team to support this aim. Identify a lead officer to monitor internet and both local and social media. Challenge stigma: Media campaign to support world suicide prevention day Update council and stakeholder webpages to ensure effective signposting for those bereaved by suicide	20 July 2017 20 July 2017 Ongoing work 1 Sept. 2017 1 April 2017	Summit organised and reporting standards published. Reduced stigma around suicide and reduction in copycat suicides. Suicides are reported appropriately and sensitively. Communication Action Plan Officer identified Campaign held Webpages up to date and those bereaved access support
6. Support research, data collection and monitoring		To update data on the JSNA summary on suicide.	As per JSNA timetable	JSNA suicide chapter up to date

Appendix 8: Membership of the Berkshire Suicide Prevention Steering Group as at December 2016

Angela Baker	Deputy Centre Director	PHE South East
Angus Tallini	GP and Mental Health lead for Berkshire West CCGs	Newbury & District NHS CCG
Anthony Barrett		NHS
Belinda Dixon		RBWM
Caroline Attard	Nurse Consultant, In-patient wards	Berkshire Healthcare Foundation NHS Trust
Carol-Anne Bidwell	Public Health Programme Officer	Wokingham Borough Council
Charlotte Ryall	Coroner's Officer	Reading Borough Council
Chris Allen		NHS
Colin Bibby		SEAP
Daren Bailey		Berkshire Healthcare Foundation NHS Trust
Darrell Gale	Consultant in Public Health	Wokingham Borough Council
Debbie Daly	Director of Nursing and Quality	NHS Berkshire West CCGs
Eugene Jones		Berkshire Healthcare Foundation NHS Trust
Geoff Dennis		Berkshire Healthcare Foundation NHS Trust
Gillian McGregor		Reading Council
Gwen Bonner	Clinical Director Reading Locality Clinical Director Research	Berkshire Healthcare Foundation NHS Trust
Helen Ranasinghe		Samaritans
Helena Fahie	Public Health Support Manager	PHE South East
Janette Searle	Preventative Services Development Manager	Reading Borough Council
Jason Jongali	Head of Mental Health & Learning Disability Commissioning	NHS Berkshire West CCGs
Jillian Hunt		Bracknell Forest Council
Jo Greengrass		NHS
Jonathan Groenen		Thames Valley Police
Julia Wales,		Slough Council
Kate Ford		Thames Valley Police
Kate Jahangard		Reading Council
Katie Simpson	GP and Mental Health lead for Berkshire East CCGs	NHS CCG
Ken Hikwa		Berkshire Healthcare Foundation NHS Trust
Kim McCall		Reading Borough Council
Lesley Wyman	Consultant in Public Health	West Berkshire Council
Lisa McNally	Consultant in Public Health	Bracknell Forest Council
Lise Llewellyn	Strategic Director of Public Health	Public Health Services Berkshire
Natalie Mears	Public Health Programme Officer	RBWM
Mark Spencer	Detective Chief Inspector, LPA Commander - Slough	Thames Valley Police
Sally Murray	Head of Children's Commissioning	NHS Berkshire West CCGs
Nadia Barakat	Head of Mental Health & Learning Disabilities Commissioning	NHS Berkshire East CCGs

Nick Davies		RBWM
Rachel Johnson	Public Health Programme Officer	West Berkshire Council
Ramesh Kukar		Slough Council of Voluntary Services
Reva Stewart	Locality Director	Berkshire Healthcare Foundation NHS Trust
Rukayat Akanji-Suleman	Public Health Programme Officer	Slough Borough Council
Safron Simmonds	Project Manager	NHS Berkshire West CCGs
Sarah Bellars		NHS
Sue McLaughlin	Clinical Director / Nurse Consultant Slough locality	Berkshire Healthcare Foundation NHS Trust
Susanna Yeoman		Berkshire Healthcare Foundation NHS Trust
Tandra Forster	Head of Adult Social Care	West Berkshire Council
Tanya Demonne	Mental Health Coordinator, Safeguarding	Royal Berkshire Hospital Foundation NHS Trust
Timothy Foley		SEAP
Tony Dwyer		Berkshire Healthcare Foundation NHS Trust
Trudi Sams		

Back Cover to be designed and add contact details of Shared Team etc.

URL of Strategy

The Berkshire Suicide Prevention Strategy

Darrell Gale FFPH

Reading Borough Health & Wellbeing Board

24th March 2017

Reading Borough Council
Working better with you

Where are we today?

- Comments on Draft Strategy were received from a range of stakeholders.
- Many regard formatting and ordering of the strategy
- Final draft (minor amendments and formatting) agreed by Steering Group February 2017
- Action plans at Berkshire and Unitary levels
- New National Strategy to come …….

Reading Borough Council
Working better with you

Stretch Target

- Suggested by stakeholders
- To exceed the 10% reduction target in the Sustainability & Transformation Plans (STPs) and NHS 5 Year Forward View - Mental Health
- To attempt to achieve a 25% reduction from 2014 levels by 2020

Reading Borough Council
Working better with you

Latest Statistics

- 2015 total suicide figures just published (Dec. 2016)
- Figures show an increase in numbers for Berkshire as a whole
- We will include the new figures as well as the rates from earlier data as they show the trends

Reading Borough Council
Working better with you

Latest Stats –Raw Data

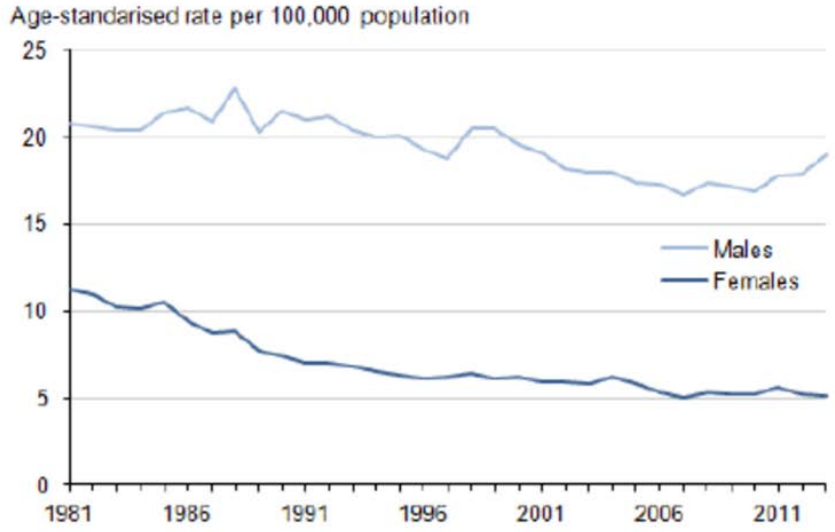
	2014	2015	Difference
Bracknell Forest	5	10	+ 5 (+ 100%)
Reading	12	18	+ 6 (+ 50%)
Slough	15	9	- 6 (- 40%)
West Berkshire	5	6	+ 1 (+ 20%)
RBWM	11	11	-
Wokingham	6	14	+ 8 (+ 233%)
Berks Total	68	83	+ 22%
SE Total	794	756	- 5%
England Total	4882	4820	- 1%

Reading Borough Council
Working better with you

The National Picture

Figure 1: Age-standardised suicide rates: by sex, deaths registered in each year from 1981 to 2013

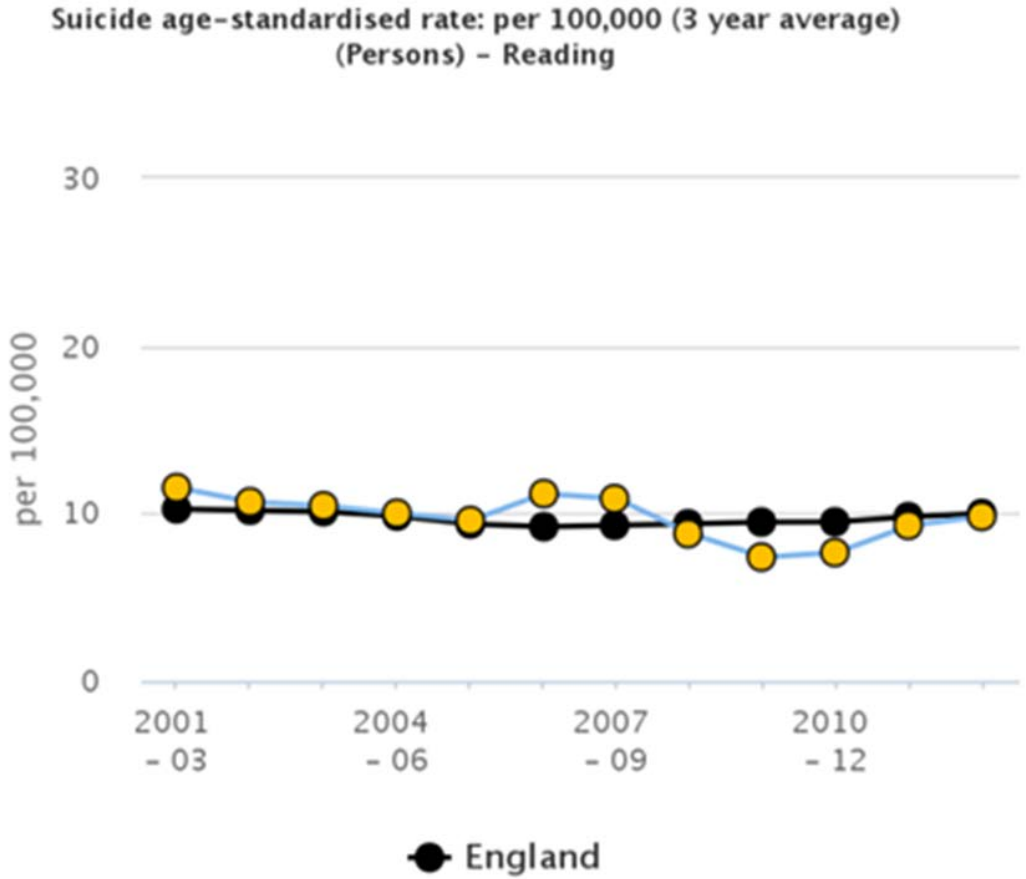
United Kingdom



Source: Office for National Statistics, Northern Ireland Statistics and Research Agency, National Records of Scotland

Reading Borough Council
Working better with you

The Local Picture



Reading Borough Council
Working better with you

Over-arching Recommendations

- That the Steering Group revisit their terms of reference and membership and become known as the “Berkshire Suicide Prevention Steering Group”, with the aim of providing the governance to this strategy and its action plans.
- That organisations represented on the Berkshire Suicide Prevention Steering Group consider nominating a suicide prevention champion from within their membership.

- That all agencies represented on the Steering Group commit to an annual Action Plan of their own which can then be brought together to create a Berkshire-wide Action Plan for each year of the Strategy.
- Sign off / endorsement of this strategy by all Health & Wellbeing Boards in Berkshire.
- Launch this strategy at a multi-agency suicide prevention summit, by October 2017.
- Ensure strategic fit with the action plans of the Berkshire Crisis Care Concordat

Reading Borough Council
Working better with you

Recommendations – High Risk Groups

- 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 and middle aged men.

Reading Borough Council
Working better with you

Recommendations –Specific Groups

- 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.

Reading Borough Council
Working better with you

Recommendations – Reduce access

- 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.
- That the Steering Group seek a named Highways England officer to act as a liaison link and group member, and to share real-time intelligence of highways network incidents.
- That local authority public health teams work with other council departments such as car parks and open space services to identify local actions to prevent suicide including staff awareness training.

Reading Borough Council
Working better with you

Recommendations – Support bereaved

- Ensure bereavement information and access to support is available to those bereaved by suicide.

Reading Borough Council
Working better with you

Recommendations – Support Media

- Liaise with local media to encourage reference to and use of guidelines for the reporting of suicide through a summit with local press and media organisations, and to provide information to professionals on the sensitive reporting of suicide. By 20 July 2017
- (BBC Berkshire have been asked to host)

Reading Borough Council
Working better with you

Recommendations – Support Research

- Develop working relationships between individual coroners and local public health teams ensure local plans are evidence based and responsive. Coroners can be invited to become formal members of any local suicide prevention groups or networks
- Coroners can also inform the local authority or Director of Public Health if they identify particular areas of concern, e.g. locations used for suicide, possible clusters of suicide, increase in a particular method or new and emerging method of suicide.
- Refresh the Berkshire-wide Suicide Audit for deaths in the period 2014-16 to include new categories based on best practice.

Reading Borough Council
Working better with you

Next Steps

- Format final version of strategy
- Seek sign-off from other Health and Wellbeing Boards
- Deliver actions

Reading Borough Council
Working better with you

NHS Wokingham Clinical Commissioning Group | NHS South Reading Clinical Commissioning Group | NHS North and West Reading Clinical Commissioning Group | NHS Newbury and District Clinical Commissioning Group

CAMHS Transformation Plan – Implementing Future in Mind across Berkshire West CCGs and Reading Borough Council

JOINT REPORT FROM SOUTH READING CLINICAL COMMISSIONING GROUP, NORTH & WEST READING CLINICAL COMMISSIONING GROUP & READING BOROUGH COUNCIL

Sally Murray (CCG), Andy Fitton (Reading Borough Council)

1. PURPOSE OF REPORT AND EXECUTIVE SUMMARY

To provide the annual update on service development and improvement across the comprehensive Child and Adolescent Mental Health Service (CAMHS) system, that is responding to the Future in Mind plan.
For the Board to endorse the October 2016 refreshed Future in Mind transformation plan which is referenced in point 2.2 below through the web-link. (hard copy attached at Appendix 1 without embedded links)

2. POLICY CONTEXT

2.1 The report of the government's Children and Young People's Mental Health Taskforce, "Future in Mind – promoting, protecting and improving our children and young people's mental health and wellbeing", was launched on 17 March 2015 by Norman Lamb MP, the then Minister for Care and Support. It provides a broad set of recommendations across comprehensive CAMHS that, if implemented, would promote positive mental health and wellbeing for children and young people by facilitating a greater access and standards for CAMHs by greater system co-ordination and a significant improvement in meeting the mental health needs of children and young people from vulnerable backgrounds.

2.2 With the requirement for system wide transformation by 2020, all CCGs were tasked with creating a Local Transformation Plans. Reading's Health and Wellbeing Board approved Reading's plans in October 2015 which enable additional recurrent funding to be released from NHS England to the West of Berkshire Clinical Commissioning Group (CCG). The latest refreshed version can be found at: http://nwreadingccg.nhs.uk/mental-health/camhs-transformation

2.3 Berkshire West CCGs, with support from all 3 Local Authorities holds a joint meeting once a month to oversee and support the implementation of the Local Transformation Plans. This meeting is now called the 'Berkshire West Future in Mind' group and includes a broad representation of providers of services e.g. Berkshire Healthcare Foundation Trust (BHFT), voluntary sector partners, Royal Berkshire Hospital Foundation Trust (RBH), parent carer representative, Schools, Healthwatch as well as the University of Reading.

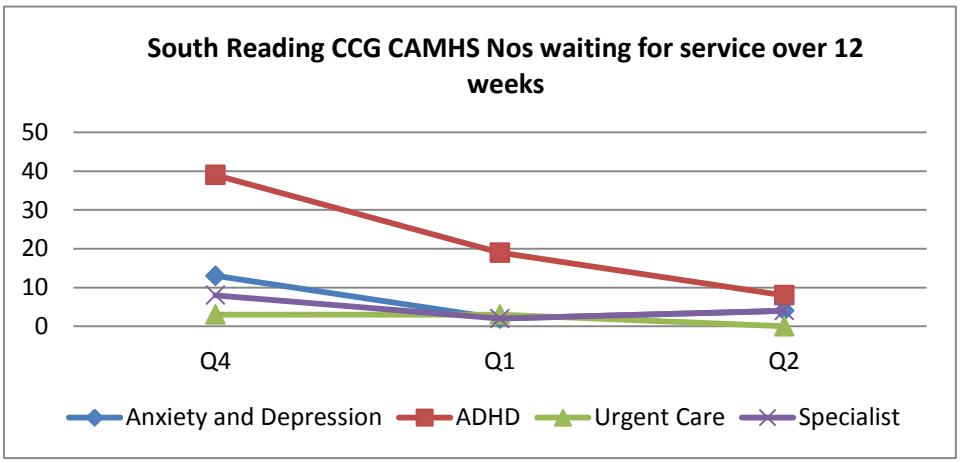
3. Areas of Progress Since last H&W board report (March 2016) are as follows:

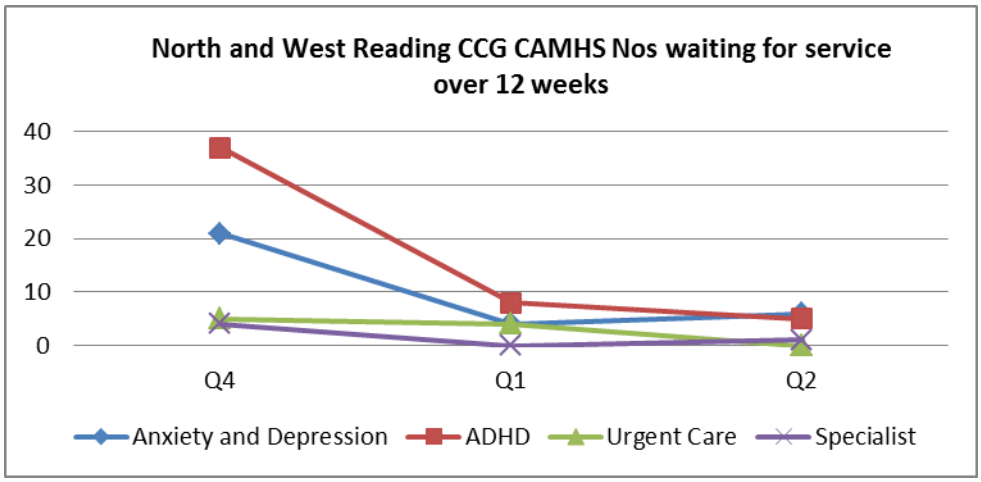
3.1 The JSNA document which describes CAMHS was available in March 2016 and is currently being reviewed to upload a 2017 version by Public Health.

3.2 Berkshire Adolescent Unit is now a 7-day, 24-hour a day service that is now a registered tier 4 provision in Berkshire. The number of beds has also now increased from 7 to 9 and so fewer children requiring this level of intervention need to be placed outside of Berkshire.

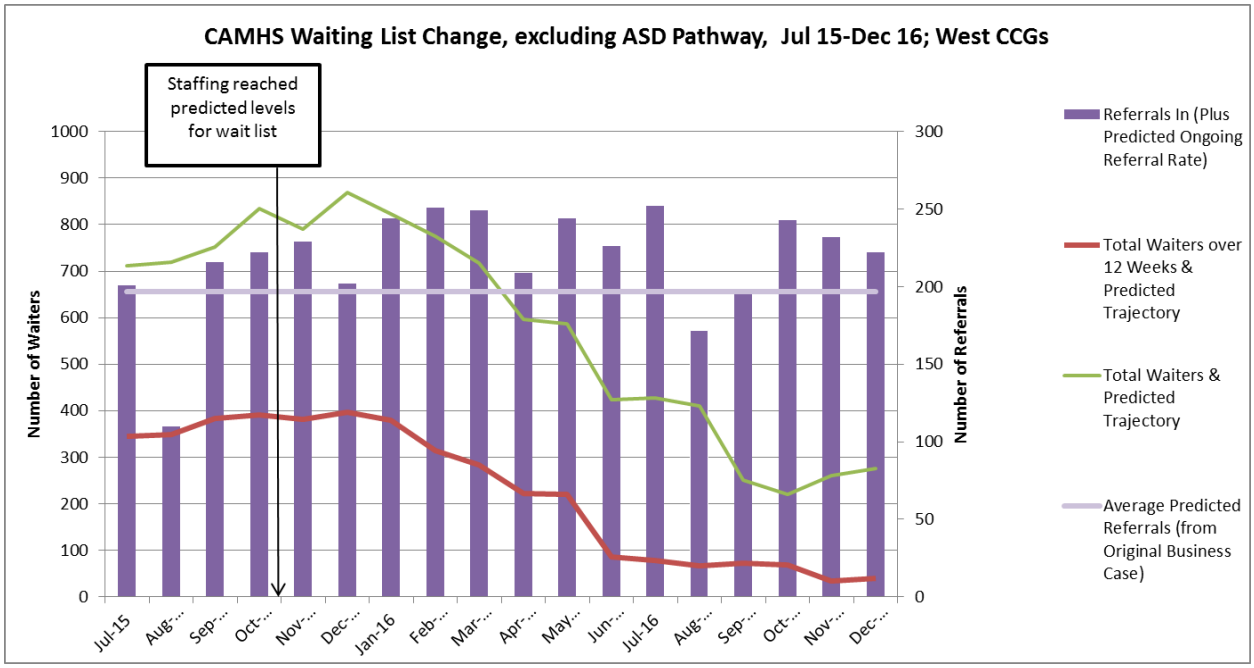
3.3 The Common Point for Entry is now open 8am to 8pm Monday to Friday. The current average waiting time for referrals to CPE is 4 weeks. Currently the national average waiting time for a first CAMHS appointment is 9 weeks.

3.4 There continues to be a reduction in waiting times with more children and young people receiving timely evidence based treatment across all 5 care pathways. Graphs below show the downward trend (Q4 15.16 to Q2 16.17) of Reading Children/Young People having to wait over 12 weeks access to mental health support from BHFT. The top graph is for the South Reading CCG and other for North and West Reading CCG that combined provides the full Reading picture.

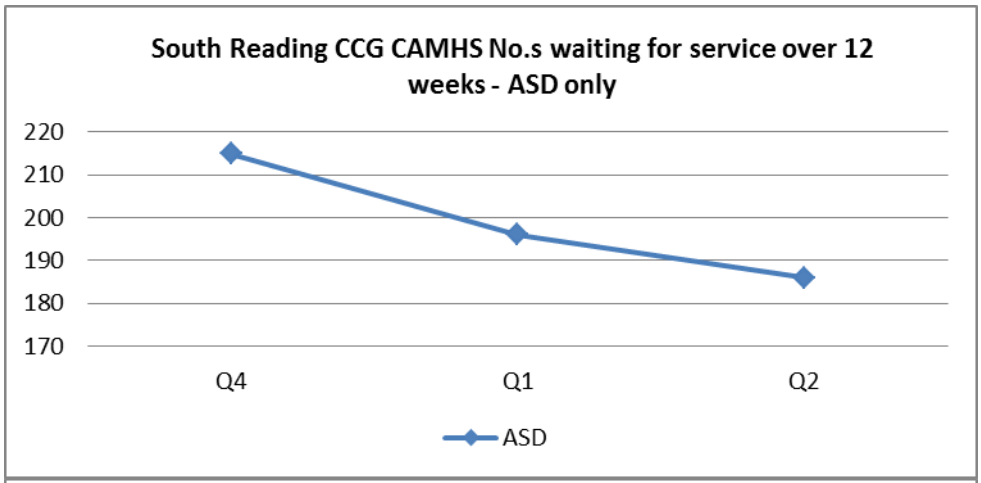


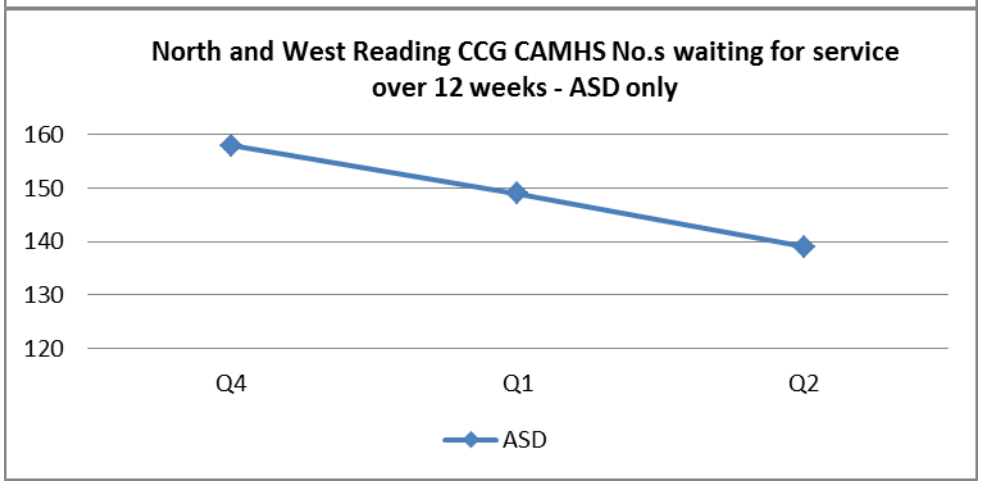


3.5 This improvement for children and young people has been delivered against ongoing high rate of referrals for CAMHS tier 3 supports. This is evidenced in the graph below that outlines 12 of the 18 months having 700 referrals a month for Berkshire West area but the two line graphs of both total waiting number (green line) and children waiting over 12 weeks (red line) both descending over the same 18 month time frame.



3.6 Waiting times on the autism assessment pathway have reduced but remain the most challenging to improve. Graphs below shows the downward trend (Q4 15.16 to Q2 16.17) of Reading Children/ Young people having to wait over 12 weeks access to ASD diagnosis pathway from BHFT. The top graph is for the South Reading CCG and other for North and West Reading CCG that combined provides the full Reading picture.

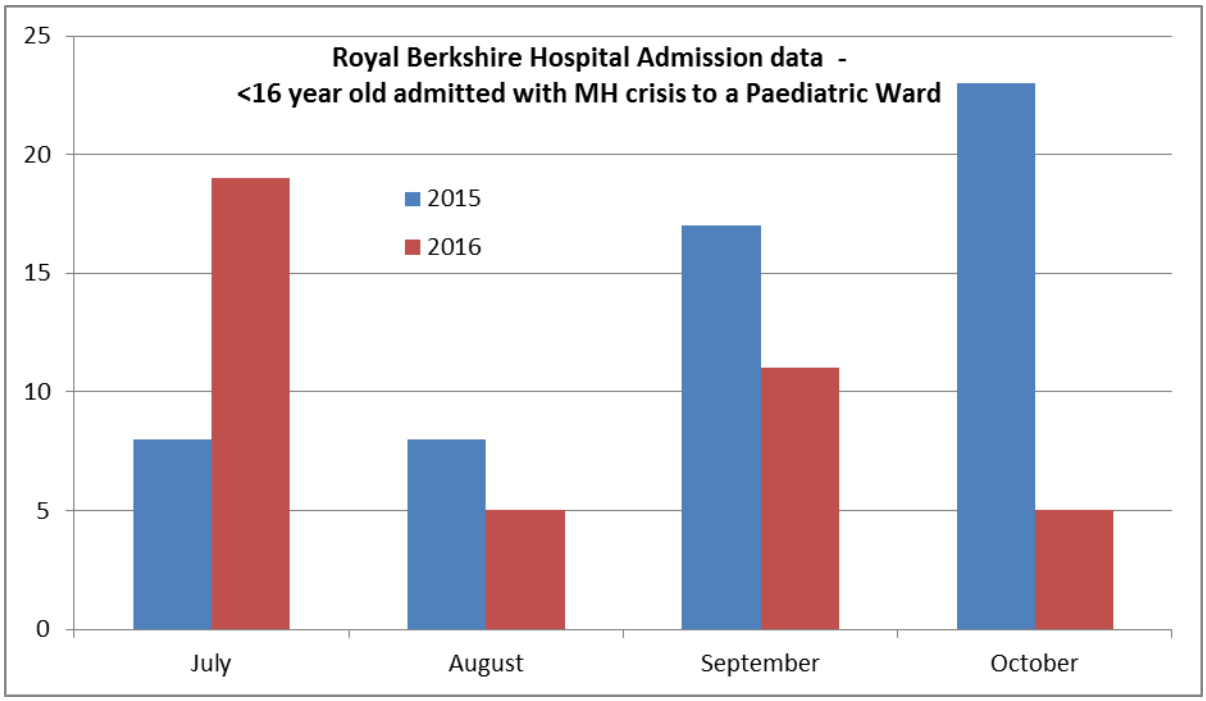




3.7 Berkshire West waiting times for autism assessment remain lower than the national average. However waits remain longer that both the commissioner and provider want locally. The current local target is to reduce waiting times for autism assessment to a maximum of 12 weeks by October 2017. Additional funding has been made available to expedite reduction in autism assessment waiting times for children under the age of 5 years by running additional weekend clinics. In addition Autism Berkshire and Parenting Special Children have been commissioned to provide support to families at the pre and post diagnosis stage.

3.8 The CAMHS Urgent Response Pilot, integrated with Royal Berkshire Hospital (RBH), is now in place 8am until 8pm Monday to Friday and 10am until 6pm on Saturdays and bank holidays providing timely mental health assessments and care. A consultant is on call at all other times. 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 or subsequent crisis. The service also provides wrap around support when there are delays in sourcing a Tier 4 in CAMHS patient bed. Response time to assessment has reduced and length of stay in both A & E and paediatric wards has reduced with improved facilitation of admission to Tier 4 units when required. There has been a correlated reduction in use of agency Registered Mental Nurses at RBH. There has also been a reduction in the number of minors admitted to the Place of Safety at Prospect Park Hospital.

3.9 The graph below shows a reduction in admission to the paediatric wards through August, September and October compared to the same period last year. This is both against trend for the same period last year and in context of the usual seasonal increase in admissions and highlights the effectiveness of the team in supporting young people in crisis and alleviating the pressure on acute emergency and paediatrician care systems. RBH data for November and December is not yet available but manual data from RBH indicated the improvement has been maintained



3.10 A business case to convert the urgent care pilot to a fully commissioned service has been received by the CCGs. 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.

3.11 Five support community services have been enhanced or set up:

- Peri-natal mental health service
- CAMHs Community Eating Disorder service
- All age Early Intervention in Psychosis service
- Anxiety and Depression pilot
- Police and Crime Commissioner has additional resources to enhance the therapeutic service offer for victims of sexual assault and to other crimes, which includes children/ young people.

3.12 Young SHaRON builds on the success of the long standing SHaRON service for adults with Eating Disorders. Expansion of the web based Young SHaRON now also supports women with perinatal mental health issues and their partners. The Young SHaRON online platform has been expanded so that parents and carers of children and young people who have been referred to the Autism Assessment Team can access help and advice. Feedback has been very positive. A further subnet will soon provide online consultation for workers who have undergone PPEPCare training.

3.13 Reading continues to offer a good Primary Mental Health Worker (PMHW) and Education Psychology (EP) service. Youth Counselling is jointly commissioned between the Local Authority and CCG which is being reviewed. Reading young people have a choice of counselling services in the town and the majority of schools offer on-site access to trained counsellors.

3.14 Co-working with the University of Reading, the Local Authority is providing 4 Webster Stratton parenting programmes for 3-11 year olds. This has been added to the Triple P parenting offer already in place and University is researching the impact of this project on children with emerging challenging behaviour.

3.15 The Local Authority has set up a Schools Link project with 9 local schools that is aiming to build the knowledge and skills of teachers and associated school staff in identifying and responding to early mental health concerns. It is hoped that more schools will join this project.

4. NEXT STEPS

4.1 The refreshed Berkshire West Transformation Plan (January 2017 onwards) has been approved by NHS England as both clear on the progress (as outlined above) and the remaining priorities ahead.

4.2 Our Local Transformation Plans continue to be about 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 or in-patient admission. Help will be offered as soon as issues become apparent.

4.3 For Reading the focus is on:

- Engineering a new model of delivery that tackles access and prevents young people being lost in the system.

- Investment in our staff and workforce, strengthening the working culture and level of support at all levels of service delivery, but in schools in particular.
- Building a stronger Early Intervention offer that builds the resilience in children and young people and providing support as early as possible.

4.4 As the plan becomes operational the intended outcomes will be that children and young people and their families are more resilient. There will be fewer children and young people escalating through to urgent or specialist interventions. There will be a positive impact on the perinatal mental health of mothers in the early years of children. There will be more young people escalating through to urgent or specialist interventions. There will be a positive impact on the perinatal mental health of mothers in the early years of children. There will be more young people reporting positive outcomes at a universal and targeted intervention level, including a positive experience of their services.

4.5 The plan expects these outcomes to be reached over the next 4 years:

- Children and young people mental health needs will be identified early, especially in universal services such as schools, setting and GPs
- Help will be easy to access, it will be coordinated, including the young person and family in the decision making process and provided in places that make sense to them.
- If support is required at a targeted or specialist/ urgent level that this is provided quickly, at a high quality level and safely.

5. Financial information

5.1 Current Tier two funding arrangements for 2016-17 is outlined in the table below. This is a mix of directly provided Local Authority provision as well as funded work in the voluntary sector. This information does not account for all the provision in tier two but the majority that is funded by the Local Authority and the CCG.

Service	**Expenditure**
Primary Mental Health Workers	£209,500
Educational Psychologists	£479,900
Youth Counselling service (Commissioned)	£86,000
Reading Mencap	£20,000
Berkshire Autistic Society	£60,000
Parenting Special Children	£25,000
PPEPCare training	£15,000
Total	£895,400

5.2 Current Tier three funding arrangements for 2016-17 are outlined in the table below. This is solely funded from the NHS Berkshire West CCGs

Service	**Allocation**
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.	£6,306,000This is the total 16/17 allocation for specialist (Tier 3) CAMHs.
Community Eating Disorders- this is a pan Berkshire service due to the population size required.	£236,000- Berkshire West contribution

CAMHs urgent care pilot project	£208,000 Future In Mind resources plus £150,000 non recurrent system resilience monies from 15/16

5.3 Additional CCG funding for perinatal mental health services and Early Intervention in Psychosis (age group 14 years and above) have been made available which are outside the scope of this report.

5.4 The recurrent Mental Health transformation funding has been used to improve a range of outcomes for children and young people mental health and spent across tiers 1 to 3 with a range of partners. The money outlined below in the bullet points is released to the 4 named CCGs and managed by Berkshire West CCGs.

- North and West Reading £145,265
- South Reading £151,892

6. BACKGROUND PAPERS

6.1 Future in Mind paper:
https://www.gov.uk/government/publications/improving-mental-health-services-for-young-people

6.2 Transformation plan guidance;
http://www.england.nhs.uk/wp-content/uploads/2015/07/local-transformation-plans-cyp-mh-guidance.pdf

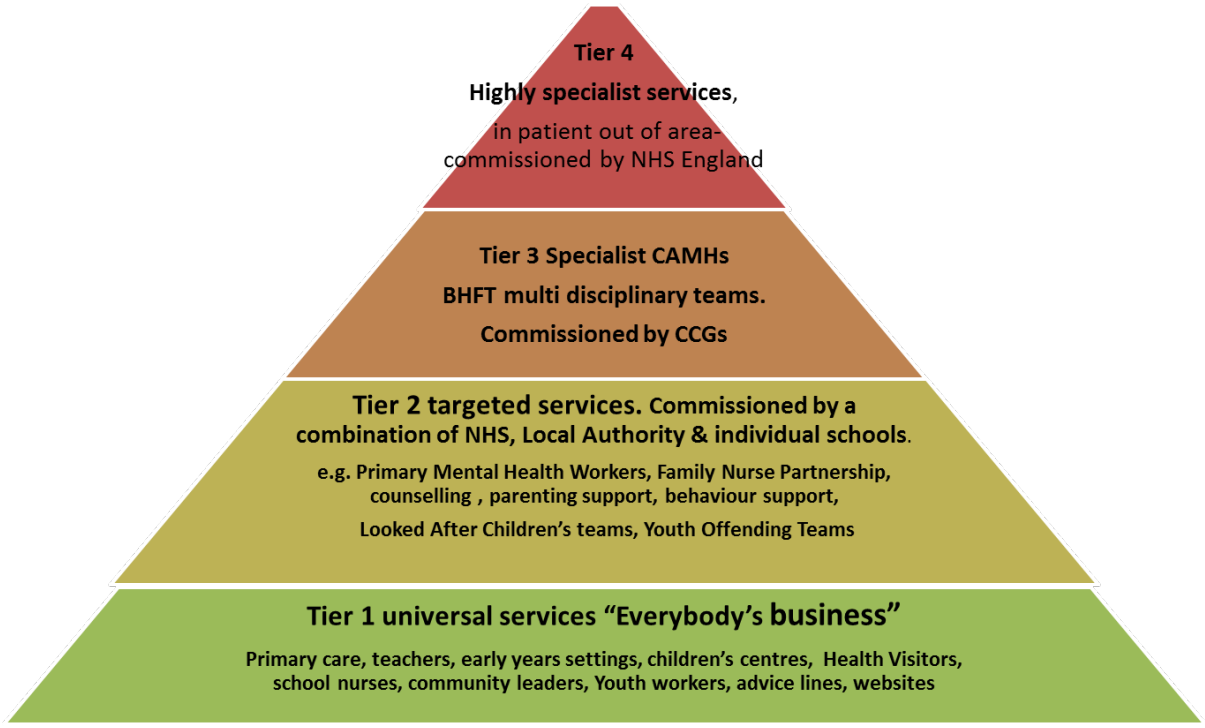
6.3 Links to Local Transformation Plans on the CCG websites (includes and easy read version and Frequently Asked Questions section)
http://nwreadingccg.nhs.uk/mental-health/camhs-transformation

Appendix 1 – Acronyms used in the report

Acronym	Full description
CAMHs	Child and Adolescent Mental Health Service
CCGs	Clinical Commissioning Group
JSNA	Joint Strategic Needs Assessment
ASD	Autistic Spectrum Disorder
BHFT	Berkshire Healthcare Foundation Trust
CATs	Children's Action Team
CPE	Common Point of Entry for BHFT
EHWB	Emotional Health Wellbeing
LSCB	Local Safeguarding Children's Board
DoH	Department of Health
HV	Health Visitor
YOS	Youth Offending Service
ADHD	Attention Deficit Hyperactivity Disorder
RBHFT	Royal Berkshire Hospital Foundation Trust
ELSA	Emotional Literacy Support Assistants
PMHW	Primary Mental Health Workers

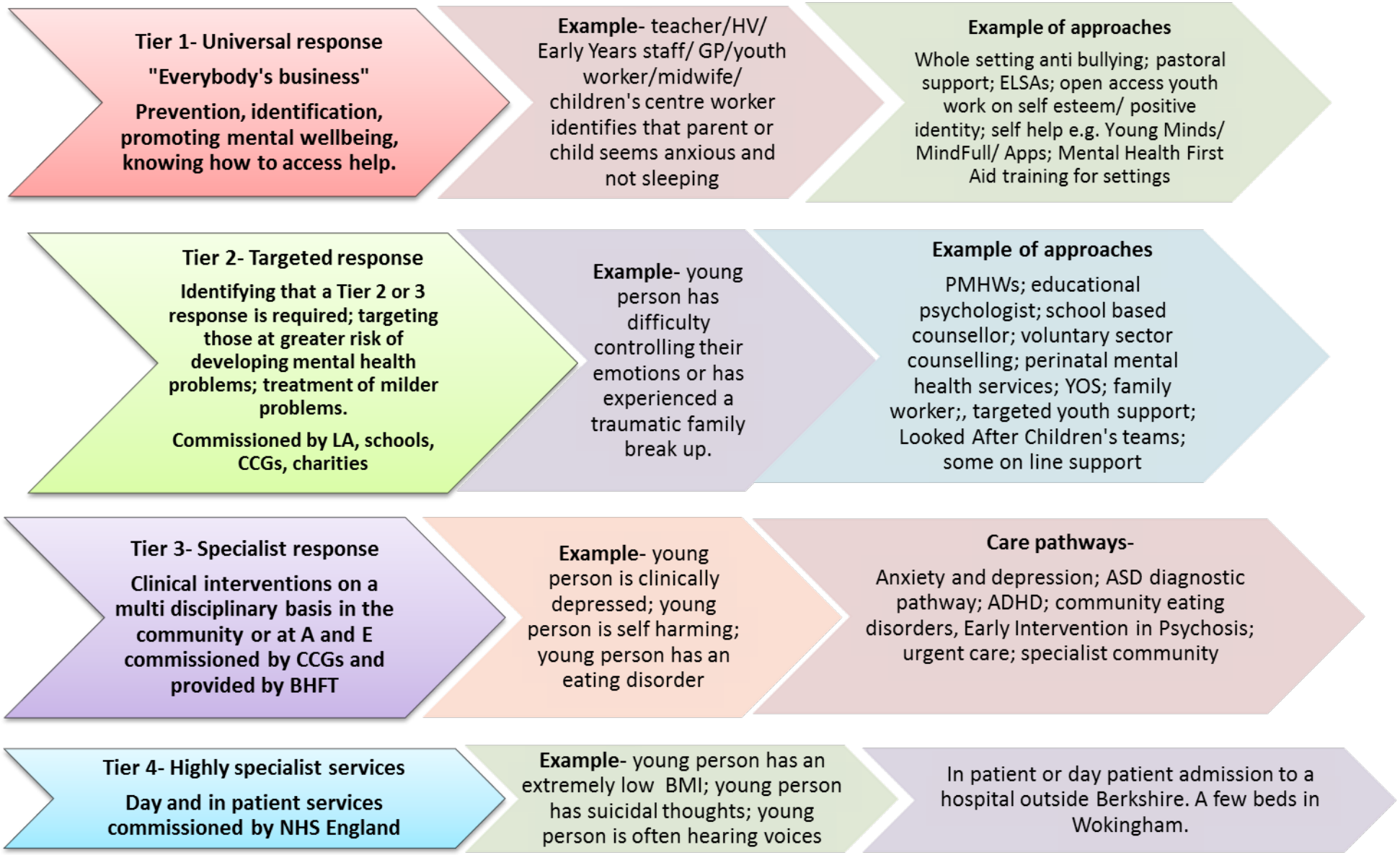
Appendix 2

How emotional health and wellbeing/ CAMHs services are commissioned in Berkshire



A "good" CAMHs service has timely, effective and efficient integrated working across Tiers (and therefore agencies) - reference Joint Commissioning Panel for Mental Health 2013 www.jcpmh.info. This means that children, young people and families should be able to access emotional health and wellbeing support in early year's settings, voluntary sector, schools, the community and primary care before needs escalate to Tiers 3 or 4.

Appendix 3: Comprehensive Mental Health service provision for children and young people in Reading



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

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

Berkshire West CCG area with Reading, West Berkshire and Wokingham Local Authorities

Executive summary

Following the publication of "Future In Mind" – *promoting, protecting and improving our children and young people's mental health and wellbeing*, the report of the government's Children and Young People's Mental Health Taskforce in 2015, Berkshire West Clinical Commissioning Groups worked with partners to develop Local Transformation Plans for Children and Young People's Mental Health and Wellbeing for the period 2015 -2020. These plans were approved by the respective Health and Wellbeing Boards in October 2015 and were subsequently published on CCG websites.

Links to the original Transformation Plans can be found here

http://www.nwreadingccg.nhs.uk/mental-health/camhs-transformation

http://www.southreadingccg.nhs.uk/mental-health/camhs-transformation

http://www.wokinghamccg.nhs.uk/mental-health/camhs-transformation

http://www.newburyanddistrictccg.nhs.uk/mental-health/camhs-transformation

This refresh document provides an overview of progress against the original transformation plans and identifies further work which is required by 2020.

Our starting point

Future in Mind – promoting, protecting and improving our children and young people's mental health and wellbeing, the report of the government's Children and Young People's Mental Health Taskforce, was launched in March 2015.

The report sets out the case for change in mental health services for children and young people. It makes recommendations for improving a number of things about mental health services for children and teenagers: the quality of services; how quickly and easily services can be accessed when they are needed; better co-ordination between services; and, a significant improvement in meeting the mental health needs of children and young people no matter what their background.

By addressing all these areas the report aims to promote good mental health and wellbeing for children and young people and ensure there are high quality services in place to care for children and young people if they need them.

In spring 2014 Clinical Commissioning Groups in Berkshire West asked service users, schools, doctors and mental health workers **what they thought about local mental health services**.

Their responses suggested that many children, young people and their families thought that services weren't good enough – explaining that waiting times were too long, that it was difficult to find out how to access help and, sometimes, that they didn't like the way that they were treated by staff. They said that there were delays in referrals and the advice given to families while waiting for their child's assessment was insufficient.

Future in Mind provided a structure for planned changes in Berkshire West. The ambition became not simply to adjust existing services, but to transform them. Our original Transformation Plans provide a snapshot of where we were in the Autumn of 2015, how we arrived at our plan and articulates the actions we felt were required. This document provides an overview of progress against the original transformation plans and identifies further work which is required by 2020. A section on wider BHFT transformation of Children, Young People and Families service is included

The Local Transformation Plans cover the whole spectrum of services for children and young people's emotional and mental health and wellbeing in each local authority area including

- How we will improve prevention and early identification of difficulties for all children

- How we will improve targeted working for more vulnerable groups such as children in care, those in contact with the criminal justice system, victims of crime, young people who are at risk of exclusion from school, traveller communities. These youngsters are most at risk of health inequalities.
- How we will work with Local Authorities and partners to provide early help when issues become apparent
- How we will improve the quality and timeliness of specialist CAMHs
- How we will improve care for children and young people experiencing a mental health crisis or psychosis
- How we will reshape services for children and young people with eating disorders to enable quicker and better specialist support outside hospital
- How we will collaborate with other commissioners to provide more streamlined and cost effective care pathways with care delivered closer to home

While the three original local transformation plans share many common elements, the route into emotional health and wellbeing services in each area is being reviewed, based on the services available in each local community.

Local need identified in JSNAs

http://www.reading.gov.uk/article/9485/Children-and-Adolescent-Mental-Health

http://jsna.wokingham.gov.uk/developing-well/children-and-adolescent-mental-health/

http://info.westberks.gov.uk/CHttpHandler.ashx?id=37350&p=0

Children's social and emotional wellbeing is not only important in its own right but also as a contributor to good physical health and as a factor in determining how well they do at school (National Institute for Health and Care Excellence, 2008).

Social and emotional wellbeing refers equally to:

- Emotional wellbeing (e.g. feeling happy and confident)

- Psychological wellbeing (e.g. feeling in control of one's life, being resilient, and displaying assertiveness)
- Social wellbeing (e.g. the ability to have good relationships with family and friends)

About half of adults with mental health conditions experienced their first symptoms before they reached 14 years of age. Children who develop mental health problems will need additional timely treatment from the appropriate mental health service supported by the wider services around the child. Just like physical health, where inequalities often exist between different groups of the population, this is equally apparent in the emotional health of children with poorer outcomes often in the most vulnerable members of society.

Our local JSNAs recognise that the section on Child and Adolescent Mental Health cannot be read in isolation and further reading needs to be carried out around, adult mental health, drug use, alcohol issues, domestic abuse, children in need and safeguarding to name a few.

There is compelling evidence of the effectiveness of interventions to improve children's and young people's resilience and emotional well-being that demonstrates getting the right help at the right time.

Nationally the number of children and young people presenting with emotional health and wellbeing issues is increasing. This is also reflected locally in services provided across the system.

Recommendations from the JSNA analysis have a focus on whole system working with an emphasis on prevention and early intervention. This is reflected in our Local Transformation Plan-

Reading recommendations-

- Engineer a new model of delivery that tackles access and prevents young people being lost in the system.
- Invest in our staff and workforce, strengthening the working culture and level of support at all levels of service delivery, but in schools in particular.
- Build a stronger Early Intervention offer that builds the resilience in children and young people and providing support as early as possible.
- Include families in the support process as well as include peers and friends in supporting the delivery of services, particularly to help young people feel and think differently about mental health issues, achieving less fear, stigma and discrimination.

- Reading's JSNA will be refreshed in January 2017 to capture changes since Future In Mind was initiated.

West Berkshire recommendations-

Currently there is a resource gap for Chronic School Refusers, some of whom have late diagnosis of autism. Autism is a lifelong disability that affects how a person makes sense of the world, processes information and relates to other people.

- Schools have indicated they want more early help for pupils with a range of mental health issues, and more training for school staff.
- Currently there are difficulties accessing tier 4 provision for our young people (including LAC), who have most severe types of mental health problems.

Wokingham recommendations-

Alongside the recognition from CAMHs of the need to improve its service offer, partnership reviews have identified the need for all tiers of emotional health and wellbeing provision to work together as a better system, so that children and young people are identified early and access any support they need is provided quickly at the lowest and least restrictive tier possible.

All agencies should realise the benefits of co-production and working together to improve the mental health of children and young people.

- Reduce waiting times
- Increase tier 2 provision to ensure early intervention
- Increase resources to meet demand
- Free up CAMHS staff time to work with partner agencies
- Improve support in schools Encourage positive mental health in our schools and colleges •Create MH hubs in schools - training package offered by PMHW and EPs in schools to all staff and parents.
- Improve information about services on offer and how to access them
- Improve communications and administration
- Create a more young-person-friendly environment
- Provide better post-diagnostic support particularly around a diagnosis of ASD or ADHD
- Provide better out of hours access and crisis support

- Provide a local 24/7 inpatient services

Prevalence Reading data

Table 2: Current mental health prevalence

Indicator	Reading	South East	England	Year
Perinatal mental health: Estimated number of women requiring support during pregnancy or postnatal period	326	N/A	N/A	2012
Estimated prevalence of any mental health disorder: % population aged 5-16	9.0%	8.5%	9.3%	2014
Estimated prevalence of emotional disorders: % population aged 5-16	3.5%	3.3%	3.6%	2014
Estimated prevalence of conduct disorders: % population aged 5-16	5.5%	5.1%	5.6%	2014
Estimated prevalence of hyperkinetic disorders: % population aged 5-16	1.5%	1.4%	1.5%	2014
Prevalence of potential eating disorders among young people: Estimated number of 16 - 24 year olds	3,000	126,533	N/A	2013
Prevalence of ADHD among young people: Estimated number of 16 - 24 year olds	3,134	134,099	N/A	2013
Fixed period exclusion due to persistent disruptive behaviour: % of school pupils	1.1%	1.2%	1.0%	2011/12
Fixed period exclusion due to drugs/alcohol use: % of school pupils	0.08%	0.13%	0.10%	2011/12
Children who require Tier 3 CAMHS: estimated number of children <17	635	N/A	N/A	2012
Children who require Tier 4 CAMHS: estimated number of children <17	30	N/A	N/A	2012

Prevalence data for West Berkshire Council area

Table 2: Children estimated to have a mental health disorder

Category	Count
Boys aged 11 to 16	780
Boys aged 5 to 10	580
Girls aged 11 to 16	615
Girls aged 5 to 10	280

Source: ChiMat CAMHS Needs Assessment Profiles

Table 2 shows the estimated number of children in West Berkshire who have a mental health disorder, by age and gender. These figures are based on annual modelling performed by Child and Maternal Health Intelligence Network (ChiMat). In this modelling, national estimates have been applied to the local population size.

Table 3: Boys aged 16 to 19 estimated to have a neurotic disorder

Category	Count
Mixed anxiety and depressive disorders	200
Generalised anxiety disorder	65
Depressive episode	40
All phobias	25
Obsessive compulsive disorder	40
Panic disorder	20
Any neurotic disorder	340

Source: ChiMat CAMHS Needs Assessment Profiles

Table 3 shows that among the boys aged 16 – 19 years in West Berkshire who from neurosis, an estimated 59% suffer from mixed anxiety and depressive disorders, and another 19% suffer from generalised anxiety disorder.

Table 4: Girls aged 16 to 19 estimated to have a neurotic disorder

Category	Count
Mixed anxiety and depressive disorders	455
Generalised anxiety disorder	45
Depressive episode	100
All phobias	80
Obsessive compulsive disorder	35
Panic disorder	25
Any neurotic disorder	705

Source: ChiMat CAMHS Needs Assessment Profiles

Table 4 shows that among the girls aged 16 to 19 years in West Berkshire, an estimated 64.5% suffer from mixed anxiety and depressive disorders and another 14% suffer from depressive disorder.

Currently there is no information about how many of these children have parents with mental health or alcohol/ substance misuse problems, or live with domestic violence

The following table shows the estimated current prevalence of mental health problems in children and young people in Wokingham.

Indicator	Wokingham	South East	England	Year
Perinatal mental health: Estimated number of women requiring support during pregnancy or postnatal period	233	#N/A	#N/A	2012
Estimated prevalence of any mental health disorder: % population aged 5-16	7.3	8.5	9.3	2014
Estimated prevalence of emotional disorders: % population aged 5-16	2.9	3.3	3.6	2014
Estimated prevalence of conduct disorders: % population aged 5-16	4.1	5.1	5.6	2014
Estimated prevalence of hyperkinetic disorders: % population aged 5-16	1.2	1.4	1.5	2014
Prevalence of potential eating disorders among young people: Estimated number of 16 - 24 year olds	1,889	126,533	#N/A	2013
Prevalence of ADHD among young people: Estimated number of 16 - 24 year olds	2,026	134,099	#N/A	2013
Fixed period exclusion due to persistent disruptive behaviour: % of school pupils	0.6	1.2	1.0	2011/12
Fixed period exclusion due to drugs/alcohol use: % of school pupils	0.04	0.13	0.10	2011/12
Children who require Tier 3 CAMHS: estimated number of children <17	670	#N/A	#N/A	2012
Children who require Tier 4 CAMHS: estimated number of children <17	30	#N/A	#N/A	2012

Data sourced from Public Health England profiles available at http://fingertips.phe.org.uk/

Our ambition

The vision for Berkshire West is to ensure that every child or young person gets the help they need when and where they need it. By 2020 support will be individually tailored to the needs of the child, family and community – delivering significant improvements in children and young people's mental health and wellbeing.

The Local Transformation Plans are about 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 or in-patient admission. Help will be offered as soon as issues become apparent.

Successful delivery of the plans will mean 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, youth justice, social care, third sector 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.
- Pregnant women and new mothers with emerging perinatal mental health problems can access help quickly and effectively, as can their partners.
- More children and young people with a diagnosable mental health condition are able to access evidence based services
- Vulnerable children can access the help that they need more easily. This includes developing better links between agencies who support victims of sexual assault and victims of crime; enhancing emotional and physical healthcare service to young people who are in contact with criminal justice and developing services to support Liaison and Diversion for young people who have had a brush with the law. Ensuring that the needs of Looked After Children, children at the edge of care and children who are at risk of exclusion are met.

- 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 in patient care, this is provided as close to home as possible. There is a smooth and safe transition into and out of Tier 4 services. Local services support timely transition back into the local area.
- More young people and families report a positive experience of transition in to adult services.

How will services change to deliver the local transformation plan?

The way services are organised will transform from a traditional tiered model, where care and support is delivered and commissioned by separate organisations, to a model where the community itself and the volunteer and professionally-led-services within Berkshire West take an active role. This will not only look different on paper, but also feel different for those using children's and young people's mental health services.

Collaboratively commissioned pathways will result in service users' experience of care becoming increasingly seamless, more coordinated and quicker to access. Collaborative commissioning is a crucial factor in making the transformation happen- partners are working together to identify then minimise gaps and areas of duplication; jointly agreeing new and improved ways of working; holding each other to account for delivery of the new care pathways; jointly reviewing service user outcomes and feedback then adjusting care pathways accordingly.

How will we know that we are making a difference?

Our commissioning decisions and transformation plan is outcomes focussed

- more people will have good mental health

- more people with mental health problems will recover

- more people with mental health problems will have good physical health

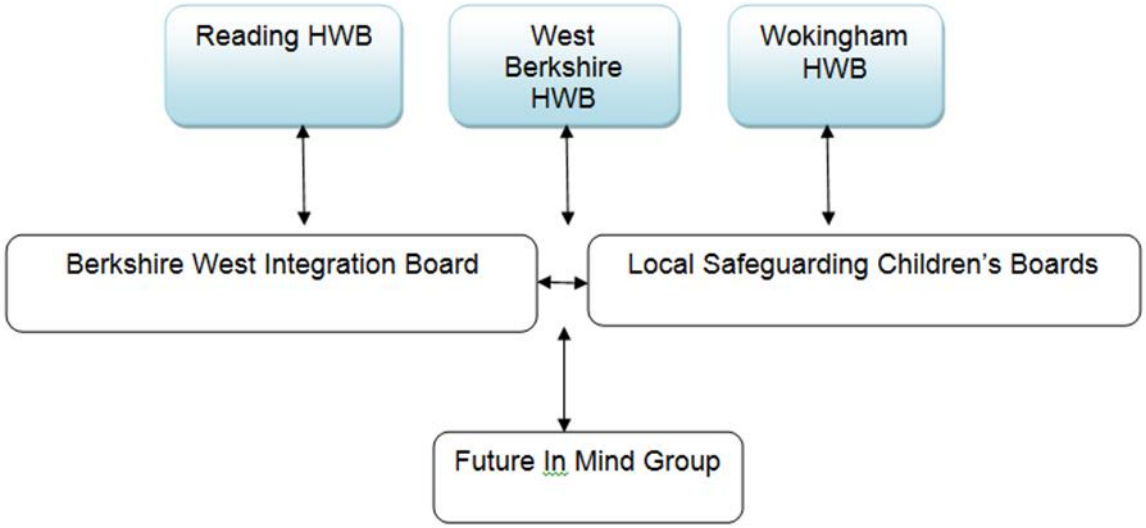
- more people will have a positive experience of care and support

- fewer people will suffer avoidable harm

- fewer people will experience stigma and discrimination.

Governance

Each local transformation plan was signed off by the respective Health and Wellbeing Board. Progress is being overseen by the Health and Wellbeing Boards. The Future In Mind multidisciplinary group meets monthly to consider, challenge and champion the changes. The Future In Mind group is chaired by the Director of Joint Commissioning NHS Berkshire West CCGs.



Appendix 1 provides links to the latest reports to the various Health and Wellbeing Boards

Appendix 2 provides the Terms of Reference of the Future In Mind group.

What has happened since Autumn 2015?

Since our initial Transformation Plans were published we have worked together to make sure that the actions we had initially commissioned are on track to deliver improvements and to identify further areas that we need to develop across the system.

A range of new and enhanced services have been commissioned. Each initiative has a project plan with Key Performance Indicators and expected outcomes. Original project plans can be found in Appendix 3. Providers report quarterly to commissioners and the Future In Mind group. This allows partners to learn from good practice, discuss and challenge progress to date, explore risks and collectively find solutions to mitigate risks. Highlights of Q1 reports are in Appendix 4. NHS providers and providers of CYP IAPT compliant services flow data for the MH Services data set. Smaller voluntary sector organisations provide quarterly reports containing numbers of individuals seen, demographic information and outcomes.

Meaningful service user participation embedded within all services and at service planning level is a core principle of CYP IAPT. CYP IAPT is well established in Berkshire West and the importance of meaningful service user participation is reflected in how we approach service development and delivery across all of Future In Mind thinking (not just CYP IAPT). Each organisation represented at the Future In Mind group is required to demonstrate how service user engagement has shaped service design and delivery. Providers are required to present

1. What service provision challenges have service users and families identified?

2. What have you done as a result of the feedback?

3. What has been the impact?

4. What opportunities/skills have service users and families provided you with?

5. How have you used the opportunity?

6. What has been the impact?

A joint outcomes framework has been developed by providers from the voluntary sector, LAs and NHS. All providers are required to report on outcomes as part of their contract agreement. The outcomes framework has been presented at regional learning events.

An example of this is the development of a pocket sized emotional health and wellbeing advice, guidance and sign posting booklet for secondary aged pupils commissioned through Future In Mind resources. Young people told us that they do not always know where to go for help and advice, even though services have been promoted over recent years. Commissioners heard that services need to be promoted constantly as children move between year groups in school and between schools/ settings. Some young people like using apps like SAM, visiting websites such as Young Minds and downloading materials but others prefer to have something that they discretely put in their blazer pocket and read later. Some young people told us that they had seen a booklet that had been distributed in Reading schools in 2016 and would like a version tailored to their LA area. Others liked a booklet that had been produced in London. Commissioners are working with service user groups and young people generally to develop and produce a booklet for distribution by the end of March 2017 (start of exam study leave). Links to apps and websites will be included as well as information on local face to face/ telephone services. Booklets will be available to download as well as in printed version. Distribution will be via peer mentors, School Link workers, Primary Mental Health Workers, Emotional Health Academy staff and the voluntary sector. We hope to promote the materials via a bus campaign in order to reach young people who are not in education- this idea came from the young people themselves.

Progress to date (October 2015 until September 2016) - headlines

- Waiting times for specialist CAMHs have reduced. More children and young people are having evidence based treatment (Appendix 5).
- Additional specialist CAMHs staff have been recruited and trained
- We are working to reduce crisis presentations via better risk mitigation of new and existing cases
- The Common Point of Entry is now open Monday to Friday 8am until 8pm
- In West Berkshire, the Emotional Health Academy is now operational. In Reading and Wokingham, school link projects have been commissioned. The impact of these initiatives will be evaluated over time. Quarterly reports are considered at the Future In Mind group.
- PPEPCare training has been commissioned and is rolling out across the workforce. This is part of a wider workforce development programme which includes an online workforce support hub.
- Workforce development plan for improving emotional health and wellbeing is under development following a workforce training and skills audit questionnaire for workers across the system. There is a recognition that providers need to work with commissioners and Health Education England to model the future skill mix and staffing numbers required to deliver the required changes to deliver Future In Mind. Staffing requirements are already understood for CAMHs Urgent care, CAMHs Community Eating Disorders and Autism

Assessment teams. Gaps in availability of staff on these care pathways are understood. We are already broadening out skill mix on the anxiety and depression care pathway using low intensity PWP workers, mirroring adult IAPT.

- Voluntary sector youth counselling is now commissioned in each area via 2 year contracts to provide more stability for providers. In Reading and Wokingham youth counselling has been jointly commissioned with the Local Authorities.
- Young SHaRON online platform has been developed and is now operational for a wider range of service users including those experiencing perinatal mental health issues, families who are waiting for autism assessment , advice and consultation for professionals who are worried about children and young people and adults with eating disorders.
- The number of in-patient beds at Berkshire Adolescent Unit has been increased. The unit is now open 7 days a week.
- The community perinatal mental health service is now operational with an associated Young SHaRON online support service.
- Emotional Health and Wellbeing Outcomes framework has been developed and agreed across partners. This has been implemented in contracts from 1 April 2016.
- Two voluntary sector organisations have been commissioned to provide support to families whose children are waiting for autism or ADHD assessment. We have undertaken an Appreciative Inquiry into services for children and young people with autism, including those who are waiting for an assessment.
- The neurodevelopmental care pathway (ADHD and ASD) is being reviewed within BHFT with learning from the Appreciative Inquiry work.
- Shared care arrangements between GPs and CAMHs for children and young people with ADHD have been updated.
- School exclusion data has been analysed to identify which young people are most likely to be excluded and where more help in schools might make a difference
- Additional Webster Stratton Incredible Years parenting courses have been commissioned in Reading and Wokingham.
- The children's toolkit is being expanded to include mental health and wellbeing. The CAMHs website has been expanded and updated.
- Learning from the Strengths and Difficulties Questionnaire review has been shared across partners and working practices are changing in light of learning.
- CAMHs Urgent Response service is being piloted at RBFT.
- Enhanced CAMHs Community Eating Disorders service has been jointly commissioned with Berkshire East CCGs and is now operational.
- A contract clause relating to service user satisfaction following transition into adult services was implemented in the 15/16 contract and is now "business as usual".

- New Early Intervention in Psychosis service is in place for all ages including children and young people and is meeting national targets
- Community health services for children and young people are being integrated into a single team.
- We have improved arrangements for authorising CAMHs support for Looked After Children who are placed out of area
- Service users are on interview panels for staff appointments.
- As service changes have been implemented, newsletters have been circulated to partners to keep them informed and engaged.
- A business case has been developed and submitted to NHS England Health and Justice Commissioners to enhance local services for young people who are in contact with the criminal justice system. We hope that an enhanced service will be in place for 17/18.
- We have reviewed local support arrangements for victims of crime and sexual exploitation.
- We have ensured that our Future In Mind plans are aligned to SEND reforms and Transforming Care arrangements.

Project plans for each of the new services are in Appendix 3.

More detailed update on progress against the Local Transformation Plan October 2015- September 2015

Aspiration in the original Transformation Plan	Where are we now?
Good emotional health and wellbeing is promoted from the earliest age Children, young people and their families are emotionally resilient	An enhanced perinatal mental health service has been commissioned and is fully operational. Service users and their families have told us that we need to change the way we work together with them to provide services in a way that is more joined up, makes more sense and gives lots of information clearly when it is needed most. Community health services for children and young people are being integrated into a single team. This means that physical health (e.g. occupational therapy, speech and language therapy, community nurses) and mental health workers are working much more closely and providing a more holistic service to children and families. Reading Youth Cabinet has a CYP mental health awareness campaign underway in schools. MindEd is being promoted across agencies. We are unable to assess how many people have accessed this online resource, although commissioners have received positive feedback on the content. Additional Webster Stratton parenting courses have been commissioned in Reading and Wokingham. This work is linked to a University of Reading research project aimed at developing a wider range of evidence based parenting interventions for young children with challenging behaviour. In the long term it is hoped that this work will reduce the number of children who go on to have involvement with the criminal justice system and the number of young people who are excluded from school. Emotional Health Academy has been co-commissioned and launched in West Berkshire. Its purpose is to help children, young people and families to find support for emotional wellbeing earlier, faster and more easily. http://info.westberks.gov.uk/index.aspx?articleid=32142 School Link projects are underway in targeted Reading and Wokingham schools- this trains school staff in PPEPCare emotional health and wellbeing modules, encourages the development of resilience in pupils, provides consultation to school staff and improves links between school staff, Primary Mental Health

	Workers, Educational Psychologists and specialist CAMHs clinicians. The impact of these initiatives will be evaluated over time. PPEPCare training is being delivered across the children's workforce including school nurses, GP's, school staff, Local Authority staff. New modules being developed include "building resilience in children and young people "and "working with families". http://tvscn.nhs.uk/psychological-perspectives-in-education-and-primary-care-ppep-care/ A variety of online Young SHaRON subnets are being developed to support professionals and families in promoting and supporting good emotional and mental health and wellbeing. http://www.sharon.nhs.uk/default.asp?fldArea=0&fldMenu=0&fldSubMenu=0&fldKey=1 Two voluntary sector groups- Autism Berkshire and Parenting Special Children- have been commissioned to provide advice, training and support to families whose children are awaiting Autism and ADHD assessment. Autism Berkshire are also providing post diagnostic support to families with teenagers as needs often change during this period. Both organisations are also commissioned to provide wider support and advice to families.
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	A Children's workforce training needs survey has been undertaken in West Berkshire. A training programme is being rolled out in response via the Emotional Health Academy and the Children's Delivery Group http://info.westberks.gov.uk/index.aspx?articleid=32142 . A workforce training needs survey is underway in Reading and Wokingham. A training programme will be developed in response. In the meantime PPEPCare training is being delivered alongside emotional first aid training. During the first 3 months of 16/17, 220 people were trained in PPEPCare modules. Subjects included self-harm, conduct disorder, anxiety and depression. Between May and December 2015, 562 delegates from Berkshire received PPEPCare training on a range of topics delivered in modules. Attendees included GPs, school nurses, teachers and SENCos, voluntary sector, youth workers and educational psychologists. School Link projects are underway in targeted Reading and Wokingham schools- this trains school staff in PPEPCare emotional health and wellbeing modules, encourages the development of resilience in pupils,

	provides consultation to school staff and improves links between school staff, Primary Mental Health Workers, Educational Psychologists and CAMHs clinicians. The impact of these initiatives will be evaluated over time. Emotional Health Academy has been co- commissioned and launched in West Berkshire. Its purpose is to help children, young people and families to find support for emotional wellbeing earlier, faster and more easily. Training and support is offered to schools. A dedicated emotional health worker for Looked After Children is in post. http://info.westberks.gov.uk/index.aspx?articleid=32142 BHFT and Local Authority staff are able to access CYP IAPT training locally, increasing the availability of evidence based interventions for children. Berkshire Healthcare CAMHs will shortly be launching a non-urgent on-line advice and consultation service through their Young SHaRON network for all professionals working with children, young people and families. This highly secure platform will offer the opportunity for professionals to discuss health concerns with BHFT clinicians, gather and share information to ensure that the family's needs are met by the most appropriate service(s). 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. Learning will be developed into an action plan to be delivered in 2017 and beyond. 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.
Help is provided in a coordinated, easy to access way. All services in the local area work together so	The multiagency Future In Mind Group meets monthly to develop, challenge and champion coordinated working across the system.

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.	Early Help services in each area provide multiagency triage of referrals to ensure that families access the most suitable help and support to meet their individual circumstances more quickly. The response might include family support, youth counselling, school support or specialist CAMHs. The emphasis is on finding solutions *with* the family, giving thought to the "whole child" and the "whole family" through a strengths based empowerment model. Additional specialist CAMHs staff have been recruited and trained. Waiting times for specialist CAMHs have reduced. More children and young people are having treatment. In 17/18 we expect waiting times to reduce further and there to be an increase in the number of children accessing help. Specialist CAMHs Common Point of Entry staff are now available 8am to 8pm Monday to Friday for advice and consultation. Referrals from workers who know the child best (such as teachers and SENCOs) are particularly encouraged in order to swiftly form a fuller picture of the child's needs and family circumstances. This information enables CAMHs to identify the most suitable type of help. Waiting times for specialist CAMHs have reduced in all CCG areas and across all care pathways since additional staff were recruited even though referrals into specialist CAMHs have continued to rise (up 18% compared to the same quarter 2014/15- Berkshire West figures). The total number of people waiting has reduced by 32% over the past 12 months (Berkshire West figures). There are more children are in treatment. An Appreciative Inquiry into how services to children with Autism are delivered across the system has been undertaken. Recommendations will be considered and developed into an action plan during 16/17. The CAMHs Urgent Response Pilot has increased availability of CAMHs staff in A and E, reducing delays in accessing Mental Health assessments at times of crisis. This service is being developed jointly between the acute hospital (RBFT) and community provider (BHFT). Frequent attenders are being proactively identified and more multiagency discussions are taking place to better understand and meet the needs of these service users. The service is developing stronger links with Children's Social Care and NHS England Specialised Commissioning. A CAMHs outcomes framework has been developed in partnership with Primary Mental Health workers,

	voluntary sector youth counselling organisations, educational psychologists and specialist CAMHs. Outcome measures take account of the service user views. All services that have been commissioned via Future In Mind resources are required to provide evidence of how engagement with children, young people and families has shaped service delivery and what the impact of these changes has been on outcomes for service users. BHFT 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.
Pregnant women and new mothers with emerging perinatal mental health problems can access help quickly and effectively.	Local perinatal mental health service has been launched. An online platform (SHaRON) for service users with perinatal mental health issues and their partners is up and running. Links to adult IAPT have been enhanced for this group.
Vulnerable children can access the help that they need more easily.	Early Help hubs and Multi Agency Safeguarding Hubs (MASHs) are operational in each area. The needs of children and their families are being considered in a more holistic manner with greater emphasis on supporting families to achieve jointly agreed care aims. Partners are working together on a THRIVE based audit of children and young people with significant emotional health needs, requiring the support of other statutory partner agencies. The outcome of this work is being reported to LSCBs. The purpose of the audit is to: 1) explore how well we identify emotional wellbeing and mental health difficulties, as individual services and collectively across multiple-agencies; 2) evaluate how effectively partner agencies identified need and risk; 3) assess the impact and effectiveness of single and multi-agency planning and impact on outcomes for children; 4) test the applicability of the THRIVE model in supporting enhanced inter-agency early identification

	and intervention, assessment and planning; to improve outcomes for children. Learning will shape service developments going forward. A process is now in place to ensure that funding requests for CAMHs services for Looked After Children who are placed out of area are considered and approved more swiftly. Likewise a process is in place to consider funding requests for vulnerable children with exceptional emotional and mental health needs who require bespoke care packages. Looked After Children and children subject to child protection plans have always been prioritised in Berkshire CAMHs. We have been liaising with the Office of the Police and Crime Commissioner, police, voluntary sector and Health and Justice commissioning to ensure that the emotional and mental health needs of children who are victims of crime or are involved in the criminal justice system are being met. We are working with partners in Specialised Commissioning and the youth justice system to develop the infrastructure required to support Liaison and Diversion schemes for young people by improving access to health services for young people who are in touch with criminal justice services. It is anticipated that these services will go live in 17/18 subject to the approval of a bid to NHS England (see Appendix 6). School exclusion data has been analysed with partners in West Berkshire to identify which young people are most likely to be excluded from school and where more emotional health and wellbeing support in schools might make a difference. This work will be carried forward into 17/18. Additional Webster Stratton parenting courses have been commissioned in Reading and Wokingham. This work is linked to a University of Reading research project aimed at developing a wider range of evidence based parenting interventions for young children with challenging behaviour. In the long term it is hoped that this work will reduce the number of children who go on to have involvement with the criminal justice system and the number of young people who are excluded from school.
Fewer children and young people escalate into crisis. Fewer children and young people	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 more quickly and urgent cases access help on the same day. Referrals are triaged for risk on the same day. Our Common Point

require in patient admission.	of Entry is now open 8am until 8pm Monday to Friday. A trial of a short term care team has been evaluated and learning has shaped service transformation. The Crisis Care Concordat plan includes steps to agree and implement a plan to improve crisis care for all ages, including investing in places of safety. http://www.crisiscareconcordat.org.uk/areas/reading/#action-plans-content A NICE compliant enhanced Early Intervention in Psychosis community service is in place and is delivering in accordance with the national access and waiting time standard targets. The new Berkshire Community CAMHs Eating Disorders Service has been commissioned jointly with Berkshire East CCGs in line with the new national requirements. All new referrals are triaged within 1 working day by a specialist eating disorders clinician. The service is on track to meet the access targets. Assurance work is required to ensure that primary care is aware and implementing the new care pathway. A paediatric ward liaison service to assess and support to young people admitted to a medical ward as a result of an Eating Disorder is going live as part of the wider CAMHs Urgent Response pilot.
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.	The CAMHs Urgent Response Pilot has a full rota in place covering bank holidays and weekends, providing timely mental health assessments and care. The service is integrated with Royal Berkshire Hospital 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 or subsequent crisis. The service also provides wrap around support when there are delays in sourcing a Tier 4 in CAMHS patient bed. In late 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. Benchmarking and analysis of data on admissions to A+E, paediatric wards and Place Of Safety to enable targeted admission avoidance work is being undertaken. Berkshire CCGs jointly commission 3 places of safety (POS) with BHFT; these are based at Prospect Park

	Hospital. One of these is dedicated for Children and Young Person with facilities for parents to stay with their child during assessment period. The POS is managed by BHFT inpatient staff and has support system in place to effectively manage mental health patient with high risk presentation.
When young a person requires in patient care, this is provided as close to home as possible. Local services support timely transition back into the local area.	Improved links are being developed with in patient providers, commissioners and social care to strengthen step up and step down arrangements. Additional beds are open at Berkshire Adolescent Unit. The Unit is now open 24/7. Pre admission Care and Treatment Reviews are undertaken for young people with Learning Difficulties and/ or autism. Future In Mind plans are aligned to Transforming Care plans.
More young people and families report a positive experience of transition in to adult services.	Ready Steady Go has been rolled out for young people across several long term condition care pathways. Learning is being disseminated across other specialities including CAMHs. A workshop has taken place to consider how Ready Steady Go can be embedded into Education Health and Care Plans for young people with Special Education Needs and Disabilities. Shared care arrangements between CAMHs and GPs for children and young people with ADHD have been updated. More young people and families have reported a positive experience of transition in to adult services – this has been measured since the CCG introduced a change into the BHFT contract.

What new information has shaped our refreshed transformation plan?

Our refreshed plan has been developed over time in response to a range of engagement events, investigations, local initiatives and reports including

- Ongoing feedback from our CAMHs service user group
- Campaigns by the Reading Youth Cabinet on improving access and reducing stigma in emotional health and wellbeing
- Engagement with experts by experience
- Reading Families' Forum report on the impact of assessment waiting times on families- "Can children and young people get support at school without a diagnosis of ADHD or ASC?" January 2016
- Engagement work in West Berkshire -"Brilliant West Berkshire: Building Community Together" comprising of workshops, community conversations and workforce skills mapping throughout 2015 and 2016. This work has resulted in the commissioning of an Emotional Health Academy.
- West Berkshire Health and Wellbeing Board CAMHs Hot Topic event February 2016
- Healthwatch Wokingham's comprehensive engagement programme with Wokingham children and young people to help us better understand the emotional wellbeing of our children and young people.
  http://www.healthwatchwokingham.co.uk/sites/default/files/totes_emosh_april_2015_2_1.pdf
- Autism system wide service review leading to an Appreciative Inquiry event held June 2016. This work has resulted in the formation of a Berkshire West Together for Children with Autism Group.
- Pan Berkshire Transforming Care work
- Refreshed JSNA chapters on Child and Adolescent mental health
  http://www.reading.gov.uk/article/9485/Children-and-Adolescent-Mental-Health
  http://info.westberks.gov.uk/CHttpHandler.ashx?id=37350&p=0
  http://jsna.wokingham.gov.uk/developing-well/children-and-adolescent-mental-health/

  The Reading JSNA is in the process of being refreshed (Jan 2017).
- Dr Anthony Hewitt's review of Health and Justice Pathways in NHS England South (South West and South Central)- June 2016
- A Berkshire West CCG review of health input into Youth Offending Teams and consideration of how services could be improved

- Engagement with NHS England Health and Justice Commissioning in preparation for a future Liaison and Diversion services for children and young people in Berkshire.
- Learning from performance monitoring and service development reports from providers
- Publication of the Government's Five Year Forward View and the Mental Health Five Year Forward View
- Development of wider Sustainability and Transformation Plans across Berkshire, Oxfordshire and Buckinghamshire
- Engagement with academics from University of Reading on evidence based interventions
- Emerging learning from a THRIVE based audit of children and young people with significant emotional health needs, requiring the support of other statutory partner agencies.

Alignment of our plan with the Buckinghamshire, Oxfordshire and Berkshire West (BOB) Sustainability and Transformation Plan (STP 44)

Our BOB STP has a focus on

- Shifting the focus of care from treatment to prevention, self-care, advice and earlier support before issues exacerbate
- Enabling service users to access services every day of the week
- Improving the coordination of services across providers particularly when service users require an urgent response, resulting in fewer people being admitted to hospital, reduced lengths of stay, care closer to home with fewer admissions outside BOB.
- Reducing suicide rates by building resilience in children, young people and families, improving childhood mental wellbeing, raising awareness of mental health issues and the help that is available, improving urgent care for people in crisis and creating a momentum for change that eliminates the notion that suicides are inevitable. (Note we have below average suicide rates across all ages in BOB).

The STP simultaneously addresses the in-year challenge of delivering the 16/17 position as well as putting in train the actions that will be needed to ensure a high quality, financially sound health system by 2020/21. All the national 'must dos' for 2016/17 described in in the planning guidance are addressed by the operational plans of each CCG.
This transformation plan is aligned with the BOB STP.

Alignment of this plan with Local Authority and LSCB plans and priorities

All three LAs and LSCBs have priorities related to improving access to early help and emotional health and wellbeing of children and young people- particularly those with additional vulnerabilities. Progress against our transformation plans is reported regularly to the respective organisations.

How BHFT have transformed care for children, young people and families

Our community health provider, BHFT are undertaking a major service transformation across all services for children, young people and families to deliver a vision that has been co-produced with service users and families. BHFT provide physical and emotional/ mental health services to the population of Berkshire.

"All children, young people and families in Berkshire will receive early and consistent information and healthcare that is available via a range of technologies and interventions, is joined up and wherever possible is delivered as part of everyday living." Co design with partners and service users has been integral to the service changes. The new model of service delivery is based on an increasingly collaborative approach with children, families and other significant people (early year's staff, teachers, care workers, voluntary sector etc) with physical and emotional health and wellbeing being considered jointly rather than separately throughout the child's life:

6: **Key Stakeholder** experience

Berkshire Healthcare NHS
NHS Foundation Trust

Service users and families

Early years

- Antenatal contact from health visitors (HV) with Toolkit available immediately for advice and information.
- New birth, 6 week, 9 month and 2 year reviews supported by Toolkit, and Young SHaRON peer support.
- Single phone number for immediate advice / help from duty health visitor or other clinician.
- Integrated drop in clinics in children's centres and nurseries – universal nursing and SALT. Advice on emotional wellbeing.
- Therapy care planning carried out with family members as equal partners, with families determining their priorities (same for for school age and families below).
- Children with complex CND needs would have one single assessment and care plan.

School age and families

- Single service triage, assessment and care planning carried out with a new focus on the family's priorities.
- Children and young people with complex CND need would have one single assessment and care plan.

Nurseries, schools and colleges

- CYPF link for service development and monitoring for each nursery, school or college (schools in clusters if possible).
- 'Offer' to meet the wider health needs of the nursery, school or college – could include child / group / class assessment and interventions, training to staff, school community, parents, drop in sessions.
- Integrated training packages for ADHD, ASD, SLI, anxiety, phonology, dyspraxia.
- Integrated training package for colleges and / or youth offending teams re: language, communication and regulation of emotion / behaviour.
- Regular planning and negotiation with nursery, school or college, to identify CYPF health priorities for the school, and examine options for delivery.

Referrers and partner organisations

- Single referral point
- Single number for advice and help
- Clear thresholds for entry
- Integrated common point of entry for all cases
- One Berkshire Healthcare senior manager (director level) for all issues re: children (LAC, CAMHS, therapies, EHC plans, KPIs, contracts)
- Consistent representation at LSCBs and CYP forums, with reps who have an understanding of ALL children's services.
- Single data reporting source.
- Integrated reporting.

7: Service comparisons

Berkshire Healthcare NHS
NHS Foundation Trust

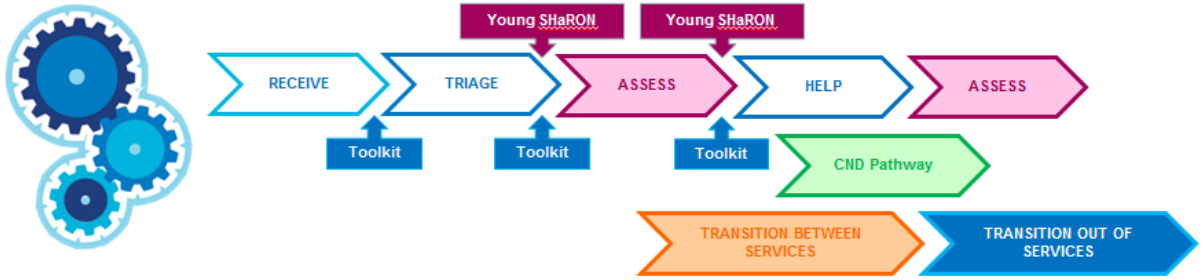
Current service features:	Future service blueprint features:
Entry is currently using inconsistent processes through three points: - Specialist Children's Services - CAMHS Common Point of Entry - CYPIT Common Point of Entry.	**Entry through one point,** where demographic data is captured and where the patient/family receive a triage assessment with advice given by the most appropriate clinician, using the Toolkit.
Professional-focused services, often resulting in fragmented service offering for people with complex needs.	**Customer-focused services** for complex cases with a mix of professionals delivering a more holistic approach and consistent service offering to those with complex needs.
Business and governance activity embedded in different services.	**Business and governance functions centralised,** providing consistency, including the reporting on all children services from one place.
Complex partnerships – A complex range of partners involving five Locality Directorates.	**Simplified partnership arrangements involving one Locality Director.**
Poor experiences reported of transitions to adult services and between children services.	**Clear processes around transitions ensuring they are planned and achieved effectively.**
CAMHS services provided in NHS clinics with limited involvement of schools.	**More service provision in schools and less within clinical environments.**

Current service features:	Future service blueprint features:
Waits between services and pathways, with limited information provided regarding the 'process' of waiting.	**Swifter access to specialist services with reduced waits and information provided regarding the process and what users should expect.**
A number of separate health services supporting nurseries, schools and colleges with no consistency regarding the services offered. Unnecessary duplication of services, multiple training offers for staff and recipients. Multiple assessments and care plans for the same child	**Schools and nurseries will be served by one service and they will influence the content of services they receive.** We will offer streamlined, holistic service, with combined professional support and training
Multiplicity of leaflets, websites, information platforms giving information and advice to service users and families.	**One source of well-regarded expert information (the Toolkit) which is readable, understandable and provides users with what they need. Advice and information covering developmental 'milestones' and early strategies will be available for families, GP practices, nurseries, schools and other professionals** The Toolkit offers strategies for families which may result in successfully avoiding a need to seek expert help.

3: The **CYPF process**

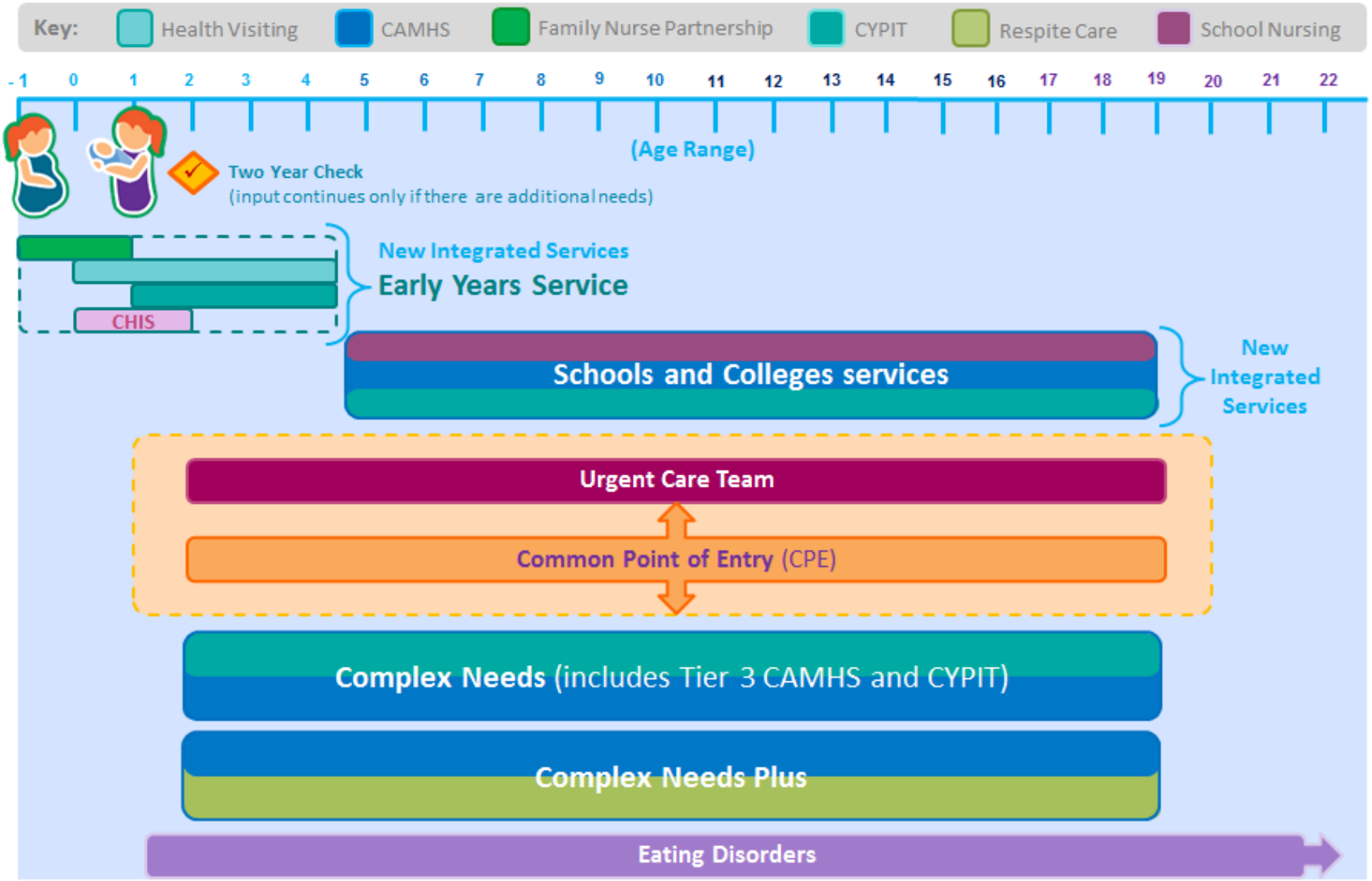
Berkshire Healthcare NHS
NHS Foundation Trust

Increasing collaborative approach with children and families along with other significant people (early years staff/ teachers).



8: **CYPF service –** final service organisation

Berkshire Healthcare NHS
NHS Foundation Trust



Further work anticipated from 17/18 onwards

	Status at end Sept 2016	17/18 targets	18/19 targets	19/20 and beyond
Waiting times for Specialist CAMHs treatment	All referrals are risk assessed on receipt. 100% urgent cases seen within 24 hours 80% referrals assessed at CPE within 6 weeks. All referrals breaching the 95% target are referrals to the Autism Assessment Team. Business case has been submitted to NHSE to reduce autism waits. Current average wait time to be seen by Specialist Community Team is 6 weeks. Current average wait time to be seen by Anxiety and Depression team is 13 weeks. We are working with University of Reading to develop an enhanced service- bid in with NHSE. Current average wait time to be seen by ADHD team is 10 weeks. The service is reviewing current working practices to identify opportunities for more	Agreed targets- 100% urgent cases within 24 hours 95% triaged at CPE within 6 weeks 95% seen by specialist team within 6 weeks 95% seen by anxiety and depression team within 6 weeks 95% seen by ADHD team within 6 weeks	Proposed targets 100% urgent cases within 24 hours 95% triaged at CPE within 6 weeks 95% seen by specialist team within 6 weeks 95% seen by anxiety and depression team within 6 weeks 95% seen by ADHD team within 6 weeks	Proposed targets 100% urgent cases within 24 hours 95% triaged at CPE within 6 weeks 95% seen by specialist team within 6 weeks 95% seen by anxiety and depression team within 6 weeks 95% seen by ADHD team within 6 weeks

	streamlined working including a pharmacy review.			
Waiting time for autism spectrum assessment	95% seen within 18 months. Current average wait time for ASD assessment is 37 weeks. Business case has been submitted to NHSE to reduce these waits.	By April 2017 95% seen within 11 months By Oct 2017 95% seen within 12 weeks	Targets to be agreed	Targets to be agreed
Increase the number of children accessing high quality mental health services	3638 (end Q1) Agree trajectory for expansion with NHSE – this work is in train	Increase TBC	Increase TBC	Increase TBC
CAMHs urgent response- includes developing admission avoidance care pathways and improving access to timely support and treatment pathways	Pilot urgent response service. Gather baseline data. Q3- BHFT to develop proposal to mainstream the service from 17/18. Proposal to consider opportunities for collaborative commissioning with neighbouring CCGs as well as Berkshire West only option. Service must form part of collaborative care pathway with Specialised Commissioning. Q4 make required service specification changes in	Commission urgent response service. Monitor progress in improving timeliness and quality of assessments, treatment and support; multiagency working; reducing the number of preventable admissions to hospital/ Place of Safety; improve patient experience Make any required changes	Monitor and amend as required	Monitor and amend as required

	preparation for new contract year. Agree KPIs.			
Improve step down arrangements from in-patient care	Linked to urgent response work. Review multiagency working.	Improve multiagency working (if required). Agree care pathway (if change is required)	Monitor and amend as required	Monitor and amend as required
Community eating disorders service	Service co-commissioned by Berkshire East and West CCGs in line with national requirements. Service will be fully staffed by November 2016. Urgent cases are already being seen within 1 week. Awareness raising and promotion with GPs.	Service to meet all national service requirements so that 95% of routine cases are seen within 4 weeks and urgent cases continue to be seen within 1 week. Assurance work to check that primary care is aware of and adhering to the revised care pathway	Monitor and amend as required	Monitor and amend as required
Early Intervention in Psychosis service	NICE compliant EIP service in place for all ages. EIP reporting in line with national requirements	Monitor and amend as required	Monitor and amend as required	Monitor and amend as required
Health and Justice care pathways	Baseline work undertaken. Bid for funding submitted to NHSE Engagement with needs assessment for a future Liaison and Diversion (L & D) scheme for CYP in Berkshire. Liaison with OPCC and NHSE on emotional health services for victims of	Assuming successful bid to NHSE, commission additional skill mix to Youth Offending Teams. Develop single service specification with KPIs for health services into YOTs. Work in partnership with NHSE Health and Justice to ensure success of CYP L & D scheme	Evaluate new services. Monitor and amend as required	Monitor and amend as required

	sexual assault. Publicise new care pathways to partners.			
Improving access to evidence based psychological therapies	Established member of IAPT collaborative. Multiagency staff encouraged to train in CYP IAPT courses. Consider training of PWP workers with University for CYP with anxiety and depression (AnDY service).	Explore "pay to train" and match funding for CYP IAPT training. If we decide to commission AnDY, monitor and evaluate outcomes. Support CYP IAPT expansion	Support CYP IAPT expansion	Support CYP IAPT expansion
Outcome measures in youth counselling	Outcomes framework agreed. Contract monitoring of outcomes in place. ARC youth counselling to lead on the development of tool to support outcome collection.	Roll out of the outcome collection tool to other youth counselling organisations.	Monitor and amend as required	Monitor and amend as required
School Link projects	Projects initiated in Reading and Wokingham. Staff recruited. Commenced training in identified schools. Establish MH consultation "surgeries" in schools. Establish pre and post	Explore outcomes from other School Link projects nationally. Test and review the training and interventions provided. Promote and expand the	Monitor and amend as required	Monitor and amend as required

	measures for staff trained and pupils involved. Launch Milky Way, the BHFT consultation sub-net for local referrers.	project to other schools if outcomes are good Review and evaluate progress – decide whether to continue project into 18/19 and beyond		
Emotional Health Academy (EHA) in West Berkshire	EHA launched and is operating in 23 schools. Staff recruited. EHA exploring options for increasing self-referrals by CYP. Outcome measures being collected.	Expand into more schools and settings if outcomes are good Test and review the Interventions provided. Review and evaluate progress – decide whether to continue Future In Mind funding of the project into 18/19 and beyond	Monitor and amend as required	Monitor and amend as required
Provision for children with autism or suspected autism	Voluntary sector commissioned to provide support to families. Jupiter, the sub-net for parents and carers of young people referred to the ASD Pathway, launched. Review and Appreciative Inquiry work completed. Together for Children with	Implement multiagency action plan to improve services Monitor and assess the impact of initiatives	Implement multiagency action plan to improve services Monitor and assess the impact of initiatives	Implement multiagency action plan to improve services Monitor and assess the impact of initiatives

	Autism group established. Multiagency action plan to improve services to be developed BHFT care pathway revised			
Provision for children with ADHD	BHFT care pathway being revised Pharmacy review to be undertaken Voluntary sector commissioned to provide support to families. Shared care agreement with GPs updated	Consider whether to undertake review and Appreciative Inquiry work for this client group Implement any multiagency action plan that is developed to improve services	Implement any multiagency action plan that is developed to improve services	Implement any multiagency action plan that is developed to improve services
Provision for children with conduct disorder/ challenging behaviour	Webster Stratton parenting programmes delivered in Reading and Wokingham in conjunction with a University of Reading research project (children aged 4-8 years). Local Authority staff trained in Webster	University of Reading undertake research activities (not funded through Future In Mind) with families identified through the Webster Stratton courses. Develop conduct disorder/ challenging behaviour pathway across the	Develop and implement conduct disorder/ challenging behaviour pathway across the system.	

	Stratton THRIVE audit Some links to Transforming Care work Some links to Health and Justice work.	system. Consider implications for children and young people with Learning Difficulties. Work to be linked to Transforming Care work where relevant. Some links to Health and Justice work		
Early identification and early help Improve integrated working Care for the most vulnerable	Consider the impact of proposed changes to commissioning arrangements for Health Visiting and School Nursing in relation to Future In Mind. Work with partners to mitigate risks. Map the collective resilience, prevention and early help offers across the system. Consider how we make the system easier to navigate. This work may proceed at different paces across the 3 Local Authorities. BHFT services for children, young people and families	To be continued and developed Embed BHFT single point of access. Monitor and evaluate BHFT integrated services through the contract Roll out of Transforming Care	To be continued and developed Evaluate BHFT single point of access. Roll out of Transforming Care	To be continued and developed Roll out of Transforming Care

	have now integrated into a single team. A single point of access for all CYP issues is planned. Action has been taken to improve knowledge and understanding of referral criteria across all partner agencies, to reduce the number of referrals that should be managed through Tier 2/early intervention services and to improve partnership working with these services. Newsletters raising awareness of referral systems , providing information on the referral process and links to more detailed referral guidelines on the service website has been sent out to key partners. Information to support improvements in referral quality is being provided via PPEPCare			

	training sessions, ad hoc training and service meetings with key agencies. As part of the wider Transforming Care work, implement person centred planning to reduce the number of young people with Learning Difficulties and/or autism placed out of area or in residential care.			
Workforce development across agencies	PPEPCare commissioned and being delivered across agencies. Additional PPEPCare modules being developed. Undertake workforce questionnaire Evaluate responses Develop workforce plan Some of this work has already been completed in West Berkshire prior to	Implement workforce plan Evaluate progress Subject to approval of the Health and Justice bid, increase awareness of how communication difficulties and autism can impact on the behaviour of young people who are in contact with criminal justice system.	Implement workforce plan Evaluate progress	Implement workforce plan Evaluate progress

	the establishment of the Emotional Health Academy. Links to CYP IAPT Launch Milky Way, the BHFT consultation sub-net for local referrers.			
Workforce planning and recruitment	BHFT and partners have recruited additional staff where required. Use of agency staff has reduced as permanent staff have come into post. Skill mix within the workforce is being considered and implemented where appropriate. A workforce plan is in place within BHFT. Recruitment and retention strategy is in place. Staff turnover is low. Staffing is monitored through quarterly reporting. Current workforce is in appendix 7. The capacity and	Monitor and continue to develop workforce plan. Implement decision relating to whether to continue to utilise PWPs in CYP anxiety and depression care pathways. Providers need to work with commissioners and Health Education England to model the future skill mix and staffing numbers required to deliver the required changes to deliver Future In Mind. Staffing requirements are already understood for CAMHs Urgent care, CAMHs Community Eating Disorders and Autism	Monitor, deliver and continue to develop workforce plan.	Monitor, deliver and continue to develop workforce plan.

	capability of the wider system is being addressed through workforce training (including the voluntary sector) and the implementation of the School Link projects and Emotional Health Academy. We aim to build capacity so that needs are addressed before they escalate into more severe and enduring issues. We trialling PWPs in CYP anxiety and depression pathways.(Jan 2017) Workforce development plan for improving emotional health and wellbeing is under development following a workforce training and skills audit questionnaire for workers across the system. There is a recognition that providers need to work with commissioners and Health Education England	Assessment teams.		

	to model the future skill mix and staffing numbers required to deliver the required changes to deliver Future In Mind. Staffing requirements are already understood for CAMHs Urgent care, CAMHs Community Eating Disorders and Autism Assessment teams. Gaps in availability of staff on these care pathways are understood.			
Accurately capturing activity- data quality	BHFT are submitting data to the MHMDS. Non NHS providers are submitting data to CCGs but currently this activity is not captured on MHMDS. Non NHS providers to do not currently have the IT infrastructure to submit data onto MHMDS. CCGs are in discussion with NHSE on how to resolve this issue.	Better data quality submissions to MHMDS	Assured data submissions to MHMDS	Assured data submissions to MHMDS

Key risks to delivery, controls and mitigating actions

Any major service transformation has challenges. Some organisations and individuals are more open to change than others. Schools in particular have competing demands on their time so while there may be a desire and recognition to change, external factors prevent change from happening at the pace required.

Each project reports on key risks to delivery and mitigating actions on a quarterly basis.

The key risks identified are (this list is not exhaustive)

Risk	**Mitigating actions**
Inability to recruit / retain sufficient staff with experience required to undertake the work.	Specialist CAMHs agency staff were retained until new starters commenced. Skill mix utilised when appropriate. Membership of local CYP IAPT collaborative- prospective staff find this attractive, existing staff are encouraged and supported to undertake additional training. Voluntary sector partners have recruited and trained additional staff/ volunteers. Supervision arrangements in place for practitioners. Providers held to account when projects/ milestones delayed- recovery plans required and monitored via the contract process Bid accepted to fund a trial of low intensity treatment for anxiety and depression delivered by skill mix staff (similar to the use of PWPs in adult IAPT) Providers need to work with commissioners and Health Education England to model the future skill mix and staffing numbers required to deliver the required changes to deliver Future In Mind
Poor system engagement	Director level sponsor. Improving emotional health and wellbeing in CYP is a multiagency priority and is championed by system leaders. Service users and champions contacting partners e.g. schools Promotion of evidence base and ready made tools (e.g. Young Minds building Academic Resilience tools)

Risk that there is a further peak in crisis/Urgent Care presentations which continues to be higher than additional capacity	Investment in whole system training and working to enable earlier intervention and crisis prevention
Financial- insufficient funds to cover all required investments	CCGs and partners working collaboratively across Berkshire/BOB to identify opportunities for economies of scale. CCGs and partners proactively bidding for grants and resources.
Poor quality of referrals resulting in delays in the child accessing the right help at the right time	Training for referrers. Regular communication updates to referrers. Proactive outreach by providers to referrers Updated referral guidelines and forms put on DXS. Use of early help hubs to identify issues more quickly and ensure that child is seen by the most appropriate service provider
Schools underestimating the level of staff involvement required to implement the School Link project, leading them to step away from the programme	Project manager assigned Utilise the strong relationships between Educational Psychologists, Primary Mental Health Workers and schools to help to facilitate the project. Publicise outcomes from other areas of the country that have seen a link between strong emotional health/ resilience amongst pupils and better academic outcomes. Promote project with governors.
Submissions to MHMDS to not capture non NHS delivered treatment resulting in our cover data being reported as lower than the reality	Non NHS providers are submitting data to CCGs but currently this activity is not captured on MHMDS. Non NHS providers to do not currently have the IT infrastructure to submit data onto MHMDS. CCGs are in discussion with NHSE on how to resolve this issue.
Staff reluctant to implement the required changes	Change management programme in place with our main community provider. Supervision arrangements in place for practitioners. Improving emotional health and wellbeing in CYP is a multiagency priority and is championed by system leaders. Service user feedback to staff and organisations Promotion of CYP IAPT training Evidence of positive changes in outcomes for service users

Appendix 1 Health and Wellbeing Board Reports

Reading Borough Council 18 March 2016

item06 HW board CAMHs report March

http://www.reading.gov.uk/article/9585/Health-and-Wellbeing-Board-15-JUL-2016

Wokingham Borough Council 14 April 2016

Wokingham HWB Emotional Health and

Appendix 2 Wokingham Emotiona

http://wokingham.moderngov.co.uk/ieListDocuments.aspx?CId=140&MeetingId=1404

West Berkshire Council- Hot Focus session on Emotional Wellbeing 11 February 2016

CAMHS hot topic session- sally expand

West Berkshire Council 7 July 2016

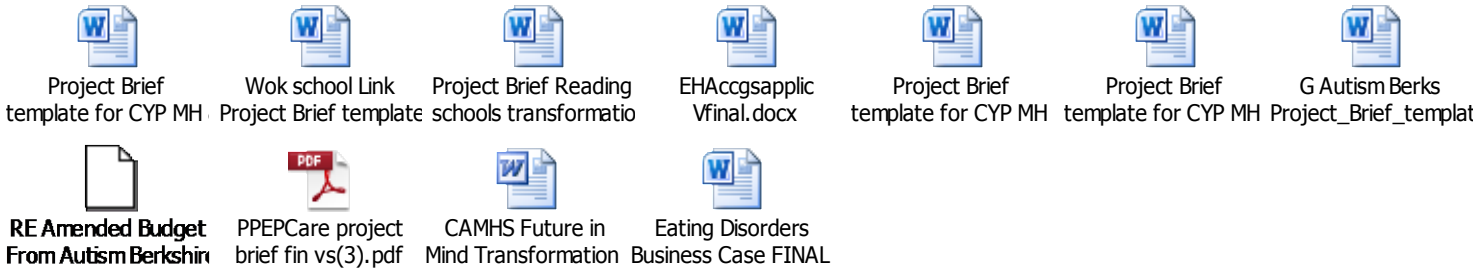
Chidlren's Delivery Group Report 7th Jul

http://decisionmaking.westberks.gov.uk/ieListDocuments.aspx?CId=345&MId=3471&Ver=4

Appendix 2 Terms of reference of the Berkshire West Future In Mind group

Paper 2 - Future In Mind Group TOR v 5.(

Appendix 3 Future In Mind project plans



Early Intervention in Psychosis and Perinatal services were commissioned through wider Parity of Esteem funding.

Appendix 4 Performance reporting- services commissioned from partners

Partner	Service commissioned 16/17	Performance Q4 15/16	Performance Q1 16/17
Autism Berkshire	Monthly Pre-Assessment Workshops: 36 in total, 12 in each locality Training on Supporting Teenagers with Autism with University of Reading (UoR) Centre for Autism: 6 in total, one training session to take place every two months, with two taking place in each locality over the project year. Three 2 day Mental Health First Aid courses: one to be held in each locality for parent/carers	7 Pre-Assessment workshops were held, attended by 52 parent/carers. 6 families received a home visit 6 families preferred to meet the Home Visit worker in the office 43 parent/ carers attended a parent support group.	9 Pre-Assessment workshops were held Supporting Teenagers workshop developed, ready for delivery from Q2 Promotional materials prepared, website developed, promoted via Twitter and Facebook Workers trained as mentors on SHaRON
Parenting Special Children	PSC will offer 20 pre diagnosis ADHD workshops which will include: Entry Level: 2 hour workshop: What is ADHD (Attention Deficit Hyperactivity Disorder) from May 2016 Level 1: 2 hour workshops: Understanding and Managing ADHD behaviours from June 2016 Monthly topic based information and support workshops West Berkshire & Reading/Wok from September 2016		3 Introduction to ADHD workshops held with 19 attendees PSC has recruited 12 new peer supporters for the Diagnosis Support Service, some of whom have children or young people with ADHD, the new peer supporters training starts in mid-September.

	Pre Diagnosis Support 1-1 peer support from September 2016		
Youth Counselling- ARC (predominantly Wokingham area)	250 clients aged 0-24 seen per quarter 1500 counselling sessions delivered per quarter 5 summer workshops for parents attended by 30 parent/ carers Target of maximum 12 week waiting time for help 2 peer mentor training sessions for young people *per annum* Implement outcomes framework during 16/17	Not applicable	271 clients seen On track 6 anxiety workshops delivered to 100 parents of anxious children Achieved Scheduled for later in the year In development- on track
Youth Counselling- Adviza Time To Talk (predominantly Reading area)	170 clients seen in first 6 months 1500 counselling sessions delivered in 6 months Target 3 week waiting time for assessment Target of 8 week waiting time for	Not applicable	73 clients seen in Q1 448 sessions offered in Q1 325 attended- recovery plan sought Off track- on track to achieve this by end Q2 Off track- recovery plan sought

	counsellor allocation Implement outcomes framework during 16/17		 In development- on track
Youth Counselling- Time To Talk (West Berkshire)- predominantly West Berkshire area	108 clients seen at Broadway House within 6 months 750 sessions held at Broadway House within 6 months 2 clients seen each week at Lambourn Surgery 2 week max waiting time for assessments 8 week max waiting time for regular sessions Min of 25 counsellors maintained Reduction in CORE score of 7 points minimum Publication and distribution of new marketing materials Implement outcomes framework during 16/17	Not applicable	55 clients concluded counselling in Q1- on track 535 sessions held in Q1 Achieved The current average waiting time for young people for an assessment is 1.8 weeks The current average waiting time for young people to start a regular session is 8.4 weeks Currently 24 counsellors with one new counsellor starting Q2 Achieved Website and logo redesigned in Q1. Materials to be launched in Q2 On track

	Run two courses (mindfulness and Being Me) using underspend from 2015/16		Both courses ran in Q1, due to conclude in Q2.
PPEPCare training	Deliver PPEPCare training to support School Link Projects in Wokingham and Reading Train trainers to support School Link Projects Deliver PPEPCare to support Emotional Health Academy and West Berkshire schools Deliver PPEPCare training for non CAMHs staff including practice staff and GPs Piloting of new modules (Resilience and ASD) Potentially developing new modules (to be explored with stakeholders)	Not applicable	220 staff attended PPEPCare sessions of average 2 hours although it also included a whole day for school nurses. Subjects included self-harm, conduct disorder, anxiety and depression. Train the trainers sessions have taken place so that LA staff and school nurses can deliver PPEPCare sessions. A subnet of SHaRON for PPEPCare trainers using a protected space on SHaRON to share materials, feedback from training sessions and support trainers in delivering training and this has been agreed and will go live in July/ August.
School Link Project -Wokingham	1. To train school staff in the PPEP care model. 2. To identify, train and support a key person per school to take a lead on emotional and mental health issues in school. Establish a support menu for this	Not applicable	40 teachers attended a PPEPCare training day Recruitment of PMHW has delayed the project

	key person that includes regular training, network meetings & supervision and this work be underpinned by a role description. 3. To hold regular joint consultation sessions on concerning children in identified schools. These are joint between key professions in Early Help services as well as BHFT as the specialist provider. 4. To identify a clear model of school based stepped care interventions that the school should be offering from their resources or in partnership with others. The School Link project will enable pilots of interventions in identified schools, which are then written up to confirm that they are the interventions required. Once the interventions have been agreed the project will then be clear on the training and support required within schools who agreed to offer these interventions in their school.		
School Link Project- Reading	1. To train school staff in the PPEP care model. 2. To identify, train and support a key person per school to take a lead on emotional and	Not applicable	3 PMHWs and 1 Educational Psychologist commenced PPEPCare train the trainer training.

	mental health issues in school. Establish a support menu for this key person that includes regular training, network meetings & supervision and this work be underpinned by a role description. 3. To hold regular joint consultation sessions on concerning children in identified schools. These are joint between key professions in Early Help services as well as BHFT as the specialist provider. 4. To identify a clear model of school based stepped care interventions that the school should be offering from their resources or in partnership with others. The School Link project will enable pilots of interventions in identified schools, which are then written up to confirm that they are the interventions required. Once the interventions have been agreed the project will then be clear on the training and support required within schools who agreed to offer these interventions in their school.		11 schools have agreed to engage in the project. Schools are identifying key staff members to lead on EWB in each school Training dates for academic year 16/17 agreed Arrangements for mental health consultations being negotiated.

Webster Stratton – Reading Personalised assessment and intervention packages for children with conduct problems in child mental health services	• 6 practitioners trained to delivery Webster Stratton 14 week course – March 6 • Identify 20 adults to join course 1 – March 16 • Couse 1 started in April 16 and ends July 16 • Identify 20 adults to join course 2 – July 16 • Couse 2 started in Late Sept 16 and ends Dec 16 • Identify 20 adults to join course 3 – Dec 16 • Couse 3 started in Late Jan 17 and ends March 17 • Identify 20 adults to join course 4 – Dec 16 • Couse 4 started in Late Jan 17 and ends March 17 • Identify 20 adults to join course 5 – March 17 • Couse 5 started in April 17 and ends July 17	Not applicable	- 9 facilitators have been trained in Incredible Years Parenting - Pilot group has been completed – 11 started, 8 finished - Parenting Group Programme for 16/17, 17/18 has been organised with 4 Incredible Years groups scheduled – 2 in South and 2 in West - Facilitators have been identified and contingency in place to cover leave/absence - Pilot group has been evaluated with practitioners and learning shared with newly trained facilitators - All materials/tools have been delivered and there are resources in both locality teams - Relevant admin support has been identified - Relevant managers/facilitators are clear on time dedicated to group and this is factored in to their case weighting

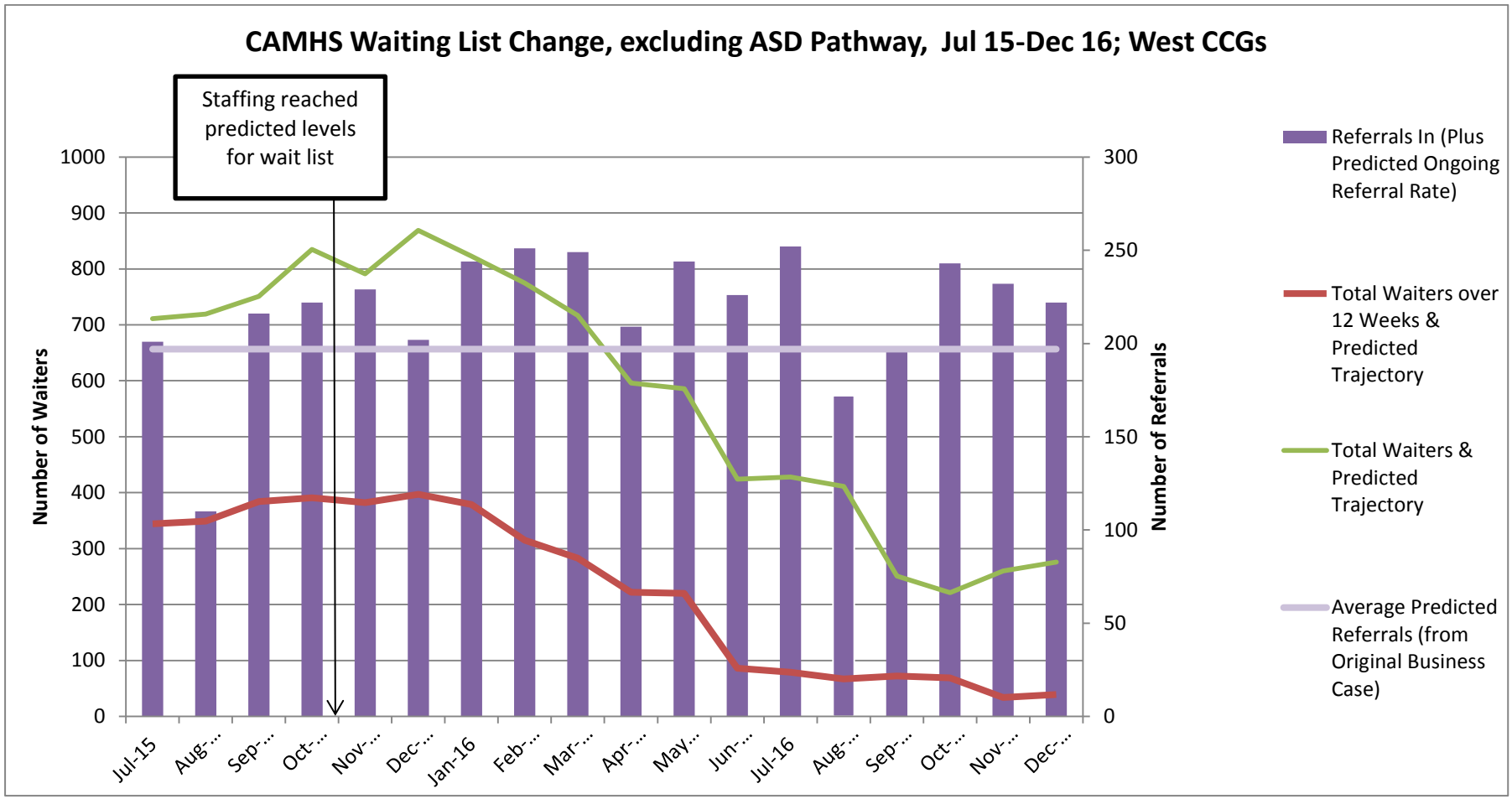
Webster Stratton- Wokingham Personalised assessment and intervention packages for children with conduct problems in child mental health services	The Wokingham project will consist of two experienced Incredible Years Facilitators working in the Early Help Team to deliver 2 – 3 courses offering a service to 55 parents over 12 months.	Not applicable	9 families completed a 14 week Pilot Incredible Years Parenting Course Courses planned and recruited to from Sept 16 Staff and researchers have been recruited and trained
Emotional Health Academy- West Berkshire	The Emotional Health Academy will act as a hub for training and interventions. The EHC will initially train 4-6 emotional health workers to work in schools and the community as early intervention practitioners. The Emotional Health Academy will offer: • Induction, initial training and continuing professional development for the EH workers • Training for schools (Mental Health First Aid, PPEPCare, bespoke training) • A quick, co-ordinated, multi-agency response via a weekly Triage • Response and intervention within the schools and community • A wider range of interventions and universal advice, support and signposting incl. web-	Not applicable	Emotional Health Academy has been launched; staff have been recruited and trained; and the EHA is now operational in schools and community settings across West Berkshire. Waiting list reduced from 120 to zero. More schools have bought into the service

	based help • A family focus with links to adult Community Mental Health Team. Key performance indicators include: • A reduction in specialist CAMHS referrals • A wider range of partner agencies offering a wider range of early interventions in the community • Positive outcomes as rated by the young people themselves, family and school • Lower rates of reported bullying • A reduction of pupils recording significant levels of anxiety using standardized measures (Spence) and DSM -5 definitions • A greater number of trained staff in schools		

Appendix 5 Waiting Times and service data

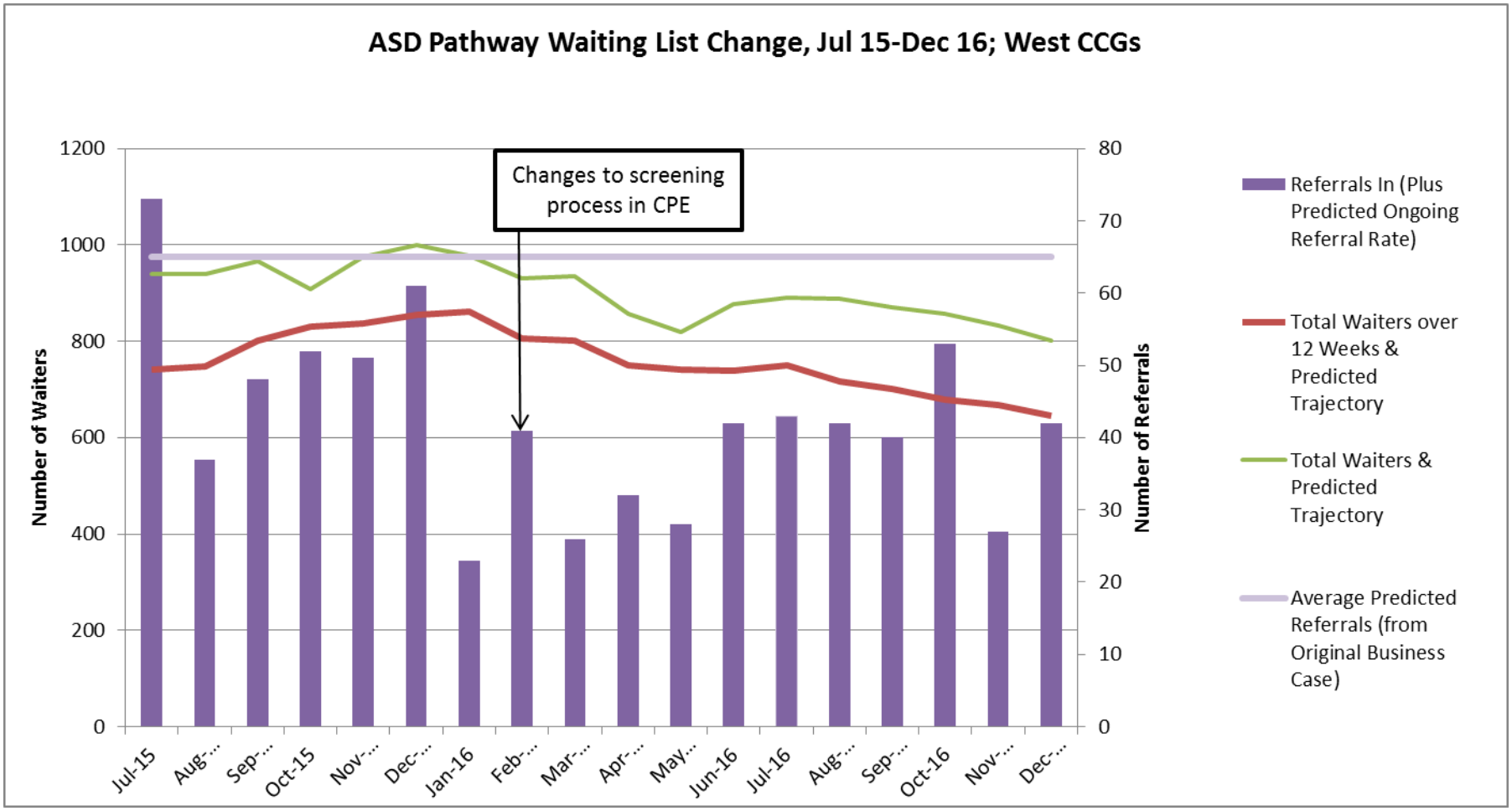
Berkshire West CCG specialist CAMHs waiting time targets 16/17 contract

Clinical Indicator	Threshold	Method of Measurement	Frequency of reporting
% of CPE/Urgent Care CAMHS patients waiting longer than 6 weeks at the end of the reporting period	≤5% from Q1 2016/17	Reported within quality schedule report using the following methodology; Numerator; Total number of CPE/Urgent Care CAMHS patients waiting at the end of the quarter who have waited longer than 6 weeks as at the last day of the quarter Denominator; Total number of CPE/Urgent care CAMHS patients waiting at the end of the quarter	Quarterly
% of Specialist Community Teams CAMHS patients waiting longer than 6/12 weeks at the end of the reporting period	Q1 ≤5% over 12 weeks Q2, Q3 & Q4 ≤5% over 6 weeks	Reported within quality schedule report using the following methodology; Numerator; Total number of Speciality Community Team CAMHS patients waiting at the end of the quarter who have waited longer than 6/12 weeks as at the last day of the quarter Denominator; Total number of Speciality Community Team CAMHS patients waiting at the end of the quarter	Quarterly
% of A&D CAMHS patients waiting longer than 6/12 weeks at the end of the reporting period	Q1 & Q2 ≤5% over 12 weeks Q3 & Q4 ≤5% over 6 weeks	Reported within quality schedule report using the following methodology; Numerator; Total number of A&D CAMHS patients waiting at the end of the quarter who have waited longer than 6/12 weeks as at the last day of the quarter Denominator; Total number of A&D CAMHS patients waiting at the end of the quarter	Quarterly
% of ADHD CAMHS patients waiting longer than 6/12 at the end of the reporting period	Q1 & Q2 ≤5% over 12 weeks Q3 & Q4 ≤5% over 6 weeks	Reported within quality schedule report using the following methodology; Numerator; Total number of ADHD CAMHS patients waiting at the end of the quarter who have waited longer than 6/12 weeks as at the last day of the quarter Denominator; Total number of ADHD CAMHS patients waiting at the end of the quarter	Quarterly
% of ASD CAMHS patients waiting longer than expected at the end of the reporting period	Q2 & Q3 ≤5% over 18 months Q4 ≤5% over 11 months (≤5% over 12 weeks by Oct 2017)	Reported within quality schedule report using the following methodology; Numerator; Total number of ASD CAMHS patients waiting at the end of the quarter who have waited longer than 18/11 months as at the last day of the quarter Denominator; Total number of ASD CAMHS patients waiting at the end of the quarter	Quarterly
Reduction in the number of ASD CAMHS patients waiting over 12 weeks at the end of each reporting period	Reduce by 15% each quarter	Reported within quality schedule report	Quarterly


CAMHS Waiting List Change, excluding ASD Pathway, Jul 15-Dec 16; West CCGs
Staffing reached predicted levels for wait list
Number of Waiters
Number of Referrals
1000
900
800
700
600
500
400
300
200
100
0
300
250
200
150
100
50
0
Jul-15
Aug-...
Sep-...
Oct-...
Nov-...
Dec-...
Jan-16
Feb-...
Mar-...
Apr-...
May-...
Jun-...
Jul-16
Aug-...
Sep-...
Oct-...
Nov-...
Dec-...
Referrals In (Plus Predicted Ongoing Referral Rate)
Total Waiters over 12 Weeks & Predicted Trajectory
Total Waiters & Predicted Trajectory
Average Predicted Referrals (from Original Business Case)

Autism Assessment Team (formerly ASD Pathway)

Graph shows progress made against waiting times targets for Autism assessments. Data shows the position before manual review for all agreed breach reasons.



Current Specialist CAMHs waiting times (30 September 2016)

CAMHs CPE & Urgent care	All referrals are risk assessed in CPE within 24 hours. 100% urgent cases seen within 24 hours. 80% of referrals assessed at CPE within 6 weeks. All referrals breaching the 6week target are referrals to the Autism Assessment Team. The current average waiting time for more in depth triage of routine referrals in CPE is 3 weeks.
CAMHs Specialist Community	The current average wait time for referrals to the Specialist Community Teams is 6 weeks 5 referrals (6.4% of total waiters) breached the 6 week target without an agreed breach reason. All have future appointments booked
CAMHs Anxiety & Depression Specialist Pathway	The current average waiting time for referrals to the Anxiety & Depression Team is 13 weeks.
CAMHs ADHD Specialist Pathway	The current average waiting time for referrals on this pathway is 10 weeks. Of the 30 referrals waiting over 12 weeks, 17 have appointments booked and 9 are being managed for non response to contact. Data quality issues are being resolved. Families are also offered help while waiting – service commissioned from Parenting Special Children
CAMHs ASD Diagnostic Team	The average waiting time for those currently waiting an assessment is 37 weeks. 95% are seen within 18 months. Families who are waiting for assessment are offered help via the Young SHaRON subnet and support commissioned from Autism Berkshire

All External Referrals to CAMHS through CAMHS CPE

	2014/15	2015/16	2016/17
April	189	210	224
May	201	222	255
June	199	212	221
Q1 Totals	**589**	**644**	**700**
	2014/15	**2015/16**	**2016/17**
July	300*	240	251
Aug	150	131	172
Sept	208	233	193
Q2 Totals	**658**	**604**	**616**

*Note high number of referrals to the ASD service related to transfer of service to BHFT from RBH

Specialist Caseload - All Berkshire West CCG's

More children and young people are having specialist CAMHs treatment with BHFT. These figures *exclude* CAMHs Community Eating Disorders Service (reported separately). These figures exclude children who are seen via the Emotional Health Academy, Youth Counselling, Webster Stratton and School Link projects. Those numbers are cited in Appendix 4. A target trajectory for increased access to specialist CAMHs will be developed in partnership with NHS England and BHFT later this year (16/17).

Care pathway	Q4 2015/16	Q1 2016/17
CAMHs Anxiety & Depression Specialist Pathway	338	318
CAMHs ADHD Specialist Pathway	1028	1002
CAMHs ASD Diagnostic Team	1256	1316
CAMHs Specialist Community	766	803
CAMHs CPE & Urgent care	170	209
Grand Total	**3558**	**3638**

Waiting times for Specialist CAMHs – trends

There are fewer children waiting to be seen by CAMHs due to additional capacity.

Total Number of Berkshire West patients waiting at end of Quarter

	Q1 2015/16	Q2 2015/16	Q3 2015/16	Q4 2015/16	Q1 2016/17	Q2 2016/17	Q3 2016/17
Total Waiting	1695	1650	1869	1653	1301	1104	1078

Numbers waiting by care pathway- Berkshire West

Numbers waiting for have reduced in all CCG areas and across all care pathways.

	Q3 2015/16	Q4 2015/16	Q1 2016/17	Q2 2016/17	Q3 2016/17
CAMHs Anxiety & Depression Specialist Pathway	162	142	52	45	34
CAMHs ADHD Specialist Pathway	272	215	110	78	83
CAMHs ASD Diagnostic Team	1000	936	877	842	802
CAMHs Specialist Community	285	273	193	59	78
CAMHs CPE & Urgent care	150	87	69	80	81
GRAND TOTAL	**1869**	**1653**	**1301**	**1104**	**1078**

Eating Disorders data for Berkshire- Unify return August 2016 and baseline position


Copy of CYP ED Care Pathways Template v


Eating Disorders Business Case FINAL

Early Intervention in Psychosis- baseline position and process


EIP BASELINE update commissioners


EIP To Be Process Map_v0.4.pdf

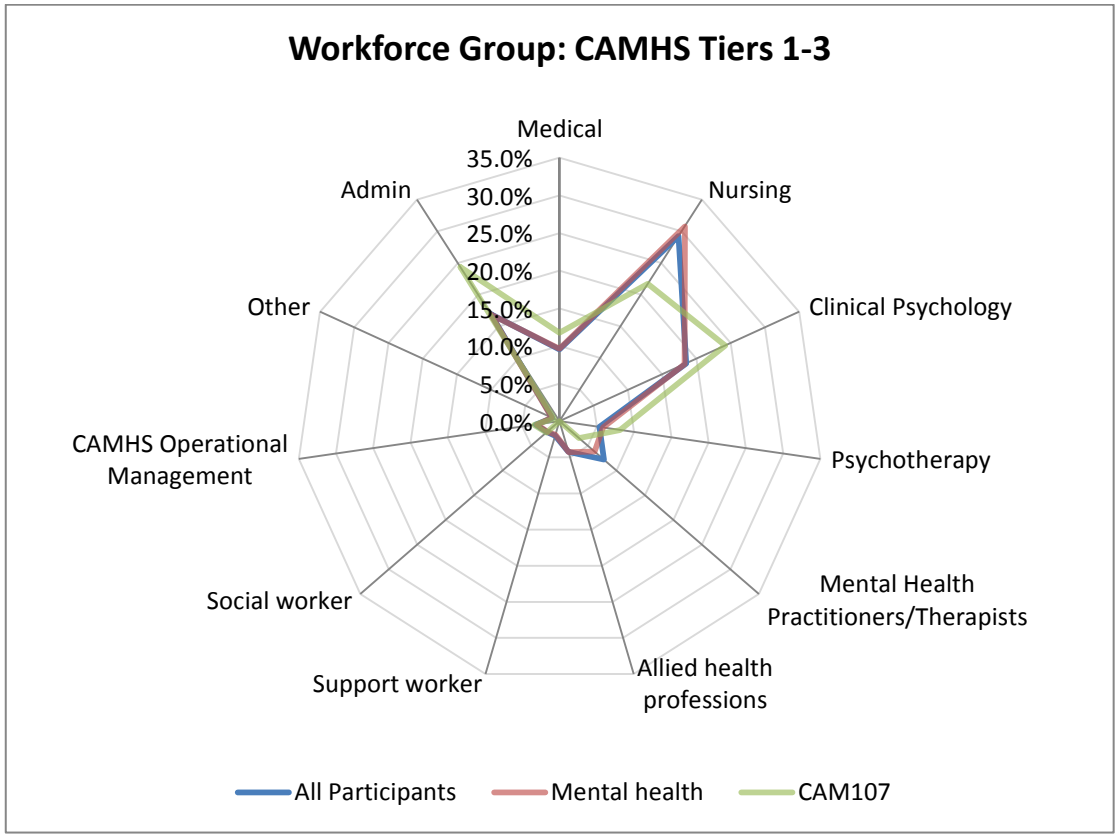

EIP update Q2 1617.JPG

Appendix 6 Latest draft of bid to NHS England Health and Justice Commissioning

Health and Justice bid Berkshire West Nc

Appendix 7 Workforce data for 2016/17.

Baseline position within the LAs is within the original Transformation Plans
National Benchmarking report (2015) staff breakdown by discipline-



BHFT staff attending CYP IAPT training 15/16 (just finishing the courses)
3 staff undertaking the transformational leadership programme; 2 undertaking CBT and 1 undertaking EEBP

BHFT Staffing baseline 15/16. This includes vacancy and is inclusive of the Eating Disorders service and Berkshire West Urgent Response pilot.
Note that some staff have more than one role so the headcount looks higher than it actually is as staff will be counted more than once. WTE is accurate.
Note also that some staff have more than one qualification. These have only been counted once.

Job role- employer BHFT	**Band 2**		**Band 3**		**Band 4**		**Band 5**		**Band 6**		**Band 7**		**Band 8a**		**Band 8b**		**Band 8c & d**		**Total Tier3**	
	H/C	WTE	H/C	WTE	H/C	WTE	H/C	WTE	H/C	WTE	H/C	WTE	H/C	WTE	H/C	WTE	H/C	WTE	H/C	WTE
Admin and clerical	3	2.57	9	6.23	5	3.80	1	0.43											18	13.03
N&M mental illness/nursing							1	0.53	15	10.1	15	10.64	3	1.18					34	22.45
Psychology					9	4.81			2	1.00	6	3.50	11	6.29	3	0.87	1	0.77	32	17.24
Psychotherapists incl family therapy									3	1.50	1	0.53	5	2.18	3	0.77			12	4.98
Art and Music therapists									1	0.50	1	0.16							2	0.66
Dieticians									1	0.53									1	0.53
Speech Therapy									1	0.60	3	1.56	2	0.80					6	2.96
Senior managers															6	4.21	2	0.86	8	5.07
Consultants																			9	6.63
Speciality doctor																			2	0.68
TOTAL																			**124**	**74.23**
Tier 2- psychology*											2	1.4	3	1.4	1	1.0			6	3.8
Tier 2 nursing*											1	1.0							1	1.0
Tier 2* Psychotherapist											1	0.5							1	0.5

H/C= headcount WTE= whole time equivalent *LA commissioned

Local authority staffing 15/16

West Berkshire Emotional Health Academy- additional staff from 16/17- four Emotional Health Workers (3.8 WTE) and a Clinical Worker (1 WTE)

Reading Borough Council-

Role	**FTE 15/16**	**Additional staff from 16/17?**	**Total**
Educational psychologists	7.1	No	7.1
Primary Mental Health Workers	3.5	1 School Link Project	4.5
Portage workers	5.6	No	5.6

Wokingham BC Tier 2 staff are employed by BHFT and are included in the table above.

Appendix 8 Future In Mind spend in 16/17 £624K available across Berkshire West CCGs

Project	Amount
Reading School Link project	£100,000
Wokingham School Link project	£100,000
West Berkshire Emotional Health Academy	£100,000
PPEPCare (to support schools, primary care and non CAMHs staff)	£15,000
CORE 24 -remainder of the CAMHs crisis pilot at RBFT	£208,000
Voluntary sector support for families awaiting ASD diagnosis- Autism Berkshire	£40,212
Voluntary sector support for families awaiting ADHD diagnosis- Parenting Special children	£9,740
Autism Appreciative Inquiry work	£5,225
Booklets & campaign for young people- to be issued Spring 2017	£10,000
Total	**588,177**
Yet to be allocated	**£35,823**

(Webster Stratton and remainder of CORE 24 crisis pilot funded from 15/16 resources)

Other spend (in addition to specialist CAMHs contract and Local Authority commissioned services) 16/17

CAMHs Community Eating Disorders £236K

Perinatal mental health £166K

Children and Young People's IAPT training backfill £251K (pan Berkshire)

Youth Counselling- Reading (Time to Talk)- £30K from CCGs plus £60K from Reading Borough Council

Wokingham (ARC)- £30K from CCG plus £59K from Wokingham Borough Council

West Berkshire (Time To Talk West Berkshire)- £29.5K from CCG

Specialist CAMHs block contract

15/16 £6,166,360 plus additional £249,535 allocated to transforming Community Eating Disorder services. Up to £500K was available non recurrently in order to reduce waiting times through use of agency staff while new posts were recruited to. This figure excludes Berkshire Adolescent Unit which was transferred to NHS England in 14/15.

16/17 £6,306,000 plus other spend as listed above.

Appendix 9 BHFT CAMHs service transformation update newsletters June, July, and September 2016

CAMHS Update June 2016.pdf

CAMHS Update Issue 2 July 2016 - Our Autism Assessment Services.msg

3 Our ADHD Services.pdf

Appendix 10 Local Authority spend (16/17 data to follow)

Reading Borough Council funding-15/16 baseline

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

West Berkshire Council funding- 15/16 baseline

West Berkshire council currently invests £120,000 in Primary Mental Health Workers and Help for Families therapeutic resources.

Grants awarded 2015/16:

Relate - £6K
Time to Talk - £27K
Homestart - £17K
Mental Health First Aid - £10K
Maternal mental health counselling group - £10K
Friends in Need - £25K

Wokingham Borough Council funding- 15/16 baseline

Wokingham Borough council invested £505,000. Wokingham Borough Council delivered services including Educational Psychology Service, Targeted Youth Support and Family Support.

Wokingham Borough Council invested £222,000 in commissioned services from BHFT (Primary Mental Health Workers), ARC youth counselling and ASSIST- ASD Outreach Service.

Meeting the needs of vulnerable people in Reading

Summary:

This report presents findings of a roundtable meeting held by Healthwatch Reading on 13 February 2017, with voluntary sector organisations who support local, vulnerable people. The aim of the roundtable was to:

- understand the impact on local people, of the first nine months of Narrowing the Gap (a new funding arrangement from 1 June 2016 that required voluntary sector organisations to bid for Reading Borough Council contracts, instead of the previous system of receiving allocated grants);
- understand the impact on local people, of the overall reduced value of RBC funding compared with the value of previous years of grant funding or commissioned contracts;
- understand any other national or local pressures on the voluntary sector, which affect their ability to deliver services;
- inform RBC commissioners and councillors of any lessons learned, for future funding rounds; and
- help fulfil Healthwatch Reading's statutory role on the Reading Health and Wellbeing Board, of representing both the public, and the voluntary sector.

The main findings of the roundtable discussion, were:

1. people seeking help from local charities have more complex needs than previously, due to a range of factors, including: funding cuts to social services, perceived gaps in NHS mental health services, perceived failures in integration of health and social care services, and perceived shortcomings to care assessments or safeguarding procedures;
2. an increasing number of people are seeking help to appeal benefits sanctions or decisions about the Personal Independent Payment (which replaces the Disability Living Allowance);
3. service users have experienced high anxiety about proposed closures of services (such as the Reading Your Way day centre);
4. NHS cuts have also hit the sector, as the value of grants awarded by local clinical commissioning groups to charities has been cut by about half, for 2017-18;
5. organisations are just about maintaining staff and volunteer numbers, but say their people are often emotionally worn down by the complexity of cases;
6. some organisations are starting to charge fees, or are having to step up fundraising efforts, to maintain service levels;
7. Narrowing the Gap has led to new and positive partnerships of voluntary sector organisations working together on joint contracts – however the 'back-office' cost-saving is believed to be negligible; and
8. the voluntary sector urges RBC to learn lessons for the next contract round, and to ensure that vital, and smaller organisations rooted in the community are supported to remain viable in years to come.

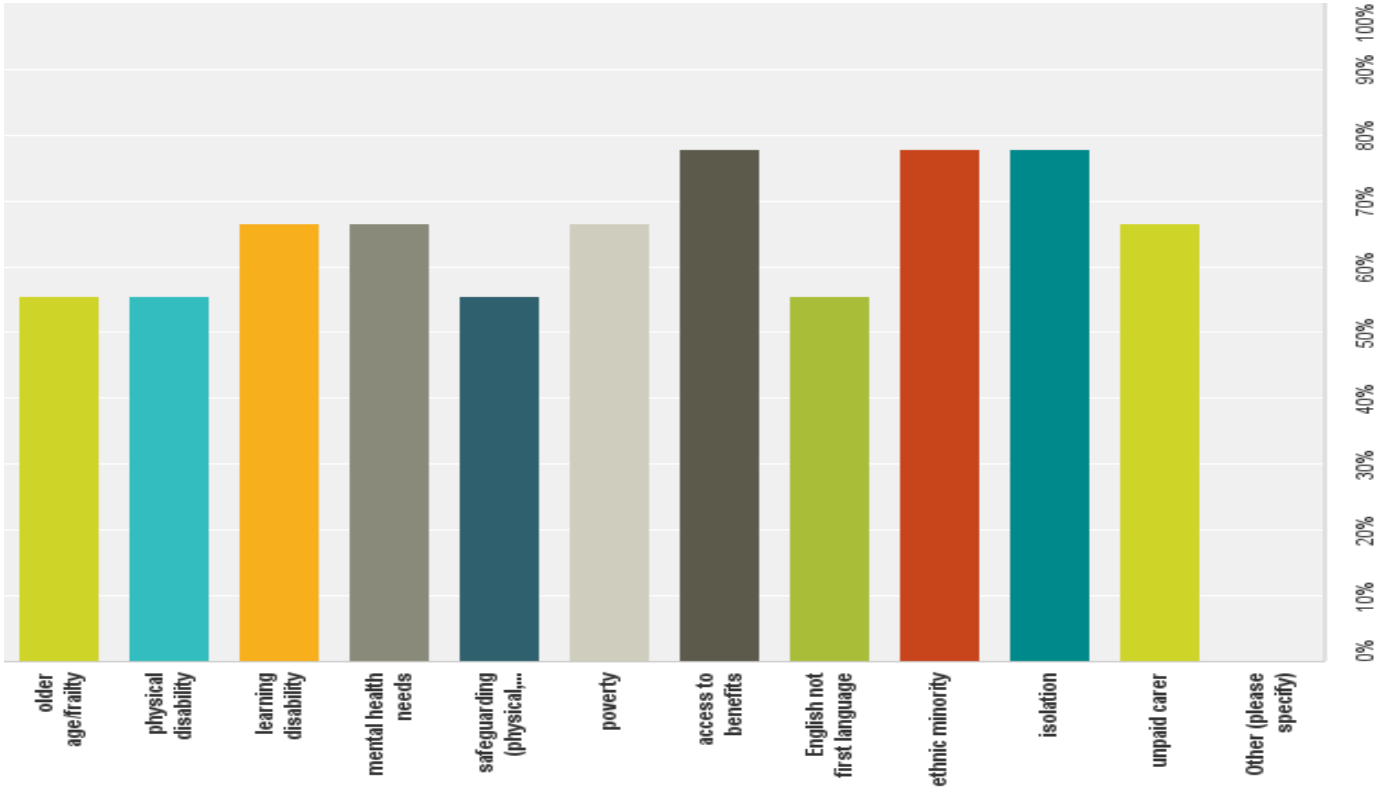
Introduction

On 13 February 2017, a group of frontline support workers, managers or trustees representing 12 different voluntary sector organisations gathered in a meeting room in Reading Central Library for a roundtable convened by Healthwatch Reading. A 13th organisation also sent comments by email.

The group mostly comprised, 28% of the 31 organisations that were awarded contracts starting on 1 June 2016, under a new commissioning framework for the voluntary sector, called Narrowing the Gap. This process has seen council corporate grants to the voluntary sector cut from £1,963,000 in 2015-16 to £1,500,000 this year (and down further to £1,000,000 in 2017-18). Other voluntary sector contracts commissioned from adult social care budgets are also being reduced from £809,000 this current financial year down to £516,000 from April 2017. The roundtable included two organisations falling into this latter category.

Roundtable attendees had agreed to spend 2.5 hours away from their organisations so they could meet their peers and share experiences of how they were supporting local adults affected by disability, isolation, debt, and other needs (see bar chart below).

What circumstance/needs are experienced by the people that your organisation assists, supports, or advises?



This report sets out a summary of the roundtable discussion, plus feedback from service users about the potential closure of a local service (see case study pgs 6-8).

Healthwatch Reading has anonymised direct quotes from individual organisation representatives, in the spirit of the collective nature of the discussion. Attendees have agreed that this paper fairly reflects their views. A full list of participating organisations is at Appendix 1, on page 17.

Main findings: People who use the voluntary sector

1. People using voluntary sector organisations have more complex needs than before

This was a universal theme raised in the roundtable. Organisations feel cases are more complex due to resource pressures on social service teams, gaps in mental health care, lack of integrated working between the NHS and social services, or a perception that statutory advice, care needs assessments for people with disabilities or who are elderly, or safeguarding procedures, are not robust enough.

"By the time a [client] comes to us, they could've been helped so many times in the previous year or six months but the agencies they've engaged with haven't had the time to help them. By the time they get to us, it's not just about listening, but trying to solve a much bigger problem than it was."

"People are coming to us on a repeat basis, often with mental health problems. We have tried to help or referred them to official agencies but they come back to us because they feel they haven't got the help or support they needed."

"In terms of our client numbers, we've found that they've remained fairly constant over the years. However, their problems are much more complex and time consuming. Reading Borough Council are getting a really good deal because the complexity far outstrips the money they're giving each of us."

Case study: "We had a lady come in who had lost her home due to financial abuse, who has a significant mental health issue. She very much needs a community psychiatric nurse but was told: 'Sorry you can't have one, we've got two [CPNs] off on long-term sick'. She came to us because she had no money, no food, no electricity and she had been sanctioned for not turning up to an ESA [employment support allowance] meeting. She had been particularly unwell at the time and hadn't opened the letter. People are not coming in with one issue – it's long-term housing, plus benefits, plus debt, and high anxiety, on top of their health issues."

"I do know we have an increasing problem with people with mental health difficulties, and we experience difficulty in knowing where to refer them."

"We have people with mental health problems who tell us they do not feel listened to. When we contact the community mental health team on their behalf, they say 'Oh, it's, that person - they are being managed, they have a care plan.' But then why does that person feel unsupported – why are they going around the system again and again?"

"We are seeing many more mental health problems that we don't know how to deal with at all – it's not our area of expertise."

Voluntary sector organisations were also helping more people who were not experiencing positive, joined up working between health and social services.

"Our workers are having to say to hospital staff that they don't believe patients are ready for discharge because they haven't yet been assessed for a care package. Our fear is that some really vulnerable people are being discharged from hospital and they're going to deteriorate again and come back to hospital. We are lobbying statutory agencies to do what they're supposed to be doing."

Case study: "We had one woman come to us who was trying to cope with responsibility of helping one of her parents, nearing the end of their life, as well as a sibling who had also been diagnosed with a serious illness. She was distressed because she had been told by hospital staff that her parent would not be eligible for any care when they were discharged from hospital. The woman was then given a different message by social service, who said her parent was actually entitled to care. During the mix-up in communication, the care package was mistakenly cancelled and was not in place when the woman's parent came out of hospital. The woman eventually got an apology but by that time was told that care was still not available because of a waiting list." The charity helped the woman chase up the entitlement to care and also offered ongoing peer support. "We end up doing more because of what isn't being done by others."

This point was echoed by another organisation: *"We had a distressed person turn up in our office in a terrible state [with two complex health needs]. Our support worker stayed with that person all morning to the point where they rang social services and were asked: 'Well, can you assess their needs and phone the care home for them…'. This never used to happen, social workers would pick up that mantle and say 'we'll do this', but we're finding more and more there is pushback."*

Another common theme raised at the roundtable was concern that safeguarding procedures were not strong as they should be.

"The safeguarding that we report has got higher – the staff are better at reporting it but I do think a lot of people who come to us are in higher need, at the point of crisis. I reported one case recently and the social worker said, 'I have tried calling, but I can't get hold of the relative, so what do you want us to do about it?' Well what I wanted, was for the social worker to reassure me that they would keep trying. My heart is in my mouth a lot of the time when we have to report safeguarding in Reading."

Local charities also feel more work needs to be done to ensure social workers are not rushing through assessments of vulnerable people.

Case study: "We know of a person who is virtually blind, has a hearing problem, and a severe learning disability. The social worker came out to do the assessment, and the quality of the questioning was, 'Can you cook your own meal?', the answer was 'yes, I really like a nice curry', tick the box. But when I said, 'What's a nice curry, what do you do?', she replied: 'I take out the packet and I pour it into a mug and pour hot water on it – curry-flavoured pot of noodles. But, according to social services, she could cook a meal."

Another charity concurred: *"We have that with our clients – it's taken at face value, 'yes, I can do that', but you've got family members saying, 'they haven't even been to the shop for 10 years – how are they buying their food?' It's quite right you should listen to the client, but it's always a get-out clause, 'that's what they said', we'll take it on face value…", because otherwise, added another charity representative "…they'll have to give them a full care package".*

Another charity worker added: *"Pointing out where social care should have done something they should – that clients haven't received an assessment – that's the vast amount of our work."*

The roundtable participants acknowledged that social workers, like the voluntary sector, are themselves struggling to cope with resource cuts and other factors.

"They [social workers] don't get the support and supervision they should have."

"There's a huge turnover of social workers, so they don't know these people [they are assessing] and they might not get in an advocate if they can't speak up for themselves. So you have people who cannot advocate for themselves, who can't answer the questions, because they don't understand them, and nor do they understand the implications of not getting it 'right'. You have someone [a social worker] that meets them for the first time and is going through a tick-box form."

2. An increasing number of people are turning to some voluntary sector organisations due to difficulties caused by central government policies.

Organisations providing information and advice to people, were most likely to describe increased demand:

"In the last quarter, up 93 per cent compared to last year."

"The numbers are rising plus 30 per cent year-on-year."

"We've had an increase in PIP [Personal Independence Payment] enquiries. They're coming to us because they've been to other agencies that are full, can't cope or can't meet their [appeal submission] deadlines, and then we need to find somewhere else to send them to meet their deadline and it's a vicious circle. There's too few people to provide the support that's needed. And it isn't a really key element of what we should be doing as it takes you away from others needing your support. It's difficult."

"A lot of our work now is dealing with people who are being sanctioned [for not complying with conditions to receive benefits]."

Case study: "We were called by a person who was having his mobility car taken away. [Under the scheme, people with disabilities can lease a car from 'Motability' to give them independence, if they receive the higher rate of mobility support within the disability living allowance, or its replacement, the personal independence payment]. They had had it for nearly 20 years and it was being taken away before they had to travel to Oxford for the appeal. Unfortunately, there was nothing we could do to help them. It's the short-termism. Maybe people who appeal will get benefits back, but then how much is it for everybody [in supporting them] in the meantime?

3. Service users have experienced high anxiety about proposed closures of commissioned voluntary sector services

Case study: Our roundtable was held just days after RBC publicly announced "Good news for mental health services in Reading" because it said it had agreed with NHS partners to continue jointly funding the Reading Your Way day service after listening to the concerns of service users.

The council had initially proposed closing the Monday-to-Friday service based in Rupert Square, from 1 April 2017. The drop-in service offers peer support and advice on work, education, health, housing and finances. (Other local services for people with mental health needs, include the Compass Recovery College – a series of short courses offered via New Directions in South Reading). Berkshire West Clinical Commissioning Groups (which plan and fund local NHS services, including mental health care) had also started publicly discussing the idea of setting up a new crisis service called Café Haven four nights a week, that could be partly run by Reading Your Way.

The RBC announcement about the future of the day service did not include any comment from any CCG representative. In 2016-17, Reading Your Way received £109,000 from RBC and £85,000 for its service. However, it is still unclear if the CCGs' funding for Reading Your Way in 2017-18 is intended to be put towards the day service, a new crisis service, or a mixture of both.

The case seems to illustrate the challenges yet to be overcome in providing integrated services for people who need help with both health and social needs.

Around 200 people use Reading Your Way, 80 of them very regularly. "They have been through the absolute wringer. You're asking the most vulnerable people to try and fight for their service. There have been people in tears and people angry. But Reading Your Way is such a community and service users have taken action through an online petition, testimonial letters, an art installation, and banners. They've also spoken to the media, they've gone to RBC council meetings and a councillor has visited."

Charity staff were also faced with extra work of doing an action plan with every individual service user about what would happen if the day service shut, as well as holding weekly group support sessions.

During the consultation, service users had found it difficult to understand the impact that receiving two different pots of money had on decision making about the future of the day service.

A consultation event on 16 January 2017, heard many Reading Your Way service users make impassioned arguments calling for the day service to be saved from closure. Their views are summarised below:

- *'Coming here keeps me well.'*
- *A service user says in her experience, there is nothing between hospital admission and the community. The [NHS mental health] crisis team are 'next to useless'. She finds she is picked up by the police, then admitted to hospital, then sent out again. She manages. But there is no visiting community psychiatric nurse, no psychiatrist. She gets medication from her GP but otherwise there is no other monitoring.*
- *A service user says, 'If you are not in crisis, don't end up with the police and are not suicidal, if you don't go to A&E, but are vulnerable, depressed, agoraphobic, what then?' She has found Reading Your Way useful. 'I don't need crisis support - I need to come somewhere on a regular basis – I couldn't go out to the Recovery College. Your Way offers me exactly what I need. It's a place where panic attacks are OK – I can run out of the room and be understood.'*
- *Coming to Your Way's drop-in is not 'social care', says another person, it is 'a lifeline'. He says that it keeps him from bouncing into crisis and out again and back again: 'I think you [commissioners of the service] actually underestimate the benefit of people coming together.'*
- *An adult with autism shares their story. They had been sent to Your Way by Autism Berkshire, in order to practise social skills, because there was nowhere else suitable for them to go. Another service user explains that they have Asperger's, and the service also matters to them for that reason.*
- *One person reflects that Reading Your Way is competing with services for Alzheimer's, drug users, children's centres, and how sad that is.*
- *A person who works in a health setting adds: 'An experiment is going to happen of a despairing kind. It is dangerous. Do the people of Reading know that mental health patients are being put at risk?'*
- *A service user describes the value of a drop-in as a place to go*
- *Some people object to the name of the 'Recovery College' as it suggests they will be 'cured' of their mental health problems, rather than learning to manage it as a life-long condition.*
- *A mental health support worker says that the previous transition of RYW from Oxford Road to Rupert Square caused lots of distress*

One of the charity representatives at the roundtable reflected: "I went to the consultation meetings and one of the things that struck me is if the service is cut, the knock-on effect will be on the statutory services, whether that is the crisis service run by Berkshire Healthcare [NHS Foundation Trust], or the [Royal Berkshire] hospital or the police. We're trying to be part of a big system but it doesn't seem to be working."

An unforeseen consequence of the consultation about the day service's closure, is that service users have also become aware of the wider swathe of proposed cuts. "For example, they're quite worried about the domestic abuse service going and they want to take action for those as well."

The roundtable also heard that some charities want to protect their clients from discussions about funding cuts to protect them from anxiety. "They love to join a good campaign, but their disability means they don't really understand any of it and we also feel we need to protect them. I think that's true with some vulnerable older people too."

4. NHS grants to the voluntary sector have also been cut

It is not just council cuts that are impacting on local people. The value of partnership development fund (PDF) grants made by Berkshire West NHS Clinical Commissioning Groups to the voluntary sector has been nearly halved for 2017-18. (see table starting on the next page)

Berkshire West CCGs' partnership development fund grants to the voluntary sector in 2017-18 and 2016-17

(Comparison table compiled by Healthwatch Reading)

Organisation	Project name & summary	2017/18 Award	2016/17 Award
ACRE	**Alafia outreach** To provide opportunities for ethnic minority families caring for children and young people (0-25).	£8,500	£10,310
Adviza	**Youth counselling** To provide counselling for young people in Reading	£30,000 *	£30,000
Age UK Berkshire	**Living Well** To provide a preventative service that assists older people with better managing their long-term health conditions, in order to minimise avoidable GP appointments and unnecessary hospital/NHS contact.	£14,800	New
ARC	**Youth counselling** To provide counselling for young people in Wokingham.	£30,000 *	£30,000
Autism Berkshire	**Targeted Support for Families and Individuals Affected By Autism: Information, Advice and Home- Visiting** To provide essential frontline support to parents and carers of a child or young people with autism.	£10,652	£20,000
Breastfeeding Network	**Reading, Wokingham & West Berkshire Breastfeeding Peer Support** To Increase breastfeeding initiation rates and increase breastfeeding duration rates.	£6,200	£13,000
British Red Cross Society	**Prevention of Admission to Hospital (PAtH)** To support people over 50 who require help to regain their independence and continue to live independently in the way they wish.	£29,000	£30,000
Engage Befriending (The Mustard Tree)	**Engage Befriending** To connect isolated older people with their local communities. Regular visits from a volunteer befriender improve health and well-being, providing vital companionship and emotional support.	£9,000	£14,246
Greater Reading Nepalese	**Integrated Health Awareness Programmes**	£4,000	£10,000

Community Organisation	To persuade people to keep active through community based physical exercises like yoga, walking for health, swimming, Zumba and sharing tips on healthy lifestyles.		
Home-Start Reading	**Home-Visiting Coordinator - health specialist** To improve the physical, mental health and wellbeing of vulnerable families with young children and to expand provision for mothers as risk of postnatal depressions.	£15,000	£22,788
Home-Start West Berkshire	**Post Natal Depression and Community Support** To reduce the impact of maternal mental health issues on children in order to ensure that children are given the best start in life and future emotional health issues are prevented.	£15,000	£19,615
Home-Start Wokingham	**Home Start Wokingham District** To improve the health and wellbeing of children under the age of 5, and their families, enabling them to actively engage with the opportunities available to them, reduce their risk of adverse outcomes and reach their full potential.	£15,000	£30,000
Indian Community Association	**Health and Wellbeing** There is increasing number of physical health issues like high blood pressure, diabetes, high cholesterol, circulatory diseases and obesity, especially within the minority ethnic communities. Mental illnesses like depression, dementia and eating disorders also affect our communities.	£4,500	£15,000
Involve Community Services	**Infrastructure Support** To provide infrastructure support to the voluntary and community sector in Wokingham Borough.	£12,000	£15,000
Newbury Family Counselling Service	**Newbury Family Counselling Service** We recognise that parenting is stressful and demanding and that the life-chances of children whose parent/s additionally suffer with a range of emotional/psychological difficulties.	£10,000	£20,314
Parenting Special Children	**Pre-and post-assessment support pathway for parents/carers of children/young people with Autism and children/young people with Attention Deficit Hyperactivity Disorder (ADHD).** Pre-and post-assessment support pathway for parents/carers of children/young people with Autism and children/young people with ADHD.	£4,728	£24,000
Parkinson's Newbury and District Branch	**Maintaining the opportunity for People with Parkinson's in West Berkshire to benefit from bespoke power-assisted physical therapy.**	£3,000	£4,800

	To increase the well-being, quality of life and life outlook for as many people with Parkinson's as possible, by increasing awareness of, and the opportunity to use, the facilities and support of the West Berkshire Therapy Centre (WBTC).		
Reading Lifeline (The Mustard Tree)	**Reading Lifeline** To improve the health and wellbeing of women and their families who are affected by any type of infertility, baby loss or postnatal depression.	£12,000	£19,000
Reading Mencap	**Reducing Health Inequalities for People with Learning Disabilities (LD) and Autism Spectrum Disorder (ASD)** To improve the health-related quality of life for adults with LD and ASD.	£15,000	£20,000
Reading Voluntary Action	**Infrastructure Support** To increase, seek out and promote opportunities for collaboration, liaison and information sharing between voluntary sector providers and statutory health and social care agencies.	£12,000	£15,000
Reading Voluntary Action	**Social Prescribing** To link patients to community-based activities to improve their health and wellbeing. To support patients with long-term health conditions and/or mental health problems or patients at risk of developing mental health problems.	£14,000	£20,000
Talkback UK Ltd	**Health and Wellbeing Connections** To address the health inequalities faced by people with a learning disability which includes access to healthcare services, treatment and attitude/understanding.	£8,000	£15,000
Time 2 Talk WB	**Youth counselling** To provide counselling for young people in West Berkshire.	£29,818 *	£29,320
Volunteer Centre West Berkshire	**Infrastructure Support** To provide and support a partnership development role that will act as a conduit for information, best practice, advice, engagement and practical support between NHS Newbury and District Clinical Commissioning Group (NDCCG), Berkshire West CSU and West Berkshire's voluntary and community sector.	£12,000	£15,000

* = second year of two-year grant

GRANT AWARDS FOR 2016-17 NOT ON LIST FOR 2017/18

(Details of total number of applications and where they came from, for 17/18, have not been made public)

Organisation	Project name & summary	2016/17 Award
West Berkshire Ostomy Club	**West Berkshire Ostomy Club** WBOC provides a regular support group for people with a stoma, including outings and information settings.	£2,500
Rahab at the Mustard Tree	**The Rahab Project** The Rahab Project is about restoring hope and belief by identifying and supporting those affected by sexual exploitation.	£15,000
Empowering West Berkshire	**EWB Partnership Development *** Empowering West Berkshire provides support to voluntary and community sector organisations.	£15,000 *
Headway Thames Valley	**Community AND Centre Based Enablement and Rehabilitation** The project aims to improve health & well-being by providing enablement and rehabilitation services for adults in West Berkshire with a brain injury.	£30,000
Depression Alliance	**West Berkshire Friends in Need** They provide an online and offline network to support people with low mood and pre-drug therapy.	£25,000
Berkshire MS Therapy Centre	**Specialist Physiotherapy for people with Multiple Sclerosis** The Berkshire MS Therapy Centre provides treatments and therapies including physiotherapy and exercise classes.	£15,000
Parkinson's Society UK (Reading branch)	**Provision of affordable and appropriate exercises for PD patients** The Reading branch offers information, friendship and support to local people with Parkinson's , their families and carers.	£10,000
Alzheimer's Society Reading	**Berkshire West Befriending Service** They offer a befriending service across West Berkshire, Reading and Wokingham to people with dementia.	£15,000
Reading Community Learning Centre	**Mental Health First Aid** RCLC ran two mental health First Aid programmes in 2016/17. The courses teach people how to identify, understand and help a person who may be developing a mental health issue.	£2,668

Dingley Family and Specialist Early Years Centres	**Dingley Family and Specialist Early Years Centres** Provision of massage/physiotherapy sessions and speech & language sessions, for children attending the Dingley service.	£30,000
TOTAL		£160,168

* Empowering West Berkshire has now merged with the Volunteer Centre West Berkshire, which did receive a PDF grant for the first time, in 2017-18.

One roundtable participant said: *"Some services that won't be getting funding for 17/18, were supporting very vulnerable people through support groups, advice and information."*

"The commissioners had asked [on the application form], will it help keep people out of hospital and help meet our priorities? Some of the smaller organisations doing good preventative work, which would ultimately prevent people needing statutory support – they missed out because it's not directly evident."

5. Staff and volunteers in voluntary sector organisations are carrying a higher emotional burden due to the complexity of client cases

Most organisations said despite their funding cuts, they had been able to maintain the same level of staff but they were worried about staff and volunteer welfare.

"The cases are always at crisis point, there are multiple problems and more stress on staff, so I'm having conversations with management about the welfare of staff giving information and advice."

Another organisation concurred: *"Our trustees are expressing exactly that, after a few traumatic cases we've had. Maybe we could find some kind of formal support and counselling that's available to us all."*

"One case had a very dramatic effect on one of our people – she was so upset and worn out."

"If there's one person away, it's like a whole department being away."

Even if pressures on staff were managed by putting clients on a waiting list for a charity's particular service, there were still holistic needs that might need to be urgently addressed. *"We work with BME women. Some of them are new to the country, some of them have been here 20 years and hardly been out of the door. They're brought to us by friends or family and they haven't had contact with any other services and they're not always registered with a GP…. You've got to sit and listen and be with a person."*

Charities also said that tight resources meant that there might be only one person in their organisation carrying out their specific role. *"I think there's an assumption that if you work in the voluntary sector, you're committed, and you're tough as old boots. But a lot of their roles are in isolation, they don't have a peer [in the same organisation] who they can bounce off."*

There was also concern that rising demand might deter volunteers. *"Three or four years ago, we were delivering food parcels to people and had time to chat and engage with them – now literally, it's, here's your parcel, and off you go to the next one. You have to get 50 out that day, rather than five. It's hard for the volunteers – if they're just delivering and moving on, they're not getting what they want from their role – they lose that passion because you stretch them too far."*

One charity also cautioned against volunteers taking on roles that might be inappropriate, or would require robust supervision from paid staff to protect the needs of vulnerable people. *"Interpretation should not be provided through 'good will' by volunteers – it should be costed. We need to push back against that kind of creep where they expect more and more."*

Another charity manger added: *"I can only echo what you've all said – staff are buckling and they need much more input. We also spend a lot of time supervising volunteers. That's not factored in [to contract specifications] and then they wonder why our management costs are so high."*

6. Some organisations are starting to charge fees, or are having to step up fundraising efforts, to maintain service levels and some fear for the future

Organisations said the funding cuts had meant they were having to dip into charity reserves, fundraise, or start to charge fees.

"Our lunch clubs were cut from Narrowing the Gap so we have had to convert that to a paid-for service. Many clients have left us because of this but we continue to deliver for others – they would rarely leave the home if it wasn't for this service. Our concern is about the deterrent for potential service users, who will deteriorate in health, as a result."

Another charity said: *"We are fundraising to employ a business development manager but I'm concerned about becoming totally focussed on fundraising and trading, and not keeping our information and advice as our core priority."*

"We feel trapped by our commitment to our client group. We might not be able to go for a long-term contract because we can't prove we'll be solvent for the duration of it and we'll have to fundraise to deliver it. Or a private company comes in, they pare back the service and the clients will come to us anyway."

"There's a limit to how much you can rely on volunteers, push your staff to unfair places, and there are some things you can't change. You can't change core costs of things like rent. We've all lost our rate top-up. We're doing our best to maintain our service…but we're incredibly anxious about the next two years…it's tough."

7. Narrowing the Gap has led to new and positive partnerships

Seven of the contracts awarded under Narrowing the Gap, involved partnerships of different charities working together, and this was overwhelmingly seen as a positive development.

"We're in a very very good partnership with [two other organisations] and that has really benefited the client, no doubt, because we play to each other's strengths. So we believe the client journey is much better and the client service is much more positive."

"Our regular meetings mean we understand more than before what each service does. The number of appropriate client referrals from other organisations has increased."

However, the partnerships were not the money-saving exercise the council might have hoped for: *"I think they thought they'd be able to limit our backroom costs, but actually, we're not all going to move into an office together. It is good for referrals, information sharing and good practice. But financially it's not cheaper."*

8. The voluntary sector urges RBC to learn lessons for the next contract round

Reflecting on the introduction of Narrowing the Gap, roundtable attendees described it as a time "where the world stopped". Trustees or chief executive officers had to attend months of meetings with RBC commissioners to influence the new framework, develop new partnerships with other local organisations, and research and write contract bids.

Going forward, *"it's not just that there's less money in the sector, it's how it's been done. Ideally what we would like to see, over the next 12 to 24 months, is the sector to at least retain its existing level of funds, and [the contracting round] taking up as less time and stress and pressure – as possible. Additional funds should be directed to where the impact of shrinking statutory services are having the biggest impact".*

Smaller organisations also needed extra support. *"I would like to see some acknowledgement that the people doing the washing up, putting out the bins, doing the fundraising, doing everything, are also the same people having to find time to do bid writing".*

Conclusion

The roundtable was regarded as a positive initiative by those who attended. *"It's really good to have a meeting like this as we often feel like we sit in isolation from our peers [in other organisations]."*

Overall, participants agreed they wanted the Reading Health and Wellbeing Board to consider the following key messages:

- The voluntary sector in Reading remains committed to supporting vulnerable people and seeks assurances that statutory agencies are doing the best they can too, especially with helping people with a mental health crisis, carrying out robust care assessments, especially of people with learning disabilities, and handling safeguarding referrals: *"We're having to do the best we can with limited resources, but so should the council, health and others."*
- Future consultations with service users about service change/closures, should include provision of extra direct support to help them cope with the anxiety caused by significant changes
- CCGs and RBC should work more effectively together to ensure there are effective 'bridges' between their services to protect vulnerable people who have no-one else in their life to support them
- There is an added value to clients of the new partnerships created under Narrowing the Gap but there should be an acknowledgement of the resources required to build and maintain those partnerships and that these costs could fall disproportionately to smaller organisations that rely on partnership bids to secure funding
- Voluntary sector staff need extra support to cope with emotional toll of some cases, perhaps through a Reading-wide supervision/support scheme
- Future funding cuts to voluntary sector organisations could ultimately lead to more pressure being put on the statutory services that vulnerable people will have no choice but to turn to.

We plan to report back to voluntary sector organisations, any feedback from Reading Health and Wellbeing Board's discussion on this paper. We are also planning a follow-up roundtable with voluntary sector organisations in October or November 2017.

Appendix 1: Organisations who contributed to the report.

12 of the organisations sent a representative, while a 13th sent comments by email. Healthwatch Reading had invited all 31 organisations who received funding under Narrowing the Gap as well as two others commissioned by RBC under other arrangements.

Age UK Berkshire

Age UK Reading

Alzheimer's Society

Faith Christian Group

Healthwatch Reading

Reading Citizens Advice

Reading Community Learning Centre

Reading Community Welfare Rights

Reading Mencap

Reading Refugee Support Group

Reading Voluntary Action

Reading Your Way

READING BOROUGH COUNCIL

REPORT BY DIRECTOR OF ADULT SOCIAL CARE & HEALTH

TO:	**HEALTH AND WELLBEING BOARD**		
DATE:	**24 March 2017**	**AGENDA ITEM:**	**11**
TITLE:	**0-19 (25) Public Health Nursing Service – Procurement Update**		
LEAD COUNCILLORS:	**Councillor Gavin Councillor Hoskin**	**PORTFOLIO:**	**Children and Families Health**
SERVICE:	**Public Health Early Help**	**WARDS:**	**All**
LEAD OFFICERS:	**Jo Hawthorne Andy Fitton**	**TEL:**	**0118 937 3623 0118 937 4688**
JOB TITLES:	**Head of Wellbeing, Commissioning and Improvement Head of Early Help**	**E-MAIL:**	**jo.hawthorne@reading.gov.uk andy.fitton@reading.gov.uk**

1. PURPOSE OF REPORT AND EXECUTIVE SUMMARY

1.1 The purpose of this report is to provide an information update to the Reading Health and Wellbeing Board on project progress for the integrated Public Health Nursing Service 0-19 (25).

2. RECOMMENDED ACTION

2.1 That progress with regard to the procurement of an integrated 0-19 (25) Public Health Nursing Service be noted.

3. POLICY CONTEXT

3.1 The Health and Social Care Act 2012 ("the 2012 Act") transferred Public Health functions from the NHS to Local Authorities commencing on 1 April 2013 with the transfer of different services being staged. The transfer of the commissioning responsibility from NHS England to Public Health, within Local Authorities, for the Health Visiting, School Nurses and Family Nurse Partnership Service took effect from the 1 October 2015. This followed the expansion of The Health Visitor "Call to Action" Programme which expanded the number of Health Visitors nationally by 4200 to deliver the Healthy Child Programme (HCP).

3.2 NHS England (NHSE) the lead commissioner and NHS Education England worked with NHS providers nationally to ensure a new cohort of qualified Health Visitors were in place to deliver the Healthy Child Programme in the form of tiered offers: Community, Universal, Universal Partnership and Universal Partnership Plus. Thus ensuring children aged 0 to 5 years of age and their families received the opportunity for best start in life with help and support.

3.3.1 The Healthy Child Programme (HCP) provides a framework to support collaborative work and more integrated delivery. The Programme (0-19) aims to:

- Help parents develop and sustain a strong bond with children
- Encourage care that keeps children healthy and safe
- Protect children from serious disease, through screening and
- immunisation
- Reduce childhood obesity by promoting healthy eating and physical
- activity
- Identify health issues early, so support can be provided in a timely manner
- Make sure children are prepared for and supported in all child care, early years and education settings and especially are supported to be 'ready for to learn at two and ready for school by five

3.4 Statutory provisions in respect of Health Visitor Services came into effect on 1 October 2015 and mandated particular elements of the HCP. The mandated elements define that all families receive 5 key mandated visits from the health visitor. These key child development reviews, are sometimes referred to as the 'backbone of the HCP' and take place at Antenatal, New baby, 6 – 8 weeks, 9 – 12 months and 2 – 2 ½ years. The mandated reviews are currently subject to review by Public Health England.

3.5 Additionally, Local Authorities including Reading took on the Public Health Duty of commissioning School Nursing to local delivery of the National Child Measurement Programme (NCMP) from the 1st April 2013. The NCMP involves the annual measurement of the height and weight of children in reception year and Year 6, and the return of the data to the Health and Social Care Information Centre (HSCIC).

4. CURRENT POSITION:

4.1 The proposed next stage in the delivery of the mandate universal health visitors and school nurses programme was considered by Adults, Children's and Education Committee on the 13th December 2016. It was agreed to bring the health visitors service and school nursing service together into a single contract. It was further agreed that the service would be commissioned from an external partner for 2 years with an option of a 1 year extension, with effect from 31st September 2017.

The overarching aims of the Reading Public Health Nursing Service for children and young people aged 0-19 (25) will include but not be limited to:

- Lead and deliver a universal Healthy Child Programme 0-19 (25)
- Provide an integrated Public Health Nursing Service linked to primary and secondary care, Early Years, childcare and educational settings
- Deliver an evidence-based service that will provide public health interventions and health care support to school age children and their families to enable children to make the most of their education and wider social opportunities, to improve health and health outcomes for children and families and reduce health inequalities
- Undertake health and development reviews to assess family strengths, needs and risks and deliver public health interventions support to all children and young people and to keep children and families safe and well;
- Work to ensure that local public health and wellbeing strategies are integrated with health visiting and school nursing teams and clear care pathways exist between the service and other key services that families, children and young people access, such as children's centres, substance misuse, mental health, sexual health, family support and midwifery services.

- Support parenting using evidence based programmes, and help parents to know what to do when their child is ill;
- Provide evidence-based advice and support to children with additional needs – via early identification, diagnosis, signposting and tailored help;
- Ensure delivery of the health visiting aspects of the newborn screening programmes
- Respond to childhood communicable disease outbreaks and health protection incidents

4.2 The new integrated Public Health Nursing Service 0-19 (25) will commence on 1 October 2017. The project is currently progressing well against the project plan and the team anticipate completion on time.

4.3 The project is being managed by a cross-directorate team, including officers from Public Health/Wellbeing, Early Help Services and Corporate Procurement.

4.4 The procurement approach which has been undertaken is a 'Prior Information Notice with Call for Competition' (PIN), in which the Council announced its intention to award a contract and invited expressions of interest to engage in a competitive tender.

4.5 Corporate Procurement published the PIN, a draft service specification and selection criteria and associated documents on 26 January 2017. As more than one expression of interest was received, officers have proceeded to undertake a competitive procurement.

4.6 The Reading Public Health Nursing Service 0-19 (25) will be a combined skill mix service including Health Visitors who work with 0–5 year olds and School Nurses who work with 5–19 (25) year olds. The service will work in full partnership with all Early Years and Early Help services in the local area and wider 0-19 services to ensure holistic, seamless care to children and families.

4.7 The primary objective of the service will be the delivery of the Healthy Child Programme. The specification has been laid out in a way to facilitate identification of the universal and targeted aspects of the service alongside the timescale in which they should be implemented.

4.8 An outcomes-based commissioning approach has been taken with regards to the new specification for this service.

5. CONTRIBUTION TO STRATEGIC AIMS

5.1 The integration of Public Health Nursing Services for children and young people aged 0-19 (25) will support the Council's Corporate Plan objective to provide the best start in life through education, early help and healthy living.

6. COMMUNITY ENGAGEMENT AND INFORMATION

6.1 Children's Services are currently consulting through to March 2017 on a remodelled children's service offer which will promote the importance of open access and the availability and delivery of health visiting services from children's centres.

7. EQUALITY IMPACT ASSESSMENT

7.1 An Equality Impact Assessment has been completed. This established that there were unlikely to be any disproportionate impacts on any groups or individuals with protected characteristics.

8. LEGAL IMPLICATIONS

8.1 The Health and Social Care Act 2012 transferred Public Health functions from the NHS to local authorities commencing on 1 April 2013, with the transfer of different services being staged. The relevant statutory provisions in respect of Health Visitor Services came into effect on 1 October 2015, including the mandated visits/reviews as outlined earlier in this report. The mandated reviews are currently subject to review by Public Health England.

9. FINANCIAL IMPLICATIONS

9.1 Health visiting and school nursing services have been funded according to modelled need through the Public Health Grant. However, the Reading Public Health grant has been cut by 6.2% in 15/16 and is to be subject to further cuts. The Government announced that the 2015/16 grant funding reduction will be recurrent and confirmed further overall reductions.

9.2 The draft budget for the integrated 0-19 (25) Public Health Nursing was agreed as £3,275,247 “in the region of £3M” at ACE Committee on 12 December 2016.

10. BACKGROUND PAPERS

READING BOROUGH COUNCIL

REPORT BY DIRECTOR OF ADULT SOCIAL CARE & HEALTH

TO:	**Health and Wellbeing Board**		
DATE:	**24th March 2017**	**AGENDA ITEM:**	**12**
TITLE:	**Health and Wellbeing Performance Update**		
LEAD COUNCILLOR:	**Councillor Hoskin**	**PORTFOLIO:**	**Health**
SERVICE:	**Wellbeing**	**WARDS:**	**All**
LEAD OFFICER:	**Jo Hawthorne**	**TEL:**	**0118 937 3623**
JOB TITLE:	**Head of Wellbeing, Commissioning and Improvement**	**E-MAIL:**	**jo.hawthorne@reading.gov.uk**

1. PURPOSE OF REPORT AND EXECUTIVE SUMMARY

1.1 This report has been developed to provide a brief overview of the partnership's performance in the priority areas identified in the Health and Wellbeing Strategy. A draft version of the Strategy was made available for an online public consultation and the final version was approved by the Health and Wellbeing Board on 27th January 2017.

1.2 *Appendix 1 – Health and Wellbeing Board Performance Update – February 2017*

2. RECOMMENDED ACTION

2.1 ***Health and Wellbeing Board members to be informed of the partnership's recent performance in areas that have been identified as priorities in the Health and Wellbeing Strategy.***

3. POLICY CONTEXT

3.1 Reading's Draft Health and Wellbeing Strategy and Action Plan for 2017-2020 were made available for public consultation between 10th October and 11th December 2016. The final version of the Strategy was approved by the Health and Wellbeing Board on 27th January 2017. An action plan based on the eight strategic priorities is now being developed and will set out in detail how the priorities will be met.

3.2 In July 2016, Reading's Health and Wellbeing Board agreed to introduce a regular Health and Wellbeing Dashboard report to ensure that members of the board are kept informed about the Partnership's performance in its priority areas, compared to the national average and other similar local authority areas.

4. THE PROPOSAL

4.1 Current Position: The final version of the Health and Wellbeing Dashboard will be developed and finalised to reflect the priorities of the Health and Wellbeing Strategy and planned activities outlined in the Action Plan. In the interim, this report has been developed to provide a brief overview of performance against the agreed priority

areas. The figures provided are the most recent that are publicly available as of 14th February 2017 and are intended to provide a snapshot of current performance, brief trend information, and comparison with similar local authorities (where available) and the England average.

4.2 Option Proposed: Note most recent performance in areas identified as priorities in final Health and Wellbeing Strategy.

4.3 Other Options Considered: None

5. CONTRIBUTION TO STRATEGIC AIMS

5.1 This proposal supports Corporate Plan priorities by ensuring that Health and Wellbeing Board members are kept informed of performance and progress against key indicators, including those that support corporate strategies.

6. COMMUNITY ENGAGEMENT AND INFORMATION

6.1 A wide range of voluntary and public sector partners and members of the public were encouraged to participate in the development of the Health and Wellbeing Strategy and, as described above, a draft of the proposed Strategy was made available for consultation between 10th October and 11th December 2016, and the final version of the Strategy was approved by the Health and Wellbeing Board on 27th January 2017. The indicators included in this report reflect those areas highlighted during the development of the strategy and included in the final version.

7. EQUALITY IMPACT ASSESSMENT

7.1 An Equality Impact Assessment is not required.

8. LEGAL IMPLICATIONS

8.1 There are no legal implications.

9. FINANCIAL IMPLICATIONS

9.1 The proposal to note the report in Appendix 1 offers value for money by ensuring that Board members are better able to determine how effort and resources are most likely to be invested beneficially in advance of the full Health and Wellbeing Dashboard.

10. BACKGROUND PAPERS

10.1 Minutes of the Health and Wellbeing Board 27th January 2017 - http://www.reading.gov.uk/article/9641/Health-and-Wellbeing-Board-27-JAN-2017

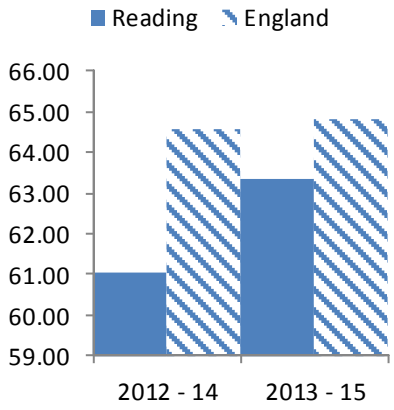
10.2 Reading Borough Council (2016) *Reading's Health and Wellbeing Strategy – Draft for Consultation* *https://consult.reading.gov.uk/css/hwbstrategy/*

10.3 Minutes of the Health and Wellbeing Board 15th July 2016 - http://www.reading.gov.uk/article/9585/Health-and-Wellbeing-Board-15-JUL-2016

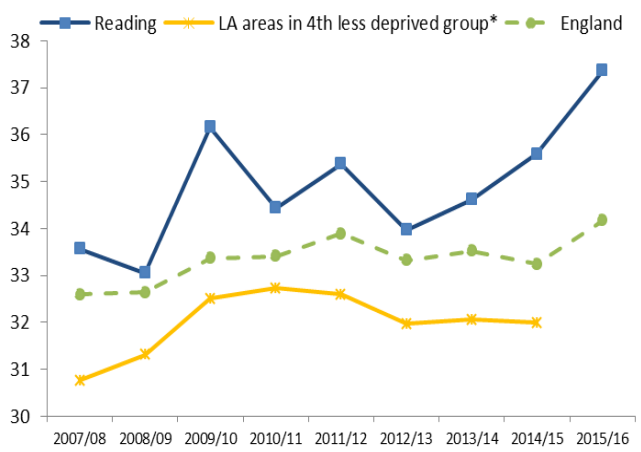
APPENDIX 1

1. HEALTHY LIFESTYLE CHOICES

Excess weight in adults - Statistically similar to England average, but previously better than average.

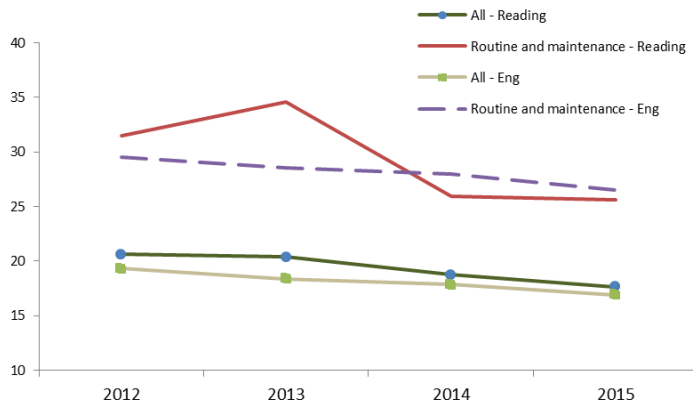


Prevalence of overweight and obesity in 10-11 year olds - in 2015/16 Reading was statistically worse than England average and other areas with similar IMD score

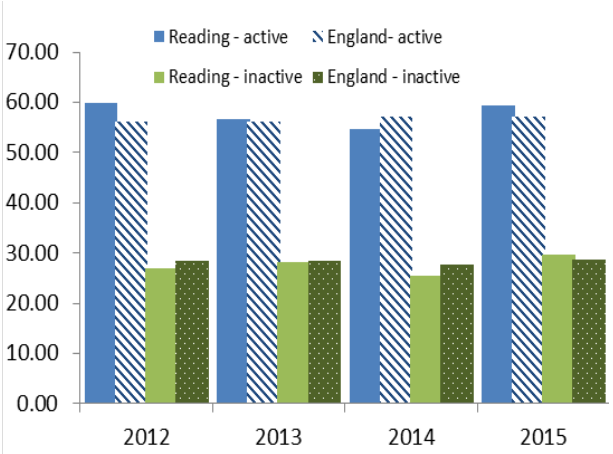


PUBLIC HEALTH OUTCOMES FRAMEWORK / ACTIVE PEOPLE SURVEY / NATIONAL CHILD MEASUREMENT PROGRAMME

Smoking Prevalence - Both indicators remain similar to national average. As elsewhere, prevalence is higher in those employed in routine and manual jobs



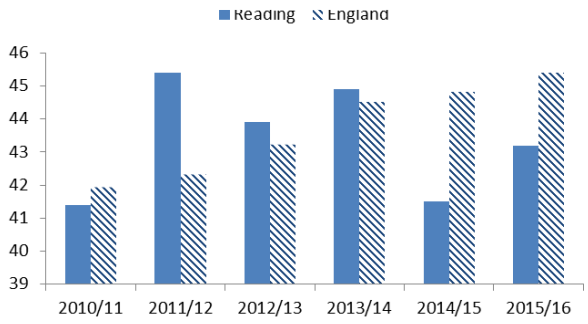
% Adults active and inactive - Both indicators remain similar to national averages



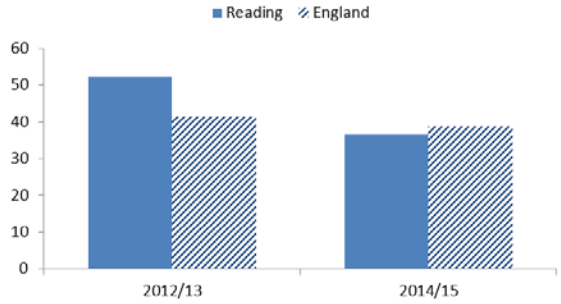
PUBLIC HEALTH OUTCOMES FRAMEWORK / ANNUAL POPULATION SURVEY / ACTIVE PEOPLE SURVEY

2. LONELINESS AND ISOLATION

% of Adult Social Care Service Users with as much social contact as they would like - remains statistically similar to national average.



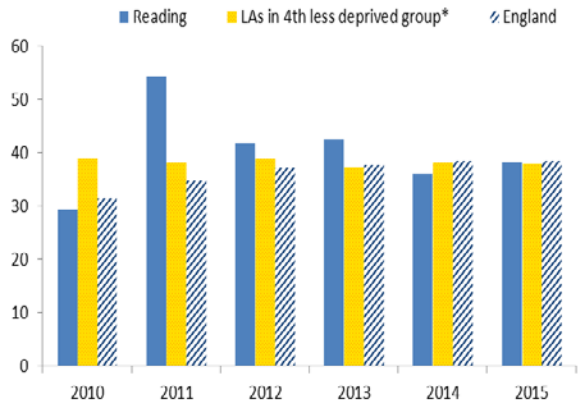
% of Carers with as much social contact as they would like - % has fallen significantly. Now similar to national average - previously better.



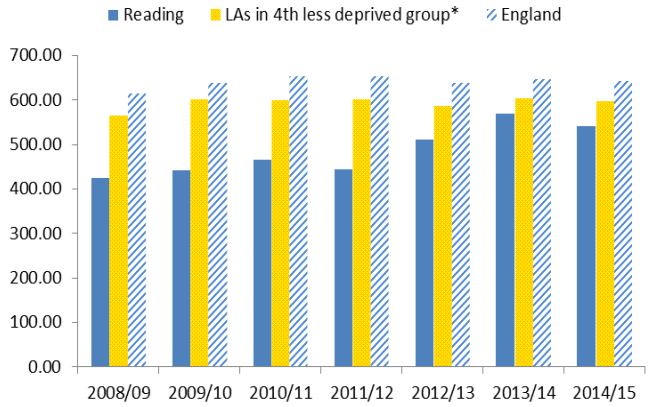
PUBLIC HEALTH OUTCOMES FRAMEWORK / ADULT SOCIAL CARE SURVEY / CARERS' SURVEY

3. SAFE USE OF ALCOHOL

% of those in specialist alcohol treatment who successfully complete - remains similar to national average



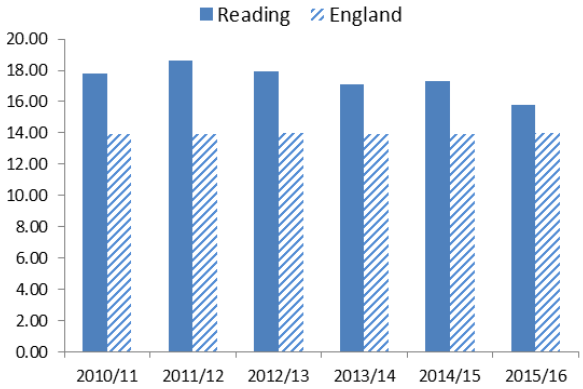
Rate of hospital admissions for alcohol-related conditions - remains better than national average and average of areas with similar IMD scores.



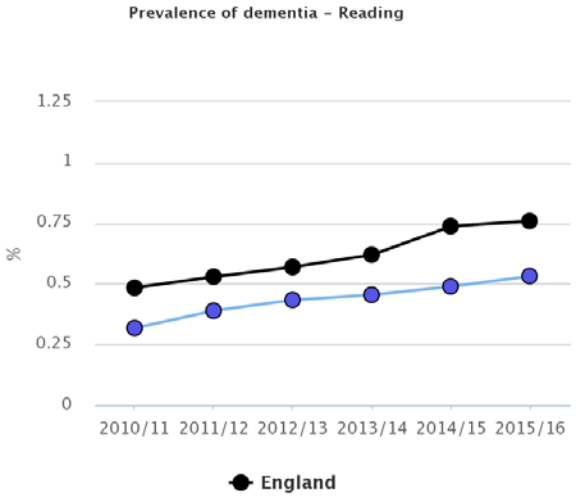
PUBLIC HEALTH OUTCOMES FRAMEWORK / NATIONAL DRUG TREATMENT MONITORING SYSTEM / HOSPITAL EPISODE STATISTICS

4. MENTAL HEALTH AND WELLBEING OF CHILDREN AND YOUNG PEOPLE

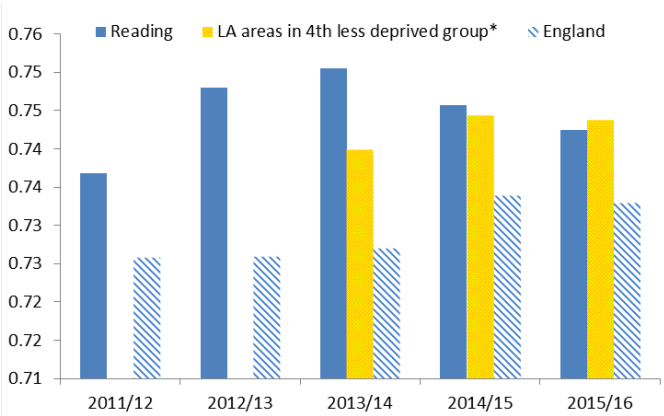
Average difficulties score for all looked after children aged 5-16 years - % continues to be higher than national average



5. LIVING WELL WITH DEMENTIA



Health score status (quality of life) for older people (65+) - continues to be similar to national average and average for areas with similar IMD scores

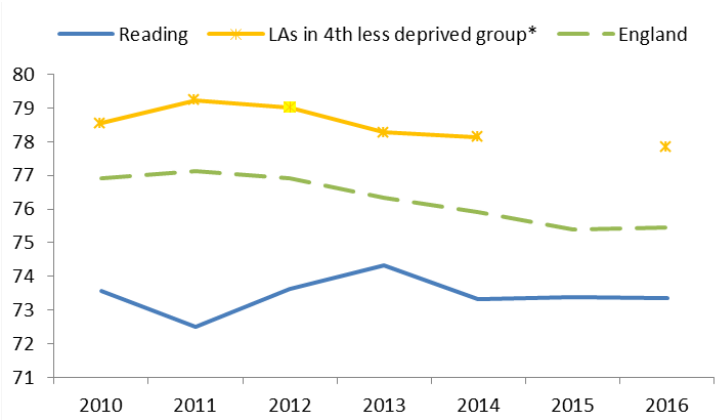


Prevalence of dementia is significantly lower in Reading than in England or in areas with similar IMD scores.

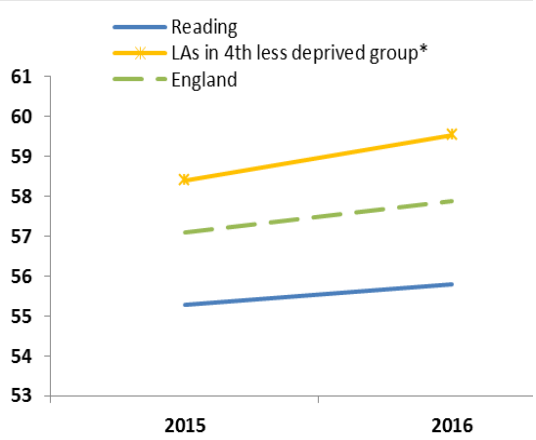
PHE DEMENTIA PROFILE / QUALITY OUTCOMES FRAMEWORK / PUBLIC HEALTH OUTCOMES FRAMEWORK / GP PATIENT SURVEY

6. BREAST AND BOWEL CANCER SCREENING

Breast cancer screening coverage - continues to be significantly worse than England average and average for areas with similar IMD scores

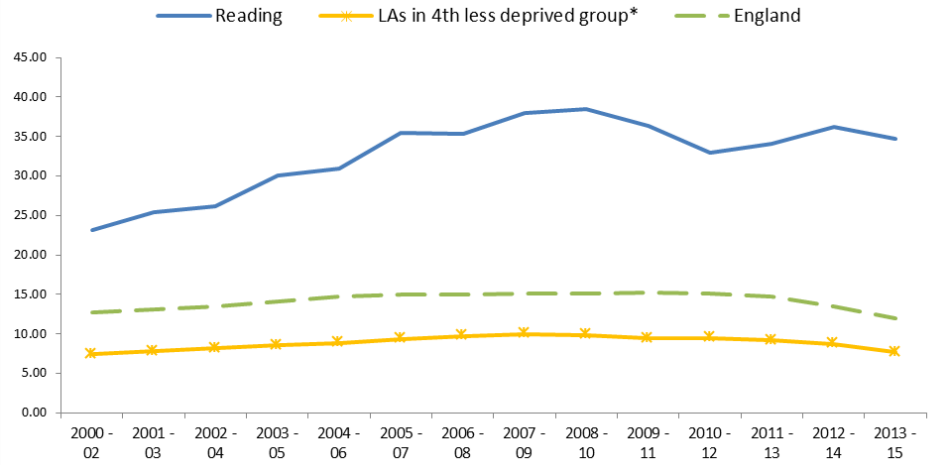


Bowel cancer screening coverage - continues to be significantly worse than England average and average of areas with similar IMD scores



PUBLIC HEALTH OUTCOMES FRAMEWORK / HEALTH AND SOCIAL CARE INFORMATION CENTRE

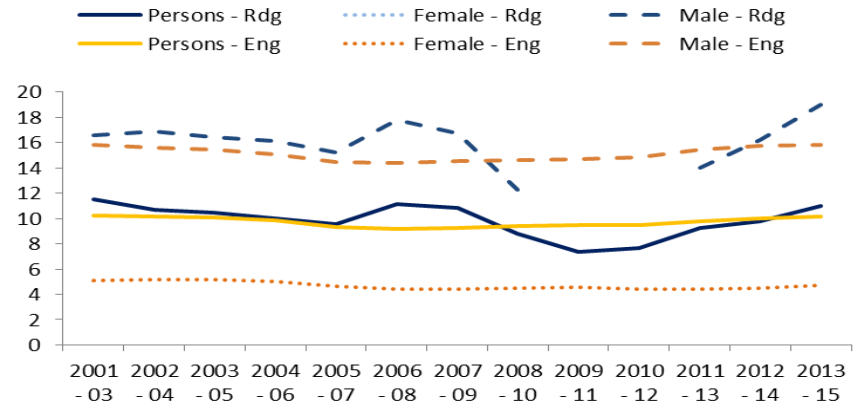
7. INCIDENCE OF TUBERCULOSIS



PUBLIC HEALTH OUTCOMES FRAMEWORK / ENHANCED TB SURVEILLANCE SYSTEM (ETS) AND ONS

Rate of new TB cases per 100,000 people is significantly worse than the England average and average of areas with similar IMD scores. Incidence has increased significantly in the last 15 years.

8. SUICIDE RATE



PUBLIC HEALTH OUTCOMES FRAMEWORK / ONS

Suicide rates for all persons and for men are similar to England average. The number of suicides by women is too small to allow rate to be calculated.

- LAs in 4th Less Deprived Group are those LA areas that fell into the 4th least deprived decile of all LA areas according to the 2015 calculation of the overall Indices of Multiple Deprivation, which takes into account income, employment, education, health, crime, barriers to housing and services and living environment.

READING BOROUGH COUNCIL

REPORT BY DIRECTOR OF ADULT SOCIAL CARE & HEALTH

TO:	**HEALTH AND WELLBEING BOARD**		
DATE:	**24 MARCH 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 and 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. At the time of this report, the final policy framework and technical guidance has yet to be published and is not expected until mid-March 2017. This means that the final funding, national conditions and planning requirements are still unclear.

1.3 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 has been made on behalf of the Berkshire West localities, but as with BCF policy guidance, the graduation criteria and process is yet to be finalised. Any final application will return to the board for formal approval.

2. RECOMMENDED ACTION

2.1 The Health and Wellbeing board are asked to delegate final sign-off of the Reading BCF Submission to the Director Adult Social Care & Health, and the CCG Accountable Officer at the Reading Clinical Commissioning Groups, in consultation with the chair of the Health and Wellbeing board. (Please see para 4.14)

2.2 The Health and Wellbeing board are asked to note the general progress to date.

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 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 adhere 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

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 has continued into Q3, based on NHS England DTOC performance figures.

As at the end of Q3, the three most prevalent reasons for people waiting for onward health or social care were as follow:

Patient awaiting -

- Further non acute NHS care
- Nursing home
- Care package in own home

Delayed transfers of care performance – Actual days delayed, 18+:

		Q1	Q2	Q3	Q4
Reading HWBB	*Plan*	*980*	*956*	*914*	*853*
	Actual	*2038*	*3133*	*3240**	
	variance %	*+108%*	*+228%*	*+254%*	

** The actual figures are taken from NHS England published information. Q1 – Q3 are complete quarters covering April 2016 – December 2016.*

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 / 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 for the year 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	3761*	
	variance to plan %	+4.5%	+0.7%	-3.9%*	

**Figures taken from the SUS data. Q1-Q3 are complete quarters covering April 2016 – December 2016.*

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 discharge 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	Sep	Oct
Reading HWBB	*2015/16*	80%	86%	83%	84%	78%	82%	86%
	2016/17	82%	87%	88%	94%	91%	92%	93%

** Figures taken from Mosaic, RBC Adult Social Care IT System. Q1-Q3 are complete quarters covering the period April 2016 – December 2016.*

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% less 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 and national targets.

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	51	77	

** Figures taken from Mosaic, RBC Adult Social Care IT System. Q1-Q3 are complete quarters covering the period April 2016 – December 2016.*

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.

However, while the service is supporting a high number of people to be discharge from an acute setting in a 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 M8 (November 2016), 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 delayed 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 October 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 until mid-March 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, HWBB'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 Again, in line with previous submissions, the BCF monies must be held in a pooled CCG / Local Authority budget.

4.14 The final submission of the Reading Better Care Fund for 2017/19 requires approval by the chair of the Health and Wellbeing board. Whilst the deadlines for submission have not been confirmed by NHS England it is likely that the timing of the next Health and Wellbeing board will not match the national deadlines. The Health and Wellbeing board are therefore asked to delegate authority to the Director Adult Social Care & Health, and the CCG Accountable Officer at the Reading Clinical Commissioning Groups, in consultation with the chair of the Health and Wellbeing board.

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 Members are under a legal duty to comply with the public sector equality duties set out in Section 149 of the Equality Act 2010. The relevant provisions are as set out below.

Section 149 (1) – A public authority must, in the exercise of its functions, have due regard to the need to:
(a) eliminate discrimination, harassment, victimisation and any other conduct that is prohibited by or under the Equality Act;
(b)advance equality of opportunity between persons who share a relevant protected characteristic and persons who do not share it; and
(c)foster good relations between persons who share a relevant protected characteristic and persons who do not share it.

Section 149 (7) - The relevant protected characteristics are:

- age;
- disability;
- gender reassignment;
- pregnancy and maternity;
- race;
- religion or belief;
- sex;
- sexual orientation.

In order to comply with the Public Sector Equality Duty, Members must seek to prevent discrimination, and protect and promote the interests of vulnerable groups who may be adversely affected by the proposals. Members must be therefore give conscious and open minded consideration to the impact of the duty when reaching any decision in relation to the Better Care Fund and Integration programmes. The Public Sector Equality Duty (S.149) to pay 'due regard' to equalities duties is higher in cases where there is an obvious impact on protected groups. This duty, however, remains one of process and not outcome.

8. LEGAL IMPLICATIONS

8.1 N/A – no new proposals or decisions recommended / requested.

9. FINANCIAL IMPLICATIONS

9.1 The Reading Better Care Fund pooled fund is expected to see a small underspend of £115k. No new funding decisions are being requested through this report.

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 spends and update the HWBB, as required.

10. BACKGROUND PAPERS

10.1 None

READING BOROUGH COUNCIL

REPORT BY DIRECTOR OF ADULT SOCIAL CARE AND HEALTH

TO: Health & Wellbeing Board

DATE: 24th March 2017 **AGENDA ITEM: 14**

TITLE: ANNUAL REPORT FROM THE STRATEGIC DIRECTOR OF PUBLIC HEALTH

LEAD COUNCILLOR: Cllr Hoskin **PORTFOLIO:** Health

SERVICE: Wellbeing **WARDS:** All

LEAD OFFICER: Jo Hawthorne **TEL:** 0118 9373623

JOB TITLE: Head of Wellbeing, Commissioning & Improvement

EMAIL: Jo.hawthorne@reading.gov.uk

1. PURPOSE OF REPORT AND EXECUTIVE SUMMARY

1.1 The purpose of the report is to inform Health & Wellbeing Board members on the Strategic Director of Public Health's Annual Report. The Annual Report is written using information from the latest available needs assessment and evidence supplemented from other sources such as education and other community services.

2. RECOMMENDED ACTION

2.1 HWB members note the Annual Report from the Director of Public Health.

2.2 For HWB members to consider how the report will influence the work to reduce health inequalities.

3. POLICY CONTEXT

3.1 There is a statutory requirement for the Director Public Health (DPH) to produce an annual report. Annual reports should:

- Contribute to improving the health and well-being of local populations, and tackling health inequalities
- Promote action for better health, through measuring progress towards health targets.
- Assist with the planning and monitoring of local programmes and services that impact on health over time.

3.2 The annual report is the DPH's professional statement about the health of local communities, based on sound epidemiological evidence, and interpreted objectively. The report should be publicly accessible.

4. THE PROPOSAL

4.1 The role of the DPH is to be an independent advocate for the health of our residents. Whilst the Annual Report is the independent report of the DPH and as such does not require public consultation, colleagues from Wellbeing and Reading Children's Services

have added valuable expertise and assistant in shaping its content.

4.2 **Update from last year's Annual Report**

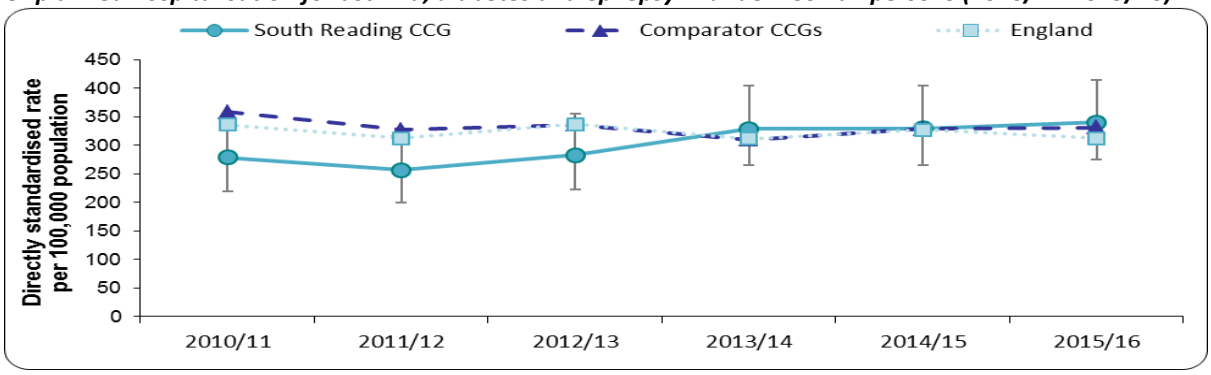
Last year's report focussed on children and the major causes of ill health but also how education and life chances had a complex but interlinked relationships with health. It stated that the transfer of health visiting services into local authority commissioning was an opportunity to link all Early Years' Services and maximise the support given to all families through the mandated services but also to pay close attention to those families with more vulnerability. The new specification for health visiting services makes those links.

With regard the wider determinants of health and its impact on children, last year we noted the key role education plays in promoting good health. This year we can see that the attainment of GCSEs a* - C grade (including Maths and English) has reduced from 59% in 2013/14 to 51.4 in 2104/15 , and the percentage of 16-18 year olds not in education or training has worsened as well (8.1 2014/5 v 6.3% 2013/4), though encouragingly the percentage of children entering reception with good stage of development has increased from 63.7% (2013/14) to 67.1% (2014/15) - this is now just above the England average.

In the previous year's report we noted that children are high users of services, sometimes for conditions that could be prevented. Reading continues to be an outlier in the number of 0-4 year olds who attend A&E services, indeed the trend is worsening: in 2013/14 763/1,000 0-4 year olds attended A&E; in 2014/15 that number was 848/1,000.

With regards hospital admissions, admission for lower respiratory tract infection still continue to rise in South Reading, overall admissions from epilepsy, asthma and diabetes have been static

Unplanned hospitalisation for asthma, diabetes and epilepsy in under 19s - all persons (2010/11-2015/16)



4.3 Aim of 2017/18 report

Tackling premature mortality, deaths that occur before 75 years (avoidable deaths) are a key driver for improving life expectancy and reducing health inequalities. These avoidable deaths are driven by two major causes: *amenable deaths* - those driven by problems / reduced access to health care and *preventable deaths* those that are driven by wider public health issues. The report briefly shows how the major improvements would be achieved through systematically and visibly addressing preventable causes of death.

Preventable deaths are more common in men and the clinical grouping where preventable deaths have their biggest impact is in cancer, though at a more detailed level, ischaemic heart disease is the single disease where prevention would have the biggest impact.

The report summarises in appendix 1 the key public health issues that impact on preventable deaths. It highlights the impact that lifestyle factors have on the health of our residents. Whilst there is general consensus and increasing visibility of the impact of obesity, physical

inactivity, tobacco, alcohol and high blood pressure on health, sometimes the conversation is couched in terms of the long term with scepticism about the impact on health and social care in the short / medium term. Prevention is seen as a "nice to do" but has made way in prioritisation debates to immediate pressures in services.

The STP in BOB has identified from national evidence those approaches that will make an impact on health outcomes and care over 5 years.

This report presents more fully the evidence behind these lifestyle factors, the impact that these factors have on the individual in terms of health risks and the impact these factors have in driving demand for care. It also presents some of the evidence for action. Hopefully the report will provide professionals with new information on lifestyle factors and a different perspective on drivers for increasing demand, which will change the nature of the conversation about prevention and self-care. If we are to make a difference to our health and our subsequent need for health care then we need to make a radical change in how we as individuals and communities take responsibility for our own health but also as professionals support individuals and communities in addressing quite entrenched habits and lifestyles.

4.4 Children and Avoidable deaths

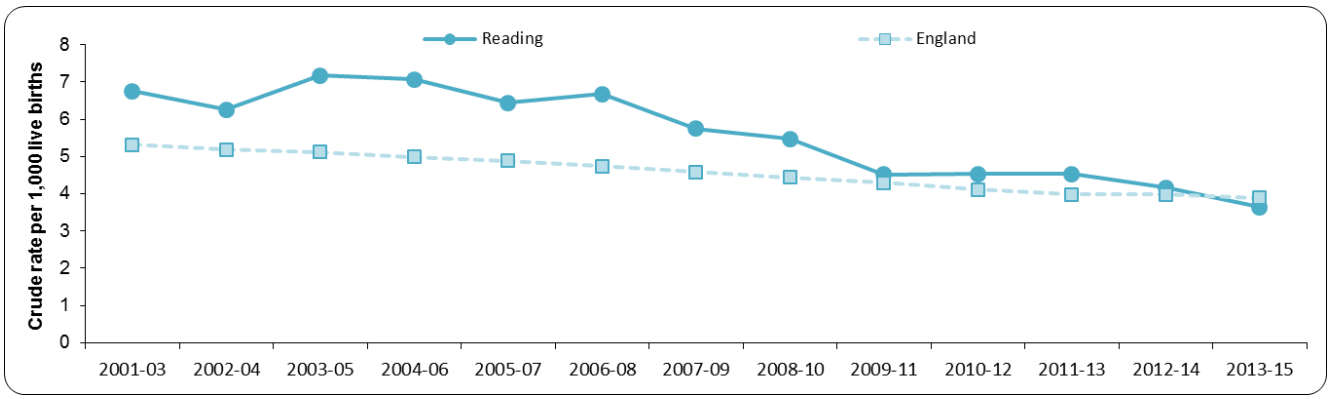
Whilst this report is focussed on adults, since this is where these lifestyle factors either occur or have their measurable impact, there are avoidable deaths in children.

In 2014, just under a third of deaths (32% or 1,443 out of 4,571) in children and young people aged 0 to 19 years in England and Wales were from causes considered avoidable through good quality healthcare (amenable) and wider public health interventions (preventable). Avoidable deaths in children and young people made up 1% of all avoidable deaths in 2014.
Similarly to adults males aged 0 to 19 years were more likely to die from avoidable causes than females. Male deaths accounted for around 63% (911 out 1,443) of avoidable deaths in children and young people.

The single cause with the highest number of avoidable deaths in children and young people was accidental injuries (195 deaths: 14% of all avoidable deaths in this age group). This is followed by complications during the perinatal period (childbirth), suicides and self-inflicted injuries, transport accidents and congenital malformations of the heart.

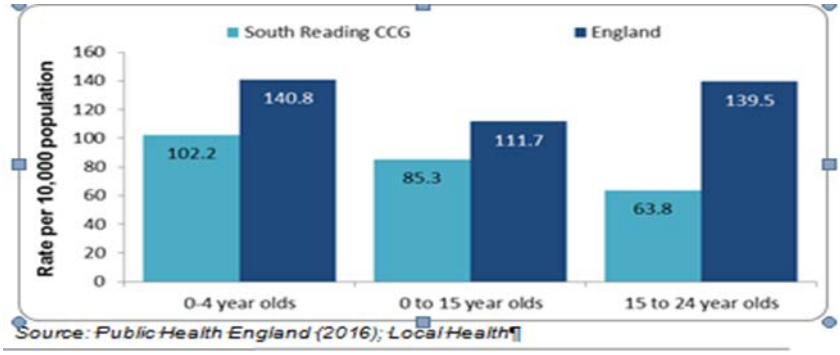
The Child Death Overview Panel continues its work to review each child's death within Berkshire and to identify and take action on any emerging underlying themes. The trend for reducing number of child deaths continued during 2015/16.

Rate of deaths in infants aged under 1 year in Reading and England (2001-03 to 2013-15



Injuries which as mentioned are the prime cause of avoidable deaths in children also cause a significant number of admission to the RBH , with admissions for children from South Reading being significantly more than the England average.

Hospital admissions for injury in children and young people by age group (2010/11 to 2014/15)



Source: Public Health England (2016); Local Health¶

4.5 Summary

Hopefully this years report allows for a debate on the role of organisations, communities and individuals in tackling the factors that drive ill health and the promotion of action currently underway or planned and the generation of a new momentum to tackle this.

5. CONTRIBUTION TO STRATEGIC AIMS

5.1 Public Health interventions at a population level contribute to Corporate Priority 2: Providing the best life through education, early help and healthy living.

6. COMMUNITY ENGAGEMENT AND INFORMATION

6.1 The report will be available for information.

7. EQUALITY IMPACT ASSESSMENT

7.1 An equality impact assessment is not relevant.

8. LEGAL IMPLICATIONS

8.1 There are no legal implications.

9. FINANCIAL IMPLICATIONS

9.1 There are no financial implications.

10. BACKGROUND PAPERS

10.1 Appendix 1 – Annual Report

Annual report 2017

Dr Lise Llewellyn

Strategic Director of Public Health

Avoidable and preventable mortality

Life expectancy has improved through the ages: in the middle ages the average life expectancy was thought to be around 35 years, rising to 47 in 1900, 65 in the 1950's, and 65 in 1971 and in 2015 it was 79 (men). (1)

Now the focus is on reducing avoidable deaths: avoidable deaths can be divided into 2 major areas : amenable and preventable deaths. Avoidable deaths in general focus on those deaths that occur prematurely before 75 years.

"People who die prematurely from avoidable causes lose an average of 23 potential years of life

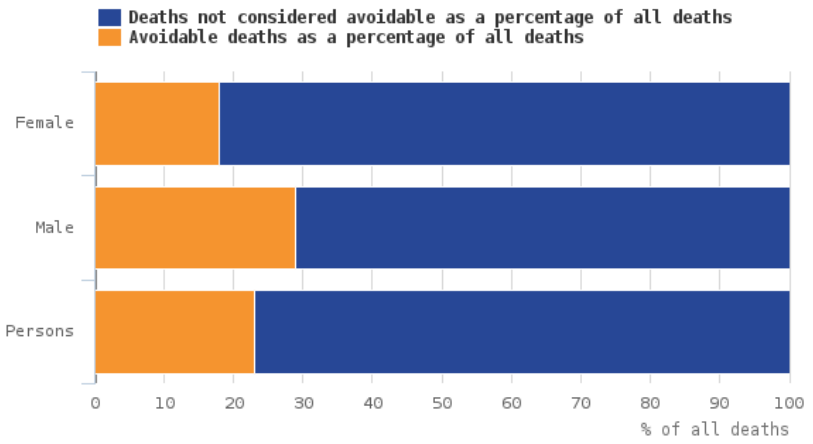
In 2014, nearly a quarter of all deaths (23%; 116,489 out of 501,424) in England and Wales were from causes considered potentially avoidable either through timely and effective healthcare (amenable) or public health interventions (preventable)(2) .

While we may say that a particular condition can be considered avoidable, this doesn't mean that every death from that condition could be prevented. Analysis focuses on deaths prior to 75 years.

Males were more likely to die from an avoidable cause than females and accounted for approximately 60% of all avoidable deaths.

Approximately 29% of all male deaths were from avoidable causes (70,108 out of 245,142 deaths) compared with 18% of all female deaths (46,381 out of 256,282 deaths).

FIG 1: % age of deaths nationally hat are avoidable



Cancers (all) were the leading cause of avoidable deaths accounting for 35% of all avoidable deaths in England and Wales in 2014.

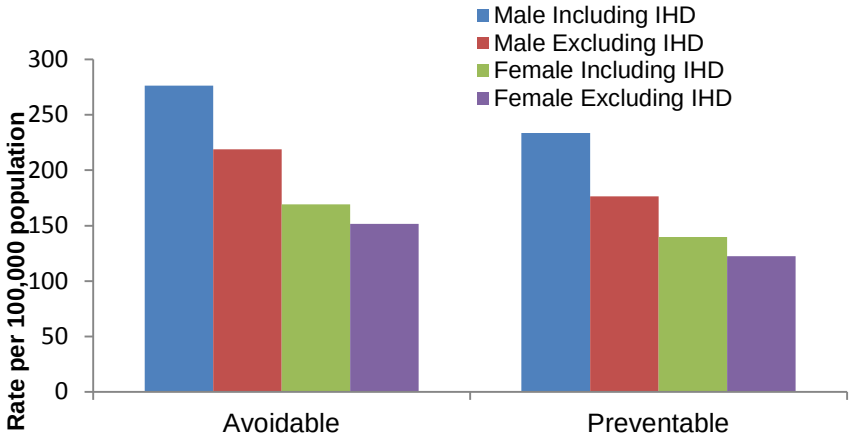
Ischaemic heart disease is the most common single disease that leads to avoidable disease.

Amenable deaths are those that a death is amenable (treatable) if, in the light of medical knowledge and technology at the time of death, all or most deaths from that cause (subject to age limits if appropriate) could be avoided through good quality healthcare.

Preventable Death are those that through our understanding of the determinants of health at time of death, all or most deaths from that cause (subject to age limits if appropriate) could be avoided by public health interventions in the broadest sense.

Local preventable deaths

Fig 2 Rates of avoidable and preventable deaths

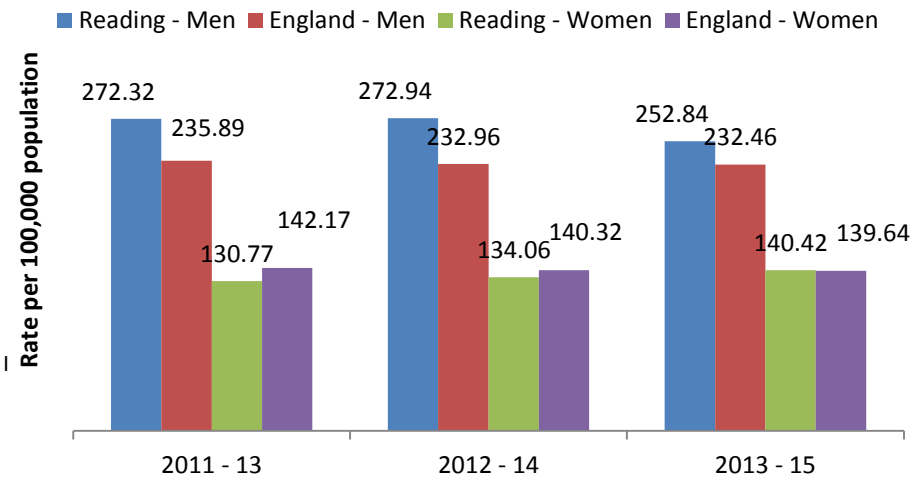


As shown in fig 2 addressing these would have the biggest impact on reducing total numbers of avoidable deaths – sadly though the emphasis does appear to be on increasing health care interventions.

We can measure preventable deaths rates in our own community. The England age standardised rate for preventable deaths is 184 deaths per 100,000, with the rate in Reading being higher at 194 /100,000. i.e. more preventable deaths in Reading.

We can see that in men the rate of preventable deaths are higher than the national average, though reducing, whilst the impact in women is around the England average but increasing : so the impact on health, early death and use of health care by more sustained application of public health measures by health and social care organisations, communities and individuals will reduce early deaths and hence also the demand of our services, and improve health considerably at the local level .

Fig 3 **Mortality rate from causes considered preventable 2011-2015**

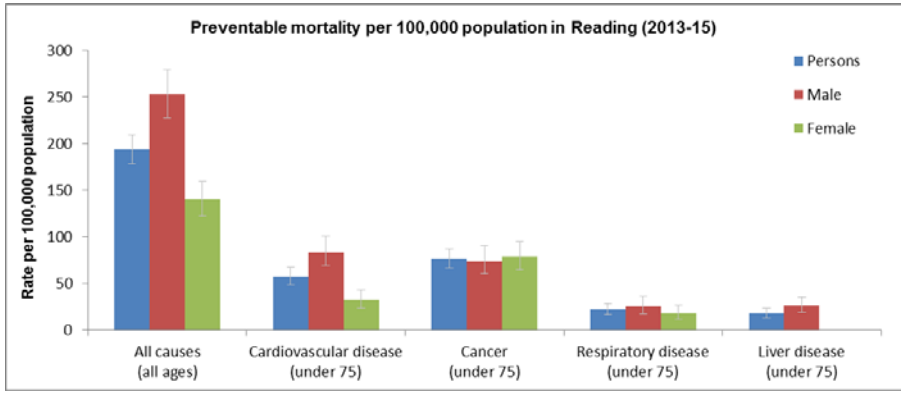


If we look at the major causes of early preventable death within Reading, we see a similar picture to that seen nationally with the biggest generic cause being cancer for all persons and impact being greater for all preventable causes on male deaths though in Reading the impact of cardiovascular disease on men is the highest single cause.

If we examine premature preventable mortality in Reading in more detail by clinical groups then we see that mortality rates are higher in men for all causes except cancer Fig 4 .

Local preventable deaths – needs checking

Fig 4

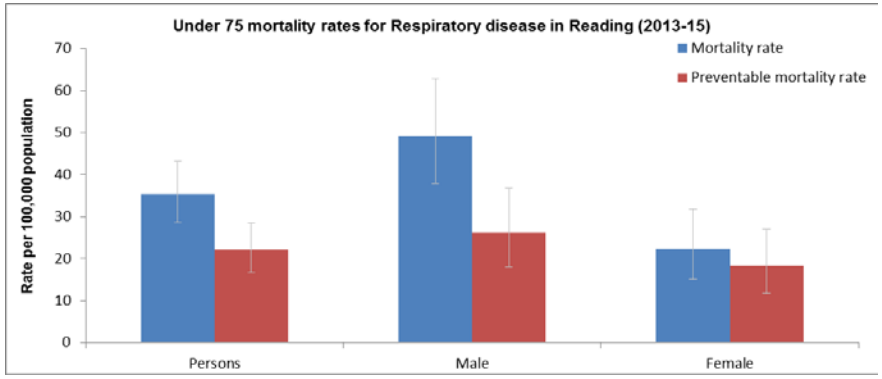


In Reading we see the highest overall liver disease preventable mortality rate in Berkshire (17.9 per 100,000 pop) – 95% of male mortality being preventable .

Fig 5

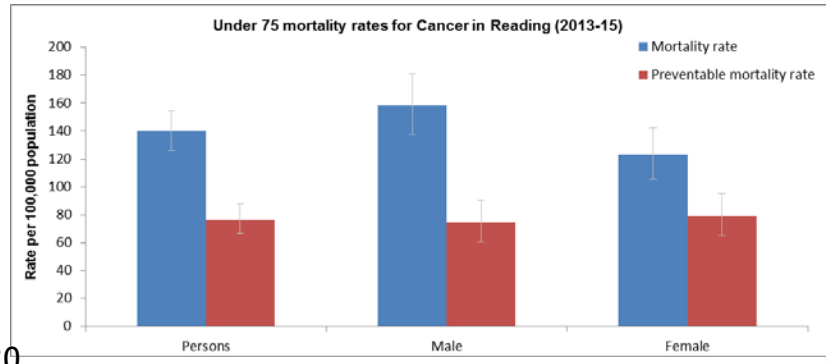
In respiratory deaths whilst females have a lower death rate the percentage due to preventable causes is much higher.

Fig 6



In cancer locally we see that the percentage of preventable cancers is higher than the national picture for men with again a greater percentage being preventable in women (64%) versus men (47%)

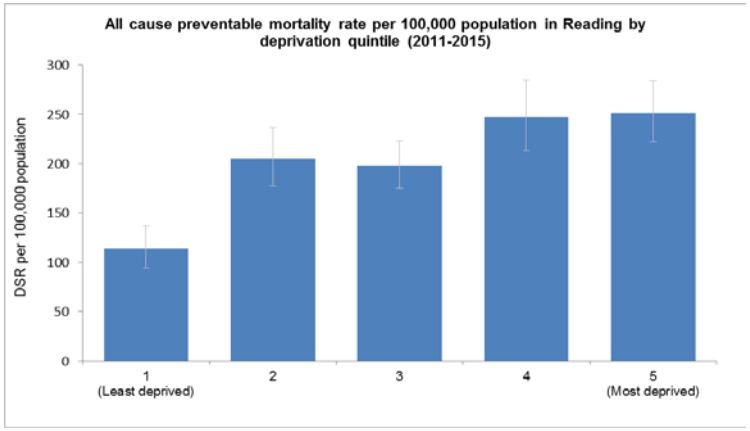
Fig 7



Preventable deaths

The impact of premature mortality from preventable causes can be examined by geography and deprivation.
Accounting for age differences Reading (along with Slough) has higher rates of preventable mortality , and almost 55% of deaths in under 75 year olds are preventable. Across all preventable deaths there is a definite link with deprivation when we group wards by their level of affluence. (3)

Fig 8



This is not unexpected since the evidence shows a consistent pattern in the prevalence of multiple unhealthy behaviours, at the core of preventable causes of ill health, with men, younger age groups and those in lower social classes and with lower levels of education being most likely to have exhibited these multiple lifestyle risks(4)
In 2008 4.2% of professional men exhibited all 4 unhealthy lifestyle behaviours, compared to 8.4% of male unskilled manual workers. Similarly, 3.1% of professional women exhibited these behaviours, compared to 7.0% of female unskilled manual workers.

Worryingly this pattern is persisting with improvement in lifestyle being greatest in those in most affluent groups (4) so the gap is widening.

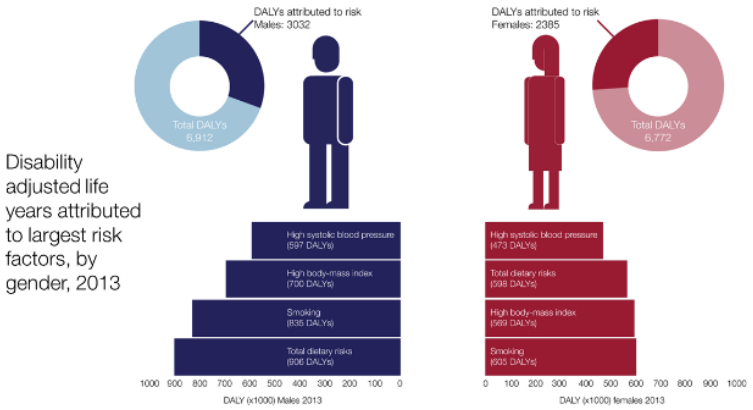
Whilst the strongest risk factors for avoidable hospital admission are age and deprivation (5).

Clustered poor health behaviours are associated with increased risk of hospital admission among older people in the UK. Life course interventions to reduce number of poor health behaviours could have substantial beneficial impact on health and use of healthcare in later life (6). Studies have shown that among men and women, increased number of poor health behaviours was strongly associated ($p<0.01$) with greater risk of long stay and emergency admissions, and 30-day emergency readmissions. Those with three/four poor health behaviours were in men, 1.37[95%CI:1.11,1.69]; women, 1.84[95%CI:1.22,2.77] times more likely to be admitted to hospital than those with no poor health attributes. Associations were unaltered by adjustment for age, BMI and comorbidity.

The impact of improving lifestyle behaviours is not restricted. In a study of over 65 year olds whilst that higher self-care confidence and being an exercise program decreased avoidable hospitalizations, starting exercise program at an older age decreased hospital admissions and also decreased utilization of emergency services in the short and medium term.(7)

Action to address early preventable deaths

There are 8 commonly agreed: alcohol use, tobacco use, high blood pressure, high body mass index, high cholesterol, high blood glucose, low fruit and vegetable intake, and physical inactivity that would reduce preventable death rates



It is estimated that 80 per cent of cases of heart disease, stroke and type 2 diabetes, and 40 per cent of cases of cancer could be avoided if common lifestyle risk factors were eliminated (WHO 2005).

An estimated 42% of cancer cases each year in the UK are linked to a combination of 14 major lifestyle and other factors.(8) The proportion is higher in men (45%) than women (40%), mainly due to sex differences in smoking (CRUK).

The impact of these lifestyle factors is not only key in casing early death within our communities but also as a major cause of illness it drives our increasing utilisation of health and care resources.

In the following section we will briefly review 5 of the major lifestyle and risk factors for preventable deaths in whom there is significant evidence regarding interventions that make a difference. We will briefly describe the pattern of these factors in our community, the impact of each in terms of illness and death, but also in terms of impact on our services.

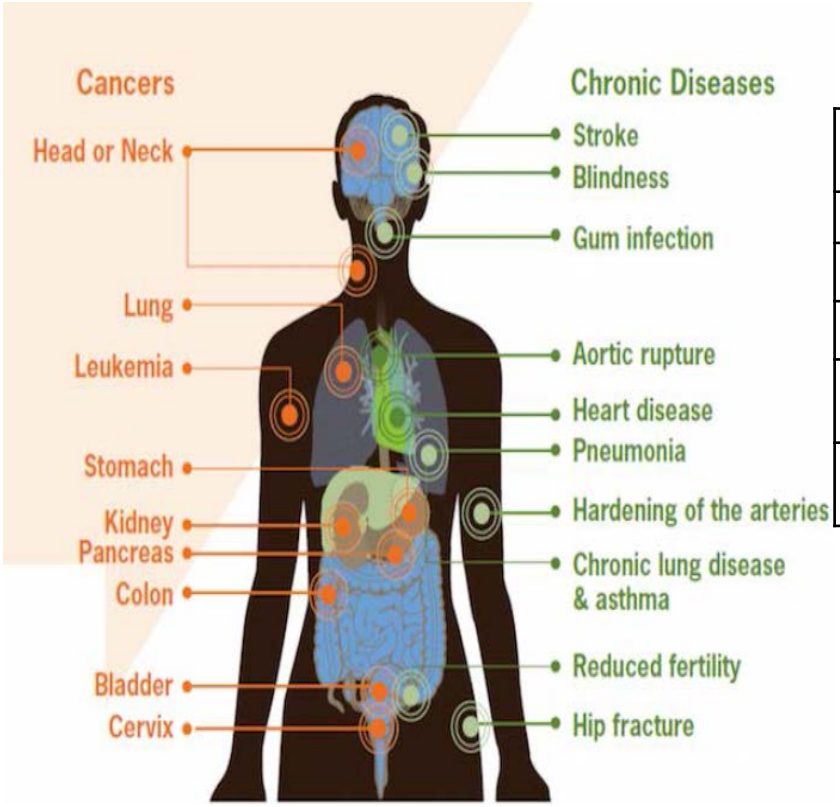
It should be noted that whilst we look at each individually there is data that shows that risky health behaviours interact and have a multiplicative rather than simply additive impact. That is, they have a greater effect together than the sum of each individual risk. For example obesity and alcohol consumption which interact to increase risks of liver disease mortality to a greater extent than the sum of each individual risk [9].

Or alcohol and smoking which together are associated with a greater combined risk for cancer than the sum of the two individual effects [10]. This may be one reason why we see greater alcohol related harm in socioeconomically deprived groups compared to affluent groups - even when the level of alcohol consumption is held constant. It's because the more deprived groups are more likely to be engaging in multiple risky lifestyle behaviours.

Smoking

Smoking remains the biggest single lifestyle cause of preventable mortality and morbidity in the world. The Tobacco Control Plan for England states that it accounts for 1 in 6 of all deaths in England.

Its impact is seen on every organ of the body.



Nationally the prevalence of smoking is decreasing ; 19% of people smoke 2016 v 46% at its peak in 1976 and average daily consumption is also reducing 11 cigarettes a day (16 – 1974)

Smoking is more prevalent in adult men (20%v 17%) , more prevalent in more deprived communities (30% routine and manual v 11% professional), and more prevalent in those with less formal education (9% in those with degrees) and younger people are more likely to smoke 9255 16-34 v 11% >60). In children and young people more girls smoke regularly and the major influence is smoking in the home(11).

2015/16	Reading BC	England
Never smoked	50.9%	48.6%
Adults resident smoking rate	17.6%	16.9%
Manual and routine smoking rate	25.6%	26.5%
Young people under15 regular smoker	6%	5.5%
Smoking in residents with severe mental illness	37.4%	40.2%

It is recognised that smoking has a profound impact on health inequalities. -, there is greater health inequality between smokers and people who have ever smoked than between people of the same sex and smoking status but different social positions.

In both women and men, people in the lowest social positions who had never smoked had substantially better survival rates than smokers in even the highest social classes. (12) 85% of the observed inequalities between socioeconomic groups can be attributed to smoking (13)

Smoking - impact

In 2012-14, there were 275 smoking-attributable deaths per 100,000 population in England. In Reading 2012 -14 the rate is 265 / 100,000.

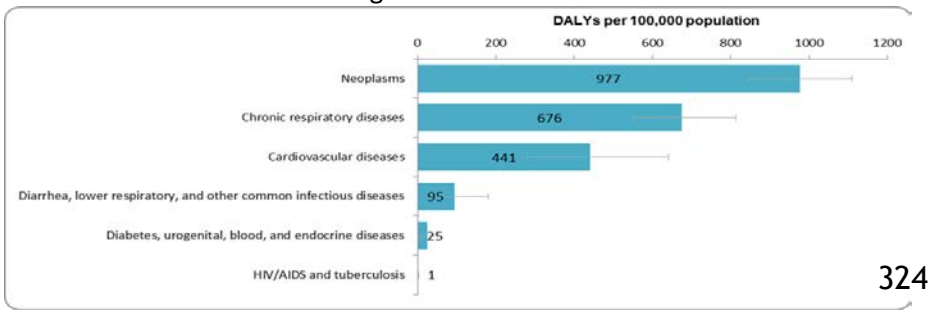
In Reading 487 deaths each year are caused by smoking – 3 deaths a week.

Disability adjusted life years (DALYs) are an important measure used in health care as they not only measure the number of years of life lost (early deaths) but also the number of years lived with disability – so give an assessment of the impact on the life of the individual effected but also that the impact the factor has on health and care usage. This analysis is now available for the South East .

Smoking is the most significant single lifestyle factor that causes the highest number of Disability Adjusted life Years (DALYs lost both regionally and nationally. - 9.1% of DALYs in the South East Region were attributable to smoking in 2013 (2,215 per 100,000 population).

This figure shows the wide impact of tobacco in the South East
Source: Global Burden of Disease (2013) (14)

The largest numbers of DALYs attributable to smoking in general causes were for cancers, chronic respiratory diseases and cardiovascular diseases. Fig 9



324

If we look at data for specific clinical illnesses and the impact of smoking on each of these then we see a different pattern : smoking accounts for at least 56% of all chronic lung disease, conditions, 70% of COPD and 80% of lung cancer (14).

23% of DALYs for neoplasms were attributable to smoking. Again, this was higher for certain cancers:

- 79% of DALYs for tracheal, bronchus and lung cancer
- 54.1% lip and oral cavity cancer
- 53% oesophageal cancer

We know that smoking prevalence is greater in men , is greater in the most deprived communities and its impact increases over time.

If we look at men aged 55-79, smoking is, as could be expected the single largest cause of DALYS but now accounts for the 12 – 14% of DALYS in the least deprived areas but is in the most deprived communities accounts for 19 – 21% of DALYS : 1 in 5 of DALYs - significantly more than in wealthier areas. (A similar pattern is seen in women).

In a study which looked at chances od survival and smoking after 28 years : people in the lowest social positions who had never smoked had substantially better survival rates (56% women and 36% of men) than smokers in the highest social classes (41% women and 24% men) . (12)

Tobacco accounts for 90% of health inequalities

Smoking - impact

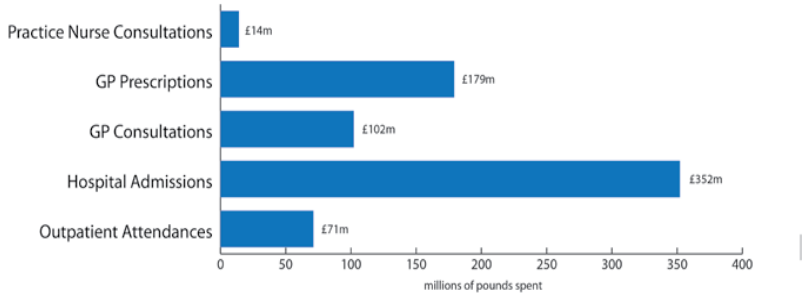
With the major impact on illness it is not surprising that smoking is also responsible for significant care use both in primary and hospital settings: tobacco use accounts for approximately 5.5% of the NHS budget.

There were 1.7 million admissions in 2014/15 across the UK for conditions that could be caused by smoking, an increase of 22% from 2004/5. With 475,000 hospital admissions attributable to smoking in 2014/15, up from 452,000 in 2004/05.

This represents 4% of all hospital admissions (6% of male admissions and 3% of females.) (14,16)

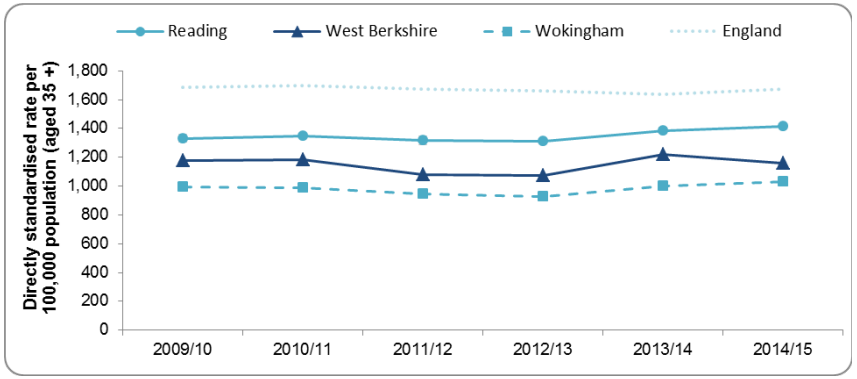
23% of respiratory , 15% of cardiac and nearly 10% of cancer admissions are attributable to smoking

Individuals with mental health problems smoke more heavily than the general population, thus contributing to as much as 43% of tobacco consumption in the UK (16) and it is estimated 3 million UK adults with mental disorders who are also smokers incur total smoking-attributable costs of £2.34 billion. A total of £719 million was spent treating smoking-related disease among people with mental health disorders of which £352m were due to hospital admissions, while other cases were treatments of cancer, cardiovascular disease and respiratory diseases (18)



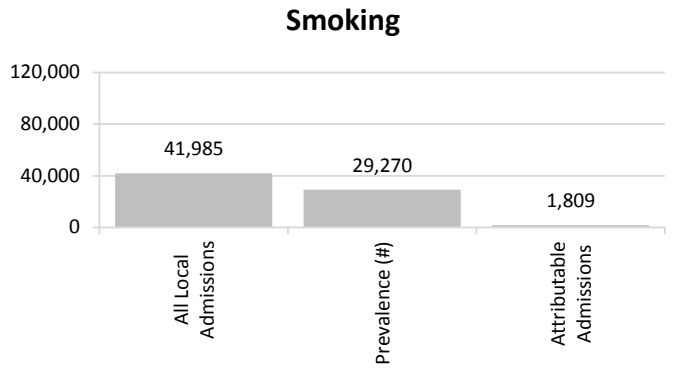
Locally in line with the lower prevalence of smoking (and our lower than average admissions in general) our rates of smoking related admissions are lower than the England average , with Reading having the highest rates across Berkshire.(15,17,20)

Fig 11



Though in West Berkshire it can be seen that over 1800 admissions a year are solely attributable to the effects of smoking. (16)

Fig 12



Smoking - impact

The costs of smoking to the NHS and to the economy in general are well understood, however, there are also costs to the social care system, which are less well known (19).

Recent research, based on adults over 50 , compared the care needs of current and former smokers with those of never smokers. The key findings were that whilst no difference could be seen in use of residential care (small sample size) smokers were more likely to have difficulties in the majority of daily activities and so were at double the risk of developing care needs. In just over half of the activities ex smokers also showed more difficulties.

The impact of smoking related ill health on the social care system, is a cost of £1.4 billion every year, up from £1.1billion in 2014. This is made up of £760 million in costs borne by local authorities, with a further £630 million being spent by those who have to self-fund their care.

Interventions

What Works The biggest short-term savings opportunity lies in helping smokers who are in contact with the NHS; the greatest long-term savings would come from preventing people from ever smoking altogether

Prevention of smoking requires strong partnership working e.g promoting smoke free environments, reducing counterfeit and illegal tobacco sales.

Smoking cessation services are widely available and the local council service continues to see more residents than the England average. In 2015/6 1103 per 100,000 in 2015/6 set a quit date (v 862 England) and 713/100,000 reporting quitting at 4 weeks (v 440 England) (20)

2015/16	Rates per 100,000 population (actual numbers)		
	Setting quit date	Successful quitters	Validated quitters (CO)
England	862	440	314
South East	674	375	271
Reading BC	1,103 (1,408)	713 (916)	433 (557)

Local Gaps However whilst we offer some support to patients within health care settings to give up smoking we have still to maximise this approach.

Recently BHFT have been proactive in ensuring that all mental health facilities are smoke free, with patients being offered nicotine replacement therapy. However all smokers should be identified during treatment and at minimum offered brief intervention and advice to promote smoking cessation as part of their treatment plans. Pregnant women should be screened via carbon monoxide screening and offered specialist support (21)

For those unable / unwilling to stop smoking permanently then temporary abstinence supported by nicotine replacement medication will deliver harm reduction. Smokers having elective surgery are 6 times more likely to have a surgical site infections and so have lengthier post operative stays and recovery periods. Simply supporting abstinence prior to surgery can reduce this risk, improve outcomes and reduce costs associated with care .

Lifestyles – High blood pressure

Blood pressure is recorded with two numbers.

The systolic pressure (higher number) is the force at which your heart pumps blood around your body.

The diastolic pressure (lower number) is the resistance to the blood flow in the blood vessels. They're both measured in millimetres of mercury (mmHg). As a general guide:

- high blood pressure is considered to be 140/90mmHg or higher
- ideal blood pressure is considered to be between 90/60mmHg and 120/80mmHg

Risk factors for high blood pressure

Blood pressure is normally distributed in the population and the risk associated with increasing blood pressure is continuous, with each 2 mmHg rise in systolic blood pressure associated with a 7% increased risk of death from ischaemic heart disease and a 10% increased risk of mortality from stroke.

Overweight or obese
Poor diet : high salt & Less than 5 a day fruit and vegetables
Low Physical activity
High alcohol
Smoker
are over the age of 65
don't get much sleep or have disturbed sleep
are of African or Caribbean descent
Family history of high blood pressure

At least one quarter of adults (and more than half of those older than 60) have high blood pressure(22)

Over 24% of people in England are estimated to have high BP High BP is one of the leading causes of premature death and disability in England. At least half of all heart attacks and strokes are associated with high BP and it is a major risk factor for chronic kidney disease, heart failure and cognitive decline .

Lowering blood pressure per se reduces risk for myocardial infarction by 20% - 25%,(23).

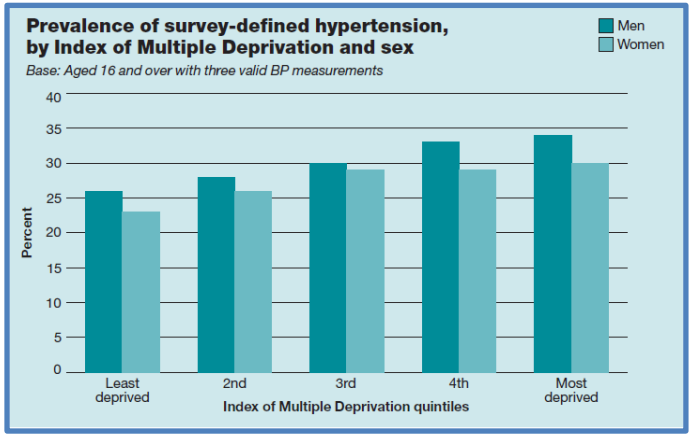
High BP costs the NHS an estimated £2bn, while social care and productivity costs are likely to be much higher High blood pressure causes stroke, myocardial infarction, heart failure, chronic kidney disease, vascular dementia and premature death.

High BP is much more common in deprived communities. The Department of Health's 2010 'Health Survey for England' noted that prevalence increased from

26% of men and 23% of women in the least deprived quintile

34% and 30% respectively in the most deprived quintile.

Fig 13



High blood pressure

For every ten people diagnosed with high BP, seven remain undiagnosed and untreated - this is more than 5.5 million people in England. Those in more deprived communities are less likely to have high BP detected though with the introduction of the quality scheme this gap has reduced (24,25), . In addition we can see the percentage of those in treatment and also adequately controlled reduces with increasing deprivation.

Income level	n	Aware (%)	Treated (%)	Controlled (%)
High	6263	49.0	46.7	19.0
Upper Middle	18123	52.5	48.3	15.6
Lower Middle	23269	43.6	36.9	9.9
Low	10185	40.8	31.7	12.7
Total	57840	46.5	40.6	13.2

(25)

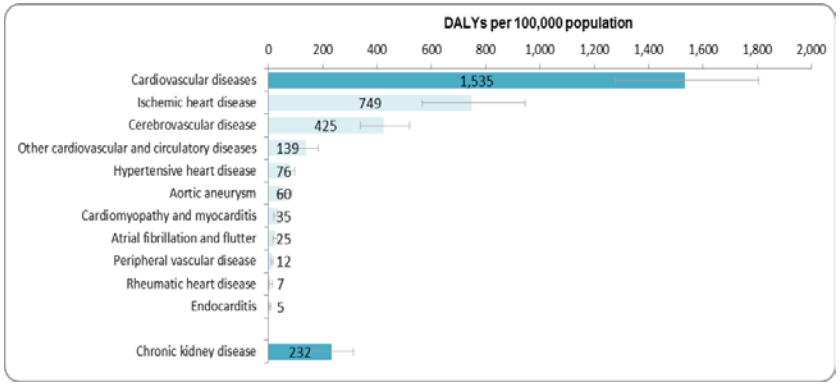
13.1% of all deaths in South East England were attributable to high blood pressure (14)

7.2% of all disability-adjusted life years (DALYs) in the South East Region were attributable to high blood pressure in 2013 (1,766 per 100,000 population).

.

The largest number of DALYs attributable to high blood pressure were for cardiovascular diseases and chronic kidney disease. Within the cardiovascular diseases group, ischemic heart disease and cerebrovascular disease had the largest number of DALYs attributable to high blood pressure.

Fig 14



Source: Global Burden of Disease (2013)

For all cardiovascular events High systolic BP accounts for 43% DALYs; 1,535 per 100,000.

In reviewing premature deaths (deaths before age 75) Reading fares badly with regards heart disease and stroke -being ranked 97 out of all authorities, with 85 deaths per 100,000 (2013-2015) and ranked 14 out of 15 in comparison to similar local authority areas. (26)

High BP –Impact

Across the 2 CCGs, (North west Reading and South Reading) there are estimated to be 50,000 people with high BP , with 29,000 currently being treated -this means that there are 21000 people unaware of their high BP (27).

Fig 15

In addition, of those that are being treated by their GP not all are achieving target BP control: 980 patients (27)

Locally it is possible to measure the impact high BP has on disease and deaths but also the impact on reducing high BP in those with high BP by 10 mm HG in Reading.

Every 10 mmHg reduction in systolic BP reduces the risk of major cardiovascular events by 20% .

If we look at the two CCGs that cover Reading then we can see the impact good control of high BP could achieve.

Condition	Current number of events	Number if treated	Reduction
Stroke	115	84	31
Heart failure	84	60	24
Heart disease	184	153	31
Death	1432	1246	186 (21)

However treatment is not simply reliant on medication : indeed across the long term conditions more than half of all patients do not take their medication as prescribed. Modification of lifestyles factors can have a major impact on high BP with no side effects (and additional positive health impacts).

Of those who address lifestyle after 10 weeks a significant percentage achieve a 10 mm reduction in BP : (28)

- Weight 40%
- Exercise 30%
- Relaxation 25%
- Alcohol 30%
- Salt 25%

Advice given during the consultation for high BP is likely to be acted upon. Compared with those who did not recall being given advice, hypertensive adults who recalled being given advice were more likely to change their eating habits, reduce salt, exercise ,and reduce alcohol consumption (28).

Indeed lifestyle modification is indicated for all patients with hypertension, regardless of drug therapy, because it may reduce or even abolish the need for antihypertensive drugs.

High BP - Intervention

High blood pressure management in the community from a long term perspective is focussed on reducing the risk factors within the community : obesity, physical inactivity, smoking and high slat intake etc. However in the short and medium term there are clear programmes that can reduce the impact of this risk factor (21)

A clear priority is to reduce the number of patients with known high blood pressure for whom treatment is not adequate. This can be achieved by annual audits of practice registers to identify effected patients, and develop the role of pharmacists and other professional to maximise achievement of treatment goals through lifestyle changes and drug therapy. . A 20% improvement in blood pressure control can be cost saving within 5 years.

A key part is wider use of self-monitoring by patients to help eliminate false readings and provide a the skills of the patient to know and monitor blood pressure in daily living to minimise false readings.

Of course it is also key to identify residents in the community who are unaware that they have high blood pressure. Programmes to identify high blood pressure before organ damage occurs through . lifestyle changes and or drug treatment will of course reduce demand for care and costs for health and social care.

Alcohol

It is known that alcohol is harmful to health and the CMO guidelines to reduce risk state that it is safest not to drink more than 14 units a week on a regular basis. And these should be spread over 3 or more days (29,30)

Alcohol is measured in units - one unit is 10ml or 8g of pure alcohol. Since drinks differ in the proportion of alcohol the number of units varies.

Alcohol drinks are often described as alcohol by volume percentage : some wines are 11% ABV - this means that a 1 litre bottle contains 11 units .

Therefore one 125 ml glass contains 1.64units : a 175 ml glass has 1.9 units and 250 ml glass has 2.5 units

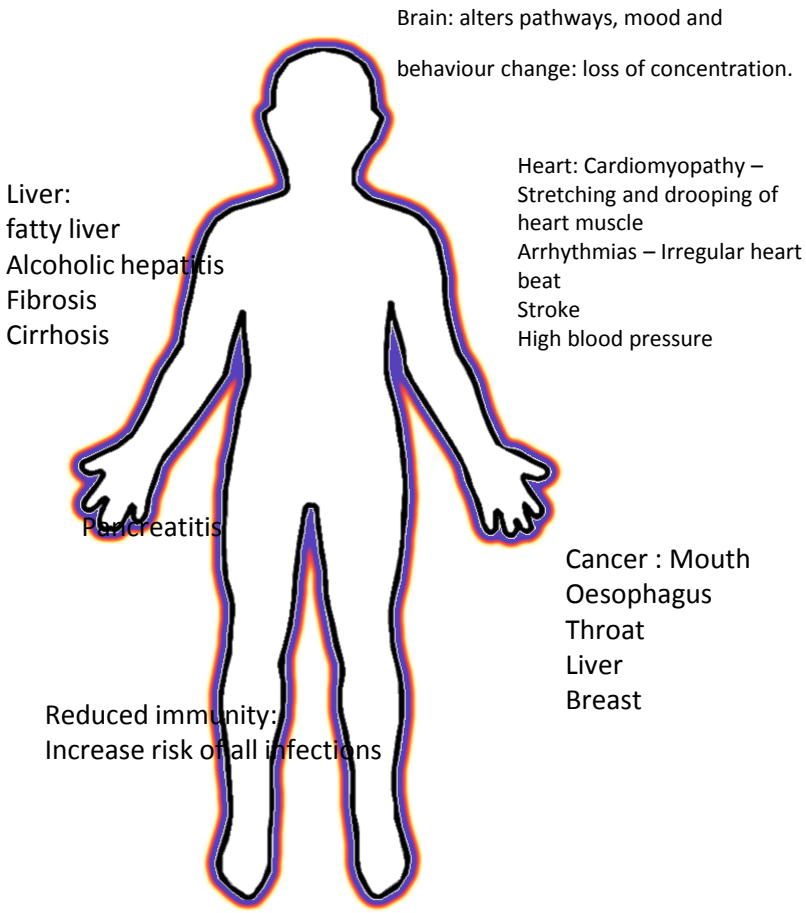
Beer : a pint of 4% beer has 2.3 units

(30)

To keep to safe limits an adult in a week should not drink more than :

331

Alcohol is the leading cause of death among 15 to 49 year olds and heavy alcohol use has been identified as a cause of more than 200 health conditions (31)



Alcohol

The economic burden of health, social and economic alcohol-related harm is substantial, with estimates placing the annual cost to be between 1.3% and 2.7% of annual GDP.

Currently over 10 million people are drinking at levels which increase their risk of harm to their health. .

- 5% of the heaviest drinkers account for one third of all alcohol consumed

Alcohol caused more years of life lost to the workforce than from the 10 most common cancers combined - in 2015 there were 167,000 years of working life lost (32)

Among those aged 15 to 49 in England, alcohol is now the leading risk factor for ill-health, early mortality and disability.

With increasing dose, there is increasing risk. For example, all alcohol-related cancers exhibit this relationship (33)

Condition		
	3 units of alcohol per day	6 units of alcohol per day
Liver disease	3 times	7 times
Mouth cancer	2.5 times	5 times
Throat cancer	1.8 times	3 times
Breast cancer	1.3 times	2 times
Hypertension	1.7 times	3 times
Ischaemic stroke	No change	2 times
Haemorrhagic stroke	1.8 times	3 times
Pancreatitis	1.3 times	2 times

The health and social harm caused by alcohol is determined by:

the volume of alcohol consumed

the frequency of drinking occasions

the quality of alcohol consumed

In addition a number of individual risk factors moderate alcohol-related harm, such as (34):

- age: children and young people are more vulnerable
- gender: women are more vulnerable
- familial risk factors: exposure to abuse and neglect as a child and a family history of alcohol use disorders (AUD)

Also in the English population, rates of alcohol-specific and related mortality increase as levels of deprivation increase and alcohol-related liver disease is strongly related to the socioeconomic gradient (32)

This despite the fact that lower socioeconomic groups often report lower levels of average consumption. This gives rise to what has been termed the 'alcohol harm paradox' whereby disadvantaged populations who drink the same or lower levels of alcohol, experience greater alcohol-related harm than more affluent populations. The reason for this is not known but may be due to a greater impact of alcohol due to lower resilience: possible higher rates of binge drinking or poorer access to services.

Public Health England has estimated the increase on average life expectancy for men and women if all alcohol-related deaths were prevented. Nationally, this would be 12 months for men and 5.6 months for women *Source: Alcohol Concern*, *Alcohol Harm Map*

Alcohol

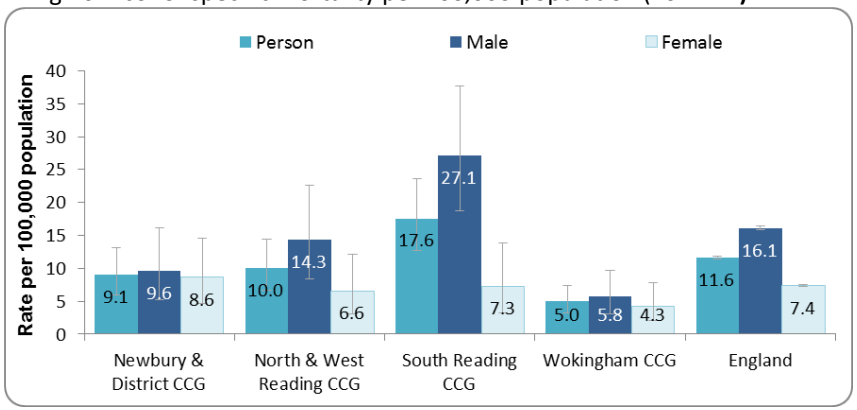
Cause of death	No. of deaths	Average age at death
All causes (England & Wales	501,424	77.6
All alcohol-specific causes	4,329	54.3
Mental and behavioural disorders due to use of alcohol	489	57.5
Toxic effects of alcohol (unspecified)	395	42.4
Accidental poisoning by exposure to alcohol	369	49.1

3.9% of all early death and poor health (DALYs) in the South East Region were attributable to alcohol use in 2013 (965 per 100,000 population).(12)

The largest number of DALYs attributable to alcohol use were for cancers, cirrhosis, mental and substance use disorders and unintentional injuries

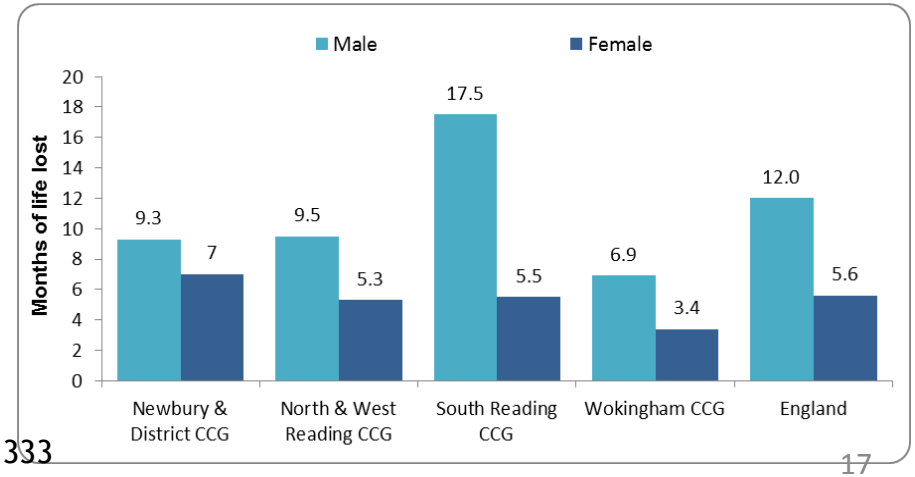
In 2012-14, 130 people died from alcohol-specific conditions in the 4 Berkshire West CCGs. 67% of these were men. The rate of deaths per 100,000 population varied in the area from 5.0 per 100,000 population in Wokingham CCG to 17.6 per 100,000 in South Reading CCG – with male deaths in South Reading being significantly higher. (14)

Fig 16 Alcohol-specific mortality per 100,000 population (2012-14)



If we look at the months of life lost due to alcohol locally then we can see a similar picture where men in South Reading lose 17.5 months – the biggest impact (15,17)

Fig17 Months of life lost due to alcohol (2012-14)

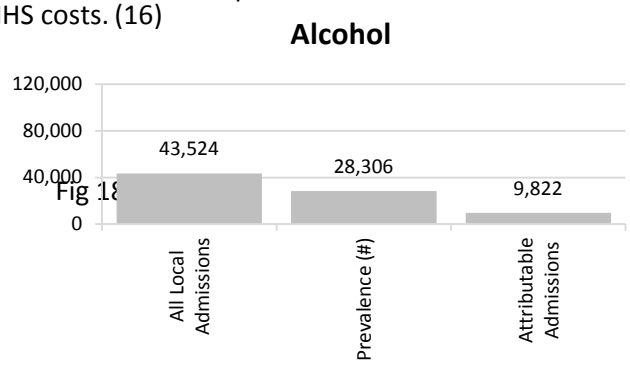


Source: Public Health England (2016); Local Alcohol Profiles for England

Alcohol

And with such an impact on early death and illness alcohol has a significant impact on hospital use. Nationally alcohol related and attributable admissions have been rising: According to the broad measure, admissions for cardiovascular disease account for almost half of all alcohol-related admissions in 2014/15. For the narrow measure, hospital admissions for cancer represent the most common condition for admissions accounting for 23% of all alcohol-related conditions

Within Reading Borough we can that there are over 28,000 at risk drinkers and that there are almost 10,000 admissions annually due to alcohol - not unexpected since alcohol accounts for 3% of all NHS costs. (16)



- Fig 18

The impact of alcohol in our society is driven by limited awareness of health risks from alcohol consumption; addictive nature of alcohol; failure of health professionals to address alcohol as a causal factor in patients' ill health and lack of local system join-up (34,31).

The public health ambition for alcohol is to reduce excessive alcohol consumption and therefore the associated burden on NHS and local authorities and wider society with consequent (31) :

Reduction in alcohol-related hospital admissions, re-admissions, length of stay and ambulance call-outs.

Reduction in the burden on NHS, police and social care services from high volume service users

Reduction in the impact of parental alcohol misuse on children

Much of the work on addressing alcohol needs to be done at a national level: continued media and awareness raising on safe alcohol consumption, national policy changes in minimum pricing, taxation and licensing of alcohol.

However there are key actions that can be taken forward locally:

Brief intervention and advice throughout health care that raise knowledge on safe alcohol levels screening patients and providing brief advice on alcohol consumption to cover potential harm and ways to reduce alcohol intake (21).

Alcohol care teams, which support patients admitted to hospital through alcohol with specialised support , coupled with assertive outreach and case management for patients and residents in whom alcohol is causing repeated hospital admissions or use of other services.

Physical Activity

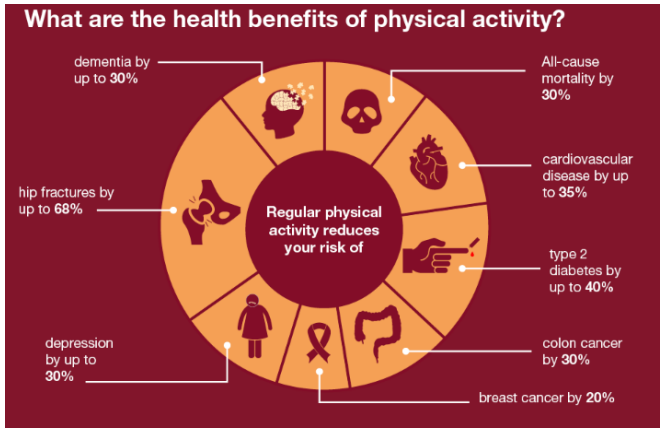
Physical activity is defined as any bodily movement produced by skeletal muscles that requires energy expenditure.

Physical activity levels can be measured either through asking people to report how much exercise they do, or by objectively measuring the amount of exercise a person is doing. Most reports use self reported activity

Physical inactivity is defined as less than 30 minutes of physical activity a week. The Chief medical Officer guidelines for physical activity not only suggest recommended activity levels but also recommend the amount of time in which we are sedentary, and encourage weight bearing exercise (35) .

The link between physical inactivity and obesity is well known, but physical activity is not, just a way of addressing obesity.

Low physical activity is one of the top 10 causes of disease and disability in England.



UK studies have estimated that around 1% of cancers in the UK (around 3,400 cases every year) are linked to people doing less than the recommended 150 minutes of physical activity each week.

1 in 8 women in the UK are at risk of developing breast cancer at some point in their lives By being active every day they could reduce their risk by up to 20% (36)

Physical activity is also important for people diagnosed with cancer and cancer survivors. Not only increasing ability to manage recovery but also reducing rate of recurrence in key cancers. Macmillan has estimated that in the 2 million cancer survivors in the UK - 1.6 million do not meet the recommended levels of physically active (37)

Physical Activity

In in 4 women and 1 in 5 men are inactive : only 24% of women and 34% of men do muscle strengthening exercises twice a week. Men are more likely to be sedentary for more than 6 hours a day(36).

Levels of activity are reducing : people in the UK are around 20% less active now than in the 1960s. This pattern is also seen in children and young people with the proportion who met the weekly physical activity guidelines falling between 2008 and 2012 . (36)

People living in in the least prosperous areas are twice as likely to be physically inactive as those living in more prosperous areas(38)

South East England has the highest proportion of both men and women meeting recommended levels of physical activity, while North West England has the lowest

Age

Physical activity declines with age to the extent that by 75 years only 1 in 10 men and 1 in 20 women are sufficiently active for good health21

Disability

Disabled people are half as likely as non-disabled people to be active

Only 1 in 4 people with learning difficulties take part in physical activity each month, compared to over half of people without a disability23

Race

Only 11% / 26% of Bangladeshi women and men are sufficiently active for good health, compared with 25% / 37% of the general population24

Sex Men are more active than women in virtually every age group, with 6 in 10 women not participating in sport or physical activity (38)

Sexual orientation and Gender Identity

- o Over a third of lesbian, gay, bisexual and transgender youth do not feel they can be open about their gender identity in a sports club26

Lack of physical activity is costing the UK an estimated £7.4 billion a year, including £0.9 billion to the NHS alone (36)

Inactivity causes 9% (range 5·1–12·5) of premature mortality, or more than 5·3 million of the 57 million deaths that occurred worldwide in 2008. (14)

Physical inactivity : developed countries is responsible for :
an estimated 22-23% of CHD,
16-17% of colon cancer,
15% of diabetes,
12-13% of strokes and
11% of breast cancer (16)

It is estimated that physical inactivity contributes to almost one in ten premature deaths (based on life expectancy estimates for world regions) from coronary heart disease (CHD) and one in six deaths from any cause.

Persuading inactive people (those doing less than 30 minutes per week) to become more active could prevent:
one in ten cases of stroke and heart disease in the UK and
one in six deaths from any cause.(38)

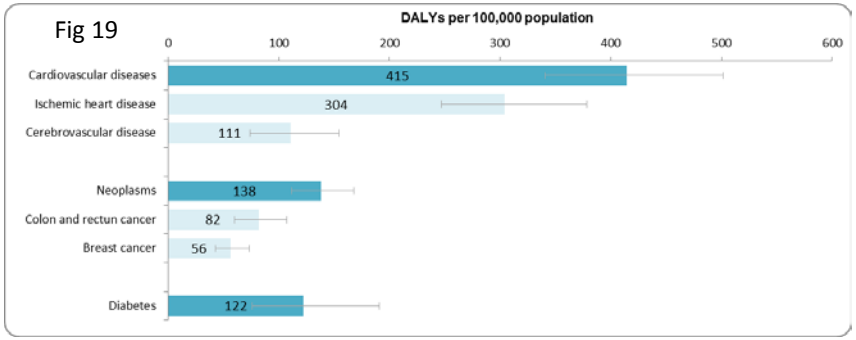
Physical activity: Interventions

In the UK the Global Burden of Diseases found physical inactivity and low physical activity to be the fourth most important risk factor in the UK for limiting illness and early death (x)

In the South East 2.8% of all disability-adjusted life years (DALYs) in the South East Region were attributable to low physical activity in 2013 (675 per 100,000 population).(12)

The largest number of DALYs attributable to low physical activity were for cardiovascular diseases, neoplasms and diabetes

Fig 19



The Health Impact of Physical inactivity (HIPI) tool quantifies the impact of physical inactivity for people aged 40 – 79.

Within Reading BC each year If 100% of this group were active then:

85 / 456 annual deaths could be prevented

15/72 annual cases of breast cancer could be averted

And 684 / 4855 new cases of diabetes could be prevented

A body of evidence now exists that links physical inactivity to increasing risk of hospital admission - emergency and other use of health and social care.. (39)

In Scotland it was shown that minutes of moderate-to-vigorous physical activity (MVPA) per day predicted subsequent numbers of prescriptions: those witgh less than 25 minutes of moderate to vigorous physical activity per day had 50 per cent more prescriptions over the following four to five years

Similarly the number of steps taken per day and MVPA also predicted unplanned hospital admissions. Those in the most active third of the sample were at half the risk of emergency hospital admissions than those in the low active group (40)

The solution is clear: *Everybody needs to become more active, every day*.(36)

Physical activity does not need to be strenuous , it can be a thirty minutes of brisk walking, a swim, gardening or dancing . Each ten-minute bout that gets the heart rate up has a health benefit . Being active is not just about moving more, we need to build our muscle strength and skills.

In addition adults need twice a week improves muscle strength and stability, which helps prevent the development of musculoskeletal disease.

A number of common characteristics are apparent in effective action to increase population levels of physical activity. These include two common factors: persistence and collaboration (40)

Four areas of action are identified by Public Health England, at national and local level.

- active society: changing our attitude to physical activity
- moving professionals: professionals across all sectors promoting activty in their work
- active lives: creating environments that make activity easy
- moving at scale: scaling up interventions that make us active

Obesity

Being overweight or obese is when a person has more body fat than is optimally healthy. Poor diet and physical inactivity are causal factors of obesity with excess weight being caused by an imbalance between energy consumed and energy expended

In the UK that is estimated to affect around one in every four adults and around one in every five children aged 10 to 11.

The annual costs associated with obesity to the NHS and social care systems are estimated to be £6.1 billion a year and £352 million

For most adults, a BMI of:

- 18.5 to 24.9 means you're a healthy weight
- 25 to 29.9 means you're overweight
- 30 to 39.9 means you're obese
- 40 or above means you're severely obese

Another simple measure of excess fat is waist circumference- men waist size of 94cm / 37in) or more
Women waist size of 80cm / 31.5in) or more a
more likely to develop obesity-related health problems

Obesity prevalence increased steeply between 1993 and 2000,. Rates of obesity and overweight were similar in 2013 to recent years.. H*ealth & Social Care Information Centre (2014); Health Survey for England 2013 (41)*

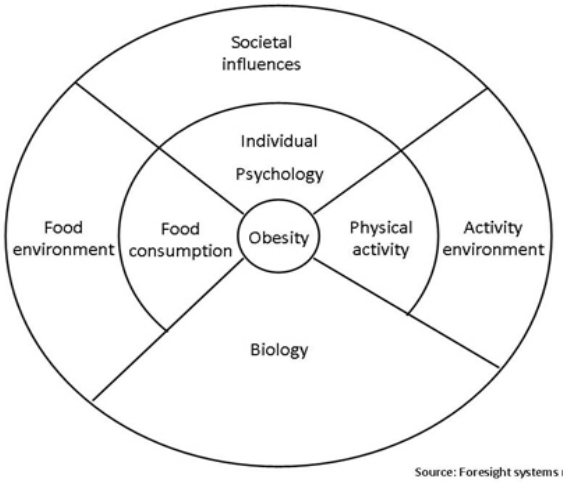
Mortality

9.0% of all deaths in South East England were attributable to a high body-mass index (GBD2013) . This was the 3rd most important risk (smoking and high blood pressure (14)

The impact of weight on life expectancy is linked to levels of excess weight

People with a BMI of 22 – 25 kg/m2 have the best life expectancy:
obese individuals live 2 – 4 years
People with BMI of over 40 - live 8 – 10 years less (42)

Increased mortality is as a result of :
higher rates of cardiovascular disease,
high BP and type 2 diabetes.
Hormone sensitive cancer - e.g breast

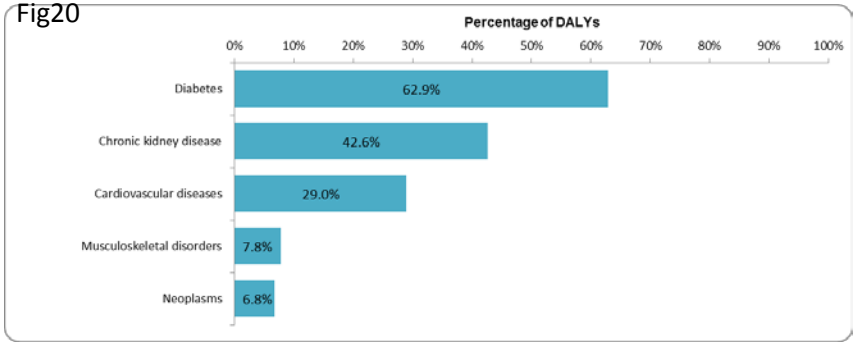


Source: Foresight systems map, 2007

Obesity: Local impact

Obesity causes 9 % of all DALY lost in the South East of England, with most overall impact being seen through cardiovascular disease and diabetes. But its impact as a cause of diabetes (63%), chronic kidney disease and cardiovascular disease due to high BP (56%) is very stark (14)

Fig20



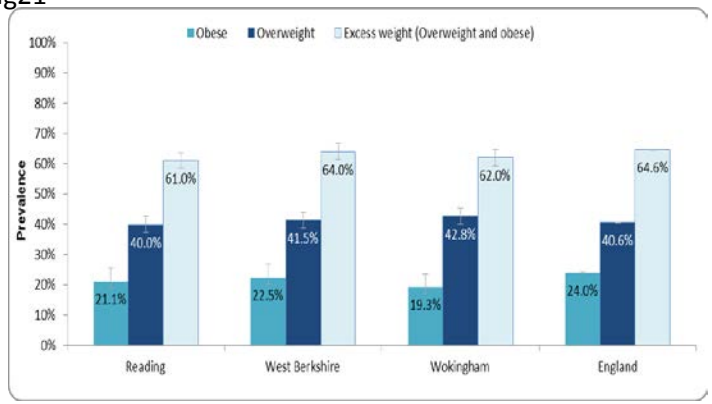
Obesity levels in the community are not uniform : obesity levels increase until late middle age and then reduce in old age. More women in communities with higher deprivation are obese . (NICE guidelines 2014)

Women from the in SEC group 1/ 2 have the lowest prevalence of obesity and those in SEC 4/5 consistently have the highest prevalence of obesity. (42,43). This is not seen in men, though for both men and women obesity is significantly reduced in those with a degree or equivalent.

Prevalence of obesity is highest in women from black African, Black Caribbean and Pakistani ethnic groups.

Locally in Reading we can see that we are below the national average with regards obesity levels . However this is not cause for complacency since this may in part be due to the lower age profile of the population in Reading since we know we have a younger age population and obesity increases with age. (42)

Fig21



In our children the figures are more worrying with 22% of children in reception being overweight or obese and 38% in year 6 (this matches and then exceeds the England average).

We would therefore expect that obesity has less of an impact on our adult hospital admissions - but even with our lower than average obesity levels approximately 1900 admissions in Reading have obesity recorded as part of the record each year , with just over 5,000 admissions being attributable to obesity (16).

Obesity: Interventions

Interventions to reduce obesity are less visible and accepted than others such as smoking cessation. There are a number of ways that can be adopted to reduce the burden of obesity for the individual and the community.

Our environments tend to promote obesity : encouraging high calorie food intake and physical inactivity. Local government partners , employers and communities can work together to change this. Promoting active travel and ensuring healthy food options in work are two examples of work to address our environment.

In addition we can improve weight management services, however the first step is for professionals to raise the issue of weight at every opportunity. There is evidence that professional believe programmes to have no lasting impact. However the evidence from published research is that interventions do work , with community based approaches being more effective than those based in primary care (44). However primary care increases the effectiveness of community approaches through discussion and referral. People referred via primary care had greater weight loss (45) -> 50%, but even just mentioning weight loss as part of a consultation results in weight loss still seen at 2 years.

A brief intervention, resulting in 1.5 kg weight loss, delivered once a year to all eligible people visiting their GP, could halve the prevalence of obesity by 2035

One other reason given for reluctance to refer is the believe that impact is short lived, whilst weight does gradually increase weight loss is still seen at 2 years and crucially even in patients who regain their weight the incidence of diabetes is significantly reduced at 10 years - the impact of the weight loss outlives the actual weight loss (47)

Furthermore Health professionals do not routinely address weight loss issues as some voice concern about the impact of the topic on the clinical relationship. However research shows that patients less than 2% of people found it to be not acceptable or unhelpful (46) and over 40% very helpful. Moreover 77% accepted the referrals to weight management services and nearly 50% completing the course

Recent evidence shows the cost benefits of weight management services even in the short – medium term. The net health and care savings: over a 5 year period, are c£30 p.a. per person enrolled (ie cumulative saving of c£150 per person over 5 years). This intervention could be cost saving to the health and care system by year 2. (21).

But it should be remembered that weight management interventions aim to have lifelong benefits.

Locally in Berkshire the second year of Eat for Health 529 people have attended courses with more than 50% more than 3% of their weight .

Of the 197 people with high BP attending , in 55 (28%) residents losing weight resulted in their BP returning to normal levels with no need for ongoing medication and significant on going health benefits.

References

1 A brief history of life expectancy in Britain *by tim lambert*

2 Statistical bulletin : Avoidable mortality in England and Wales: 2014

3 LOCAL

4 *11 Source: Buck, D et al (2012); Clustering of unhealthy behaviours over time: Implications for policy and practice; The King's Fund*

5 Purdey S[1], Huntley A. Predicting and preventing avoidable hospital R Coll Physicians Edinb 2013; 43:340–4

6 Understanding poor health behaviours as predictors of different types of hospital admission in older people: findings from the Hertfordshire Cohort Study Holly E Sydell, PhD,[1] Leo D Westbury, MSc, Shirley J Simmonds, MSc, Sian Robinson, PhD, Professor of Human Nutrition, Cyrus Cooper, DM FRCP FMedSci, Professor of Rheumatology, Director,[1,2,3] and Avan Aihie Sayer, PhD FRCP, Professor of Geriatric Medicine[1,2,4,5,6]

7 Effects of self-care behaviours on medical utilization of the elderly with chronic diseases - A representative sample study.

Chen IH[1], Chi MJ[2].

8 CRUK website - lifestyle impacts

9 Hart CL, Morrison DS, Batty GD, Mitchell RJ, Davey Smith G. Effect of body mass index and alcohol consumption on liver disease: analysis of data from two prospective cohort studies. BMJ. 2010;340:c1240.

10 Tuyns AJ, Esteve J, Raymond L, Berrino F, Benhamou E, Blanchet F, et al. Cancer of the larynx/hypopharynx, tobacco and alcohol: IARC International Case–control Study in Turin and Varese (Italy), Zaragoza and Navarra (Spain), Geneva (Switzerland) and Calvados (France). Int J Cancer. 1988;41:483–91.

11NHS digital report on smoking cessation services

12 Effect of tobacco smoking on survival of men and women by social position: a 28 year cohort study *BMJ 2009; 338 doi: http://dx.doi.org/10.1136/bmj.b480 (Published 18 February 2009) Cite this as: BMJ 2009;338:b480* Laurence Gruer, Carole L Hart, David S Gordon,, Graham C M Watt,

13*Law M, Morris J. Why is mortality higher in poorer areas and in more northern areas in England and Wales? J Epidemiol Community Health1998;52:344-52*

14 Global Burden Of Disease 2015

15 Berkshire shared service report on lifestyle and DALYS

16 PHE attributable admissions analysis 2106 KIT

17 PHOF outcomes

References

18 Tobacco Control (Wu et al, 2014)

19 *The Cost of Smoking to the Social Care System in England* January 2017, ASH in 2014 Carole L Hart, research fellow, David S Gordon, Graham C M Watt,

20 Local tobacco profiles and Berkshire contract data

21 PHE menu of interventions

22British Hyper tension society

23 Blood pressure lowering for prevention of cardiovascular disease and death: a systematic review and meta-analysis
Dena Ettehad,Connor A Emdin,Amit Kiran,Simon G Anderson,Thomas Callender,Jonathan Emberson,,
Prof John Chalmers,Prof Anthony Rodgers, Prof Kazem Rahimi, http://dx.doi.org/10.1016/S0140-6736(15)01225-8

24 *Effect of social deprivation on blood pressure monitoring and control in England: a survey of data from the quality and outcomes framework* Mark Ashworth,Jibby Medina,, Myfanwy Morgan, *BMJ 2008;337:a2030*

25 Prevalence, awareness, treatment, and control of hypertension in rural and urban communities in high-, middle-, and low-income countries CK Chow, KK Teo, S Rangarajan, S Islam, R Gupta… JAMA. 2013;310(9):959-968. doi:10.1001/jama.2013.184182

26 PHE longer lives

27 British Heart foundation : how can we do better CCG profile 2016

28 Lifestyle modifications to lower or control high blood pressure: is advice associated with action? The behavioral risk factor surveillance survey.Viera AJ[1], Kshirsagar AV, Hinderliter AL.

29 UK CMO guidelines on alcohol intake 2016

30 Drinkaware.co.uk

31 The Public Health Burden Of Alcohol: Evidence Review

32 Bagnardi V, Rota M, Botteri E, Tramacere I, Islami F, Fedirko V, et al. Alcohol consumption and site specific cancer risk: a comprehensive dose-response meta-analysis. Br J Cancer. 2015;112:580–93.

33 National Cancer Institute

References

34 Global status report on alcohol and health World Health Organization; 2014

35 Health matters: getting every adult active every day July 2016

36 Everybody Active Everyday PHE UK

37 Macmillan UK cancer and physical activity

38 Physical Activity Statistics 2015 British Heart Foundation Centre on Population Approaches for Non-Communicable Disease Prevention. Nuffield Department of Population Health, University of Oxford

39 Disease activity and low physical activity associate with number of hospital admissions and length of hospitalisation in patients with rheumatoid arthritis George S Metsios Antonios Stavropoulos-Kalinoglou, Gareth J Treharne, Alan M Nevill, Aamer Sandoo, Vasileios F Panoulas, Tracey E Toms, Yiannis Koutedakis and George D Kitas

40 Objectively Assessed Physical Activity and Subsequent Health Service Use of UK Adults Aged 70 and Over: A Four to Five Year Follow Up Study Bethany Simmonds , *fox, davies, powen ku, gray et al

41 HSCIC Health survey England 2013

42 NOO : Obesity And Health Matters 2016

43 General household survey 2014

44 Meta analysis of weight intervention Hartmann-Boyce, Johns, Jebb, Summerbell, Aveyard. Obes Rev. 2014 Nov;15(11):920-32

45 Jebb et al Lancet. 2011;378(9801):1485-92

46 DPP. Lancet, 14 (2009), pp. 1677–1686

47 *Ettehad et al 2016:

http://dx.doi.org/10.1016/S0140-6736(15)01225-8 Dta - NHS digital 2015

343