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To: All members of the Health & Wellbeing Board

(Agenda Sheet to all Councillors)

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28 September 2017

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**NOTICE OF MEETING – HEALTH & WELLBEING BOARD – 6 OCTOBER 2017**

A meeting of the Health & Wellbeing Board will be held on **Friday 6 October 2017 at 2.00pm in the Council Chamber, Civic Offices, Reading.** The Agenda for the meeting is set out below.

**AGENDA**

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**12. ESTABLISHING CLINICAL RESPONSE FOR ADULTS WHO HAVE SUFFERED FEMALE GENITAL MUTILATION (FGM)** 134

A report giving an update on the clinical response to adults who have experienced FGM.

**13. BETTER CARE FUND SUBMISSION & PERFORMANCE UPDATE** 136

A report providing the Board with an update on the progress of the Better Care Fund (BCF) submission and BCF performance.

**14. READING'S ARMED FORCES COVENANT AND ACTION PLAN –UPDATE ON WORK BEING DONE WITH GP PRACTICES RE REGISTERING VETERANS** 150

A report giving an update on work being done with GP practices regarding registering Veterans.

**15. SEASONAL INFLUENZA CAMPAIGN PERFORMANCE 2016-17** 151

A report on the performance of the influenza (flu) vaccine campaign in winter 2016-17 to summarise lessons learned and to inform the Board of changes to the national flu programme for the coming flu season and how these will be implemented in the Berkshire Local Authorities Winter Flu Plan 2017-18.

**16. PHARMACEUTICAL NEEDS ASSESSMENT UPDATE** 289

A report giving an update on the Pharmaceutical Needs Assessment (PNA) that is currently underway.

**17. DATE OF NEXT MEETING:** -

Friday 19 January 2018 at 2pm

# READING HEALTH & WELLBEING BOARD MINUTES – 14 JULY 2017

**Present:**

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| Councillor Hoskin (Chair) | Lead Councillor for Health, Reading Borough Council (RBC) |
| Councillor Eden | Lead Councillor for Adult Social Care, RBC |
| Councillor Gavin | Lead Councillor for Children's Services & Families, RBC |
| Councillor Lovelock | Leader of the Council, RBC |
| David Shepherd | Chair, Healthwatch Reading |

**Also in attendance:**

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| Corinne Dishington | Children's Centres Team Manager, RBC |
| Jo Hawthorne | Head of Wellbeing, Commissioning & Improvement, RBC |
| Jill Marston | Senior Policy Officer, RBC |
| Tony Marvell | Integration Programme Manager, RBC/CCGs |
| Maureen McCartney | Operations Director, North & West Reading CCG(CCG) |
| Lyndon Mead | Accountable Care System Programme Manager, Berkshire West CCGs |
| Melissa Montague | Public Health Programme Officer, RBC |
| Janette Searle | Preventative Services Manager, RBC |
| Mandeep Sira | Chief Executive, Healthwatch Reading |
| Nicky Simpson | Committee Services, RBC |
| Kim Wilkins | Public Health Programme Manager, RBC |

**Apologies:**

| | |
|---|---|
| Andy Ciecierski | Chair, North & West Reading CCG |
| Ann Donkin | Sustainability and Transformation Plan Programme Director, Oxfordshire CCG |
| Eleanor Mitchell | Operations Director, South Reading CCG |
| Sarita Rakhra | Commissioning Manager, Berkshire West CCGs |
| Elaine Redding | Interim Consultant, Safeguarding & Improvement, RBC |
| Councillor Stanford-Beale | RBC |
| Bu Thava | Chair, South Reading Clinical Commissioning Group |
| Graham Wilkin | Interim Director of Adult Care & Health Services, RBC |
| Cathy Winfield | Chief Officer, Berkshire West CCGs |
| Judith Wright | Strategic Director of Public Health for Berkshire |

## 1. MINUTES

The Minutes of the meeting held on 24 March 2017 were confirmed as a correct record and signed by the Chair.

## 2. QUESTION IN ACCORDANCE WITH STANDING ORDER 36

The following question had been submitted by Tony Cowling in accordance with Standing Order 36. In his absence, a written reply was provided.

**Men Dying Young in Reading**

Why do men in Reading die younger than in any other town or city in the UK? (What is different about Reading?) I would like to see some effort being put in to sorting out why this is and some actions to mitigate the cause(s).

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

On average, men in Reading are expected to enjoy good health to the age of 66.4 years (CI 64.7-68.1). This is significantly better than the England average of 63.4 years and better than most similar Local Authority areas. Healthy life expectancy in Reading has remained consistently above the England average for the last five years.

The Slope Inequality Index in healthy life expectancy suggests a man living in the most well off areas of Reading could expect to live 12.8 years longer than a man in one of Reading's most deprived neighbourhoods (CI 9.4-16.2). The gap is 13.5 for women (CI 14.7-18.5). This is less than the gap seen between the most and least deprived local authority areas nationally (18.9 years for men and 19.6 years for women).

You are correct that premature mortality is an issue in Reading particularly amongst men.

Men in Reading have a life expectancy at birth of 78.7 years (Confidence interval 78.1-79.3) and those aged 65 can be expected to live for another 18.3 years on average (Confidence Interval 17.9-18.1). These are both significantly worse than the England average of 79.5 years at birth and 18.7 years at age 65, although not the worst in the UK (men in Blackpool have the lowest life expectancy at birth in England of 74.3 (CI 73.7-74.9) and men in Manchester aged 65 can be expected to live for another 15.8 years on average (CI 15.6-16.1).).

The mortality rate from preventable causes for males in Reading is 252.8 per 100,000 (CI 228.1-279.5), higher than the England average of 232.5 per 100,000 although not significantly so, but, again, not the worst in England (again, Manchester and Blackpool have the highest rates at 409.4 and 387.1 per 100,000 respectively).

The rates of premature mortality linked to cardiovascular disease and liver disease in men in Reading have consistently exceeded the national averages, although in some periods the differences have not been statistically significant. In the most recent period the number of men committing suicide in Reading has increased (rising from 33 in 2012-14 to 38 in 2013-15).

There is strong evidence that those living in more deprived areas are more likely to die prematurely and more likely to be affected by disability. Prevention interventions, especially those focusing on increasing physical activity and improving diet and weight management, reducing smoking and alcohol use are likely to be effective in addressing many of the common causes of disability and premature death.

Our latest Health and Wellbeing Strategy sets out how, over the next three years we aim to tackle some of the above issues, and how we aim to promote healthy lifestyles in a variety of settings so that every Reading resident has a chance to maximise their health and quality of life. We will focus on actions that:

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

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

Maureen McCartney submitted a copy of a presentation by the Buckinghamshire, Oxfordshire and Berkshire West Sustainability and Transformation Plan (BOB STP) Programme Director giving an update on the NHS BOB STP, similar to one which had been submitted to the Adult Social Care, Children's Services and Education Committee on 6 June 2017. The presentation covered the STP's background, footprint, finances, priorities, programme management, progress to date and next steps.

The presentation explained that the BOB five year STP set out the challenges and opportunities that the NHS and care services across the area faced. It showed how the NHS would work together to improve health and wellbeing within the funds available. The BOB STP was one of 44 STPs in England. The BOB STP area included six NHS Trusts, seven CCGs and 14 local authorities. Although the STP covered a large area the emphasis of the majority of proposals was on what could be achieved locally. However, the BOB STP was one of the largest 'non metropolitan' footprints in England.

The BOB STP approach was to develop STP plans in local systems where it made sense with key partners, and Maureen McCartney noted that the vast majority of work in Berkshire West would continue to be done at Berkshire West- or Reading-specific levels, but there would be a BOB-wide focus to include the following:

- Shift the focus of care from treatment to prevention;
- Access to the highest quality primary, community and urgent care;
- Collaboration of the three acute trusts to deliver quality and efficiency;
- Maximise value and patient outcomes from specialised commissioning;
- Mental Health development to improve the overall value of care provided;
- Establish a flexible and collaborative approach to workforce;
- Digital interoperability to improve information flow and efficiency.

Recent action and next steps included the following:

- In March 2017 NHS England and NHS Improvement had published a national Five Year Forward View delivery plan;
- The first quarter 2017 STP delivery plan was in development and incorporated the 2017/18 and 2018/19 CCGs and Trust two year operational plans;
- Formal consultations on significant variations in the range and location of services had commenced/continued, eg The Oxfordshire Transformation Programme;

- From April 2017 onwards implementation of the NHS Five Year Forward View had continued;
- In June 2017, an executive search process had been undertaken to appoint an STP lead via a competitive recruitment process with formal appointment anticipated in late summer;
- On 15 June 2017 both Buckinghamshire and Berkshire West had been confirmed by NHS England as first wave Accountable Care Systems.

David Shepherd and Mandeep Sira referred to the Stakeholder Engagement processes, noting that the STP was very Oxford-centric, and that the Healthwatches were set up with local rather than regional remits and had limited resources, so if for example Oxfordshire Healthwatch was on a forum or received communications about BOB STP matters, it was not necessarily possible for this work or information to be shared across other BOB Healthwatches.

Councillors Eden and Hoskin noted the £500m funding gap for health services by 2020/21 under the 'do nothing' scenario that was referred to in the presentation and expressed concern that until details of the cuts therefore required were known, health and social care partners could not plan for and mitigate against the effects of those cuts and there was uncertainty for both residents and organisations. They noted that the Adult Social Care, Children's Services and Education Committee was looking to be involved in scrutinising the plans once they were available, that it was important for there to be appropriate governance and accountability to local people, and that the Council would want to be involved in public consultation on the proposals as soon as possible. Lyndon Mead noted that the Berkshire West Accountable Care System would be looking at its share of the potential deficit and how this could be closed at a meeting in the following week.

**Resolved -** That the presentation be noted.

## 4. BERKSHIRE WEST ACCOUNTABLE CARE SYSTEM

Lyndon Mead submitted a presentation giving an update on the development of the Berkshire West Accountable Care System (ACS).

The presentation gave the history to partnership working in the health and social care system and explained that Local Authorities (LAs) had identified the opportunity to develop a joint commissioning function. Health partners had identified the opportunity to explore new models of delivery based on a single budget for the whole health system, with the ultimate aim to have a single programme for the whole health and care system delivering new care models and new business models - an Accountable Care System. The reporting mechanism for the ACS and LA joint commissioning programme would be via the Berkshire West 10 governance and through to Health and Wellbeing Boards.

In 2016, local NHS partners (the four Berkshire West CCGs and the two local NHS providers, Royal Berkshire NHS Foundation Trust (RBFT)and Berkshire Healthcare NHS Foundation Trust) had applied to NHS England for a system control total and in June 2017, the Berkshire West ACS had been selected as one of only eight systems nationally to operate as an ACS in shadow form for 2017/18, awarded 'exemplar' status.

The presentation explained why an ACS was needed, due to financial and demand challenges, different parts of the health system currently being funded differently and the commissioner/provider split creating unhelpful consequences for joint planning of patient care and managing the "Berkshire West Pound".

An ACS would provide a more collaborative approach to the planning and delivery of services with collective responsibility for resources and population health, operating on a single budget for the whole health care system, with funds following the patient to support pathway and service redesign. It would be underpinned by a system financial model, managing risk and aligning incentives, with organisations working more closely in partnership, with system-wide governance arrangements. This should provide joined-up, better-coordinated services with more control and freedom over the total operations of the health and social care system in the area.

The ACS would involve new ways of working, including: shared, non-statutory governance; joint clinical improvement projects; a system control total for financial management; a cost-recovery model rather than volume; a stronger voice for primary care, and would enable further social care integration. The ACS would fit within the well-established health and social care Berkshire West 10 integration programme which oversaw joint investments and improved system working, the ACS members were part of the BOB STP and they would also continue to work with partner organisations at the Thames Valley level to plan for and deliver services effectively at larger scales.

The presentation gave details of progress to date, stating that new governance arrangements had been established in June 2016 and for 2017/18 a marginal rate with RBFT had been introduced to share risk. A stocktake had been undertaken, as part of the Five Year Forward View, of Accident & Emergency, Mental Health, Cancer and Primary Care services, and the ACS Transformation Programme had commenced, setting up new care models and new business models. The work of the ACS overlapped with the joint Berkshire West 10 programme and the two together formed a health and social care transformation continuum.

The High Intensity Users Project was given as an example of a new care model, looking at how better to manage the healthcare needs of patients who used systems a lot. Representatives from the hospital, GPs, mental health services and the police were looking at how to de-medicalise the issues, for example by looking at coaching for the patients involved.

The next steps for the ACS would be to agree a performance contract with NHS England, get transformational funding for the ACS and start managing to a system pound control total, with collective decision-making and governance. The ACS would work with emerging primary care providers, and in year two it was planned to start to bring the Berkshire West 10 and the ACS together. Nick Carter, Chair of the Berkshire West 10 Integration Board, was joining the ACS Leadership Group to provide a link between the two programmes. Lyndon reported that the template for the performance contract was being signed off nationally in the current week, but targets and funding were not yet known.

The presentation listed the areas in which the ACS would have implications for the way things worked, including: partnerships within the ACS and horizontal networks with other health providers; a new approach to the independent sector; an integrated health and local government system-wide strategy for clinical, digital, estates and

workforce; combined teams/shared leadership, being agnostic about "who" and "where"; a single-system view of performance and quality; fundamental changes in the commissioner/provider relationship; and collective, clinically-led decision making on optimal care models/pathways and allocation of the Berkshire West Pound.

By moving to an ACS model it was planned to: work more collaboratively to transform services such as Outpatients; cover the challenge of lower real-terms allocations; ensure each organisation had a stake in the system financial position rather than each constituent standing alone; better position the local NHS for wider integration opportunities with local government; provide Primary Care with a greater platform in the design and evolution of service models; and flow resource to the parts of the system where it was needed, such as primary and social care.

During the discussion on the ACS, the points made included:

- The people of Berkshire had not yet been told the details of the system. There were patient representatives on joint working groups, but patient involvement was also needed at higher levels. The ACS was at an early stage of development and it was acknowledged that it would be important to engage with patients and the voluntary sector, so that it was communicated clearly what the new system would mean for them.

- Concern was expressed that a lower control total was going to mean cuts and also about how open and transparent the details of the financial control total would be. There had been limited public engagement so far, and it would be important to not just look at clinical governance, but to engage people in designing services. The local authority could assist through its existing systems and local knowledge , for example in reaching people for consultation, such as getting in touch with parents through libraries.

- It was clarified that, whilst there had been discussions about the future of health and social care, Reading social care had not yet joined the ACS, further discussions were needed about local democratic accountability, and it would be important for there to be a Reading Borough Council representative at the ACS meetings to help with communication and get genuine partnership working.

- It was agreed that it was an appropriate time to expand the ACS Leadership Group membership to include local authority representatives and that this would be raised at the Group's next meeting.

- It was suggested that it was unhelpful to describe people as patients and there should be a change in focus in health to seeing residents as people rather than just patients, and to make links with the wider community, the voluntary sector and public health.

- Opportunities for public involvement and co-production would best be achieved by working together but it was noted that there had been limited opportunities for feedback so far.

**Resolved -**

(1) That the progress by local NHS organisations towards the establishment of an Accountable Care System be noted;

(2) That it be noted that, whilst Reading Borough Council had yet to take a decision on whether, and in what way, it might become involved in the ACS, it was committed to exploring further opportunities for integrated services with Health where this would be to the benefit of Reading residents.

## 5. MEETING THE NEEDS OF VULNERABLE PEOPLE IN READING: JOINT LOCAL AUTHORITY/CCG RESPONSE TO FINDINGS OF HEALTHWATCH READING

Janette Searle submitted a report setting out the joint response of Reading Borough Council (RBC), and North and West Reading Clinical Commissioning Group and South Reading Clinical Commissioning Group ('the Reading CCGs') to the report presented by Healthwatch Reading to the 24 March 2017 meeting of the Reading Health and Wellbeing Board on 'Meeting the needs of vulnerable people in Reading' (Minute 8 refers).

The report explained that the Healthwatch report had summarised the observations of 13 local voluntary sector organisations on delivering services to vulnerable adults in the current economic climate and had invited the statutory commissioner members of the Health and Wellbeing Board to consider, amongst other things, how more effective joint working could help to address some of the issues raised in the report.

The report listed the eight findings of the Healthwatch report and set out the joint responses to the findings from RBC and Reading CCGs. It noted that Reading needed a sustainable and thriving third sector to help meet the challenges ahead, that the sector was operating under pressure currently, and that the Healthwatch report had highlighted the reasons for needing to work together across statutory and third sector services to pool resources for residents' benefit.

**Resolved -**

That the joint response be noted and Healthwatch Reading be asked to share it with those organisations which had contributed to the 'Meeting the needs of vulnerable people in Reading' report presented to the Board on 24 March 2017.

## 6. HEALTHWATCH REPORT: HOW HOMELESS PEOPLE IN READING EXPERIENCE HEALTH CARE SERVICES

David Shepherd and Mandeep Sira submitted a report presenting the findings of a project carried out by Healthwatch Reading collecting information on how homeless people in Reading experienced Health Care Services.

The report explained that members of the public had told Healthwatch that they were concerned about an apparent rise in the number of homeless people in Reading. Healthwatch was committed to ensuring that 'unheard groups' got the chance to describe their experiences of local health and social care services in the same way as other citizens and so it had run an engagement project with homeless people.

Healthwatch had also wanted to collect experiences that could complement the findings of a Reading health audit of homeless people, led by Reading Borough Council

and carried out in January-March 2017 (the findings from which were yet to be published), and so it ran focus groups in parallel to the audit, to elicit more personal stories and experiences to complement the audit findings.

The project involved Healthwatch meeting and collecting experiences of 19 people in three focus groups, each lasting one hour, at community locations used by those clients. A £10 Tesco voucher had been offered to people for their time and involvement (an engagement method used in past projects). Participants had given their consent for Healthwatch to take photos and share their stories.

The main findings from the project were:

- Access to dental care was the most common and significant problem and evidence was heard of people removing their own teeth.

- Access to timely appointments with a known GP was difficult (which echoed concerns of the general population from Healthwatch's 2016 primary care project). People could also run out of phone credit while on hold to surgeries. People appreciated reception staff (such as those at the Reading NHS Walk-In Centre) who showed them respect regardless of their circumstances.

- Administration problems (such as last-minute outpatient appointment cancellations) were an issue for people using hospitals. Again, this was a problem also reported to Healthwatch previously by the general population. People also described issues with hospital discharge, and some felt they were denied painkillers due to assumptions about being 'addicts'.

- Sporadic Internet access meant some people could not access up-to-date information or might miss the benefits of online services.

The report urged NHS and social care commissioners to use the findings, together with results of the RBC health audit (due out later in 2017), to inform how they would address care gaps, and consider innovations such as mobile dentistry services.

Maureen McCartney said that the CCGs welcomed the report and would respond to the issues raised regarding the services they commissioned. She reported that she had spoken to the Practice Manager at the Western Elms Surgery, which had a protocol for registration which could be shared as good practice with other GP surgeries and the CCGs would facilitate appropriate discussions.

Jo Hawthorne noted that poor dental health was a problem for people in poverty generally as well as those who were homeless and that Public Health was coming to the end of a two year survey of child oral health it had commissioned, which she expected also to show poor oral health linked to deprivation. NHS England commissioned dental services, rather than RBC or the CCGs, so this issue needed looking at in more detail to see how change could be effected, using information from the Healthwatch report, the child oral health survey and the CCGs.

**Resolved -**

(1) That the report be noted and commissioners use the findings and recommendations to inform how care gaps could be addressed;

(2) That Jo Hawthorne investigate further the issues of dental care in Reading, including those issues raised in the report, once the results of the child oral health survey were known.

## 7. HEALTHWATCH READING ANNUAL REPORT 2016/17

David Shepherd and Mandeep Sira submitted the 2016/17 Annual Report for Healthwatch Reading, which gave details of the work carried out by Healthwatch Reading in 2016/17.

The report outlined the mission of Healthwatch Reading and gave details of Healthwatch Reading's priorities in 2016/17, which had focused on:

1. Empowering people to share feedback, complain or have their voice heard, by working with individuals, the local voluntary and community sector, and statutory partners. In 2016-17 Healthwatch Reading had engaged with more than 1,600 local people through a range of projects, including a week-long exercise in the emergency department of Royal Berkshire Hospital, a survey in pharmacies and GP practices, on people's experiences of electronic prescribing, and ongoing evidence-gathering from some of the 17,000 patients affected by underperformance at two local GP surgeries.

2. Ensuring everyone had an equal voice by working with the diverse community of Reading to understand how they experienced local services. This included understanding the needs of people with learning disabilities, mental health needs or in old age, refugees and those in poverty, by convening a roundtable of local charities who provided frontline support to the most vulnerable people in society. Healthwatch Reading had also developed relationships with BME organisations such as Jeena.

3. People being involved in shaping services for today and the future. Healthwatch Reading had brought a public perspective as new services were developed, through involvement in a local End of Life Care steering group, and also campaigned for better communication about transformation of services, through its seats on the Berkshire West Primary Care Commissioning Committee, Berkshire West A&E Delivery Board, and Reading Integration Board.

The report also gave details of how experiences were gathered, what had been learnt from visiting services and how Healthwatch had made a difference, how it had provided advice and information, worked with other organisations, championed the role of public involvement and involved local people in its work. It also set out plans for the work of Healthwatch Reading in 2017/18.

It was reported at the meeting that Healthwatch Reading had discovered on 7 July 2017 that they were winners of the 'Engagement in Service Change' category of Healthwatch England's annual awards 2017, for the project on why people went to the Emergency Department of the Royal Berkshire Hospital.

**Resolved -**

(1) That the report be noted;

(2) That the Health and Wellbeing Board's thanks to the Healthwatch Reading team for their work, and congratulations for their award, be recorded and passed to the team.

## 8. A HEALTHY WEIGHT STATEMENT FOR READING – IMPLEMENTATION PLAN UPDATE

Further to Minute 11 of the meeting held on 27 January 2017, Melissa Montague submitted a report giving an update on the development of an implementation plan for the Healthy Weight Strategy for Reading. The report had appended a draft Healthy Weight Strategy Action Plan.

The report explained that the Healthy Weight Statement for Reading had been endorsed by the Health and Wellbeing Board on 27 January 2017. Between March and June 2017, a multi-agency task and finish group had held four meetings to further develop the implementation plan, which set out actions to deliver on the key areas listed below, both through work led by the Council and that of partners:

- 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 to help family members be a healthy weight.
- Supporting/encouraging teenagers to eat healthily and have active lifestyles.

Since its establishment, the multi-agency task and finish group had already been instrumental in overseeing and driving forward progress across these key areas, and the report highlighted areas of progress.

**Resolved -**

(1) That the implementation plan, which had been developed with partners to deliver against the priorities set out in the Healthy Weight Statement, be endorsed;

(2) That a further report giving an update on progress on the Healthy Weight Strategy Implementation Plan be submitted to the Board in 12 months' time.

## 9. URGENT AND EMERGENCY CARE DELIVERY PLAN

Maureen McCartney submitted a report on plans for a modernised and improved Urgent and Emergency Care Service as described in the "Urgent and Emergency Care Delivery Plan" which had been published by NHS England in April 2017.

The report listed the seven key areas of change set out in the plan and set out, where appropriate, a summary of the steps which had been taken locally to date to support the delivery of the plan. The seven areas were:

1. NHS Online in 2017

2. NHS 111 – Increase the number of 111 calls receiving clinical assessment to a third by March 2018, so that only patients who genuinely needed to attend A&E, or use the ambulance service, were advised to do this.
3. Expanding evening and weekend GP appointments to 50% of the public by March 2017, then 100% by March 2019
4. Roll out of around 150 standardised 'urgent treatment centres' to offer diagnostic and other services to patients who did not need to attend A&E
5. Comprehensive front-door clinical screening at every acute hospital by October 2017
6. Hospital to Home: Hospitals, primary care, community care and local authorities working together to address delayed transfers of care
7. Ambulances: Implementing the recommendations of the Ambulance Response Programme by October 2017

The report explained that the Berkshire West A&E Delivery Board was responsible for developing and ensuring implementation of a local action plan in response to the requirements of the Delivery Plan. There was also an STP-wide Urgent & Emergency Care Plan currently being developed to deal with those aspects that required a BOB-wide (Berkshire West, Oxfordshire and Buckinghamshire) response. These were primarily around ambulance services and NHS 111 and were listed in the report.

The report stated that the local A&E Board had had a workshop in June 2017 to develop the local plan and the final version of the Berkshire West Delivery Plan would be presented to the October 2017 meeting of the Health and Wellbeing Board.

**Resolved -**

That the report, and the fact that the final version of the Berkshire West Urgent and Emergency Care Delivery Plan would be presented to the next meeting, be noted.

## 10. TUBERCULOSIS (TB) & ANTIMICROBIAL RESISTANCE (AMR) PROGRAMME UPDATE

Jo Hawthorne submitted a report giving an update on Tuberculosis (TB) and Antimicrobial Resistance (AMR) programme activities and seeking continued support for TB and AMR public engagement.

The report explained that recent data from Public Health England showed that the incidence of TB in Reading between 2002 to 2015 had been consistently higher than the England and South East average and so a TB Advocacy, Communication and Social Mobilisation plan had been developed and implemented by a multi-agency group of local stakeholders to improve awareness of active and latent TB locally, reduce stigma and improve access to testing and treatment. The report gave details of work that had been carried out so far.

It explained that a strong TB pathway with good treatment completion would contribute to prevention and control of multi-drug resistant TB and would also preserve antimicrobials for where they were most needed. Strong antimicrobial stewardship should help to ensure that antibiotics could continue to effectively treat latent and active TB.

The report concluded that there was a need for continued professional and public engagement and the Board was asked to support stakeholders to promote hand hygiene and increase understanding of the need for good antimicrobial stewardship by continuing to encourage members of all Board partners to pledge as Antibiotic Guardians and to support wider engagement with young people through schools, colleges and other settings in 2017.

**Resolved -**

That the Board continue to support public engagement for Tuberculosis (TB) and Antimicrobial Stewardship (AMS) programmes.

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

Further to Minute 9 of the previous meeting, Jo Hawthorne submitted a report on progress made on the procurement of the integrated Public Health Nursing Service for 0-19 (25) year olds.

The report explained that the Adult Social Care, Children's Services and Education Committee, on 13 December 2016, had agreed to bring the health visitors service and school nursing service together into a single Public Health Nursing Service, to start on 1 October 2017(Minute 47 refers).

A full procurement had been undertaken, which had commenced on 13 March 2017 and closed on 18 April 2017. Following contract selection, internal approval to award the contract to Berkshire Healthcare Foundation Trust (BHFT) had been secured and BHFT had acknowledged the formal award of the Reading 0-19 (25) contract letter issued to them.

The project team were currently making the necessary arrangements with Legal Services to process the contract between Reading Borough Council (RBC) and BHFT. The contract would start on 1 October 2017 for a period of two years, with the option to extend for a further 12 months. Mobilisation meetings had been arranged with representatives from RBC and BHFT to discuss implementation of the new contract arrangements.

The Reading 0-19s service would be integrated with the early intervention children's service. This would develop coherent, effective, life course services for children and young people. The model would maximise opportunities for health visitors and school nurses to be a part of the RBC priorities for keeping children safe, achieving their maximum potential and staying healthy.

**Resolved -**

That the progress on the development of an integrated 0-19 (25) Public Health Nursing Service be noted.

## 12. DEVELOPMENT OF THE HEALTH AND WELLBEING BOARD DASHBOARD

Jo Hawthorne submitted a report on the development of the Health and Wellbeing Dashboard, to be used to keep Board members informed on local trends in priority areas identified in the Health and Wellbeing Strategy, and asking the Board to

consider recommendations for frequency of the report and for setting targets for each indicator.

Development of a Health and Wellbeing Dashboard had been agreed in principle in July 2016 and the final version of the Health and Wellbeing Strategy had been approved by the Health and Wellbeing Board on 27 January 2017 (Minute 4 refers). The report stated that a draft version of the dashboard had been partially developed and decisions about targets and frequency of reporting were now required. Indicators reflecting each priority area had been identified and included in the draft dashboard.

The Dashboard would have three levels – a high level showing performance of all indicators against targets (met or not met and direction of travel), a second level showing more detailed information and benchmarking for the indicators in each priority area, and a third level showing more detailed trend data and source information for each indicator (An example was included in Appendix 1).

While each performance framework benchmarked each indicator against national performance and performance of similar Local Authority or CCG areas, and while a small number might be subject to a nationally-set target, there were currently no locally agreed targets for the indicators that would be included in the Dashboard.

The report set out the advantages and disadvantages of different options for setting targets and of different frequencies for presenting the dashboard report, recommending that Priority/Action Plan leads be tasked to use their expert knowledge to set appropriate targets for each indicator in their priority area jointly with key stakeholders, and that an annual dashboard report be presented at the end of each year to the Board, with quarterly performance updates on specific indicators to be presented by exception or on request.

Whilst the Health and Wellbeing Dashboard was still in development, two reports on Reading's performance against key indicators and Health and Wellbeing Strategy priorities were appended to the report as Appendices 2 (Performance Update) and 3 (Reading's PHE Health Profile, 2017).

The meeting welcomed the involvement of all stakeholders in the production of the dashboard targets and noted the importance of timely reporting of any problems with performance on specific indicators. It was noted that the Board would also be receiving regular reports on progress against the Health and Wellbeing Strategy Action Plan (see also Minute 13 below).

**Resolved -**

(1) That the latest progress in development of a Health and Wellbeing Dashboard be noted;

(2) That Priority/Action Plan leads agree appropriate targets for indicators with key stakeholders;

(3) That the Health & Wellbeing Dashboard be presented annually to the Board, with more regular updates on specific indicators by exception or on request.

## 13. READING HEALTH AND WELLBEING BOARD ACTION PLAN 2017-20 – PROGRESS REPORT

Jo Hawthorne submitted a report giving an update on progress against delivery of the Health and Wellbeing Action Plan which supported the 2017-20 Health and Wellbeing Strategy as at June 2017. Full details were set out in Appendix A to the report.

The report explained that, alongside the Health and Wellbeing Dashboard (see Minute 12 above), the Health and Wellbeing Action Plan update provided the Board with an overview of performance and progress towards achieving local goals. It also gave the Board a context for determining which parts of the Action Plan it wished to review in more depth at its future meetings, in line with the recent Health and Wellbeing Peer Review recommendation that the Health and Wellbeing Strategy should be used to drive the agenda of the Health and Wellbeing Board.

The appendix gave details of performance in the following eight priority areas of the Strategy:

1) Healthy lifestyle choices;
2) Loneliness and isolation;
3) Safe use of alcohol;
4) Mental health and wellbeing of children and young people;
5) Living well with dementia;
6) Breast and bowel cancer screening;
7) Incidence of tuberculosis;
8) Suicide rate.

The report stated that, as priorities (2), (3) (4) and (5) formed a natural cluster around emotional wellbeing and with a planned focus on priority (4) in the autumn to align with an international awareness day, this grouping was suggested for the first set of in-depth progress reports. The 6 October 2017 Health and Wellbeing Board would also take place shortly before World Mental Health Day (10 October 2017).

**Resolved -**

(1) That the progress to date against the 2017-20 Reading Health and Wellbeing Strategy Action Plan, as set out in Appendix A, be noted;

(2) That in-depth reports on progress towards achieving priorities (2), (3), (4) and (5) of the Health & Wellbeing Strategy be brought to the next meeting.

## 14. UPDATE ON BOB STP PREVENTION WORKSTREAM

Jo Hawthorne submitted a report giving an update on the work of the Prevention Workstream that was part of the Buckinghamshire, Oxfordshire and Berkshire West Sustainability Transformation Plan (BOB STP), working on shifting the focus of care from treatment to prevention.

The report set out the six themes that were the focus of this work, giving the vision, deliverables and progress to date. The six themes were: obesity, physical activity, tobacco, Making Every Contact Count, Digital self-care and improving workforce health. It explained that the work going on in the BOB STP Prevention Workstream

was variable across the themes, but there had been considerable progress made and collaboration across the three geographical areas within BOB and the different disciplines. The Prevention Workstream was chaired by an Operational Director for the Berkshire West CCGs and there was a presence of Directors of Public Health and their representatives from Buckinghamshire, Oxfordshire and Berkshire West.

The report had appended:

Appendix 1 – Tiers of weight management interventions
Appendix 2 – London Clinical Senate – Helping smokers quit campaign
Appendix 3 – Making every contact count stocktake
Appendix 4 – BOB STP Prevention Workstream Update Presentation – April 2017

Jo Hawthorne said that a workshop for local authority and CCG colleagues was due to be held in the next few weeks to look at the next steps and so they would be able to report back to the next meeting on what the Prevention Workstream meant for Reading.

**Resolved -**

(1) That the progress against delivery of the six themes within the BOB STP Prevention Workstream be noted;

(2) That further joint feedback be given to the next meeting setting out what the Prevention Workstream meant for Reading.

## 15. READING'S ARMED FORCES COVENANT AND ACTION PLAN – MONITORING REPORT

Jill Marston submitted a report on the Armed Forces Covenant, a voluntary statement of mutual support between a civilian community and its local armed forces community, giving an annual update on progress against the actions outlined in the associated action plan, in particular the health-related actions, and on the general development of the Covenant. The Action Plan was attached at Appendix A.

The report stated that the Council had nominated itself for the bronze award of the Defence Employer Recognition Scheme, and it was reported at the meeting that the award had been achieved.

It was reported that officers from the CCGs were working on the registration of veterans in GP practices.

**Resolved –**

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

(2) That it be noted that the Council had received the bronze award of the Defence Employer Recognition Scheme.

## 16. INTEGRATION AND BETTER CARE FUND

Tony Marvell 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+) into 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 stated that the final BCF policy framework had been released in March 2017, but the technical guidance had not formally been released by NHS England, although a draft copy of the technical guidance had been received from the Local Government Association. This meant that the final funding and planning requirements for the 2017/18 & 2018/19 BCF were still not confirmed and there was a risk of abortive work should the final guidance differ from the draft version.

The report stated that planning sessions including CCG and RBC representatives were continuing but information about timescales for the delivery of the technical guidance or the final submission date had not been received and the report noted that the Board had agreed at its previous meeting for authority to be delegated to officers to submit the BCF, in consultation with the Chair of the Board, as it had been anticipated that timescales were unlikely to fit with the Board's meetings.

It was reported at the meeting that the technical guidance had now been received, as well as information on the timescales for submission of reports to NHS England and DCLG. Refreshed BCF plans for the next two years had to be submitted by 11 September 2017, which would then be rated as approved, approved with conditions, or not approved.

It was also reported at the meeting that the April and May 2017 performance data on DTOC had now been received, showing that the Reading BCF continued to improve and that Reading had moved up from 137$^{th}$ to 99$^{th}$ out of 150 in national performance comparisons.

The meeting discussed the importance of public involvement in the development of the BCF and the challenges of achieving something meaningful in the timescales involved, and it was agreed that further work was needed on this issue. It was also noted that all stakeholders should be considering how to engage with the public on the wider STP and ACS issues.

**Resolved -**

(1) That the progress on integration and the BCF be noted;

(2) That Tony Marvell work further with partners on how to involve the public in the development of the BCF.

## 17. PHARMACEUTICAL NEEDS ASSESSMENT 2017

Jo Hawthorne submitted a report from the Berkshire Shared Public Health Team briefing Berkshire Health and Wellbeing Boards on their role in the three-year refresh of the Pharmaceutical Needs Assessment (PNA).

The report explained that, since April 2013, every Health & Wellbeing Board in England had had a statutory responsibility to publish, and keep up to date, a statement of the needs for pharmaceutical services in their area, or Pharmaceutical Needs Assessment (PNA). Each Health & Wellbeing Board had had to publish their first PNA by 1 April 2015, and was required to undertake a revised assessment at least every three years. The refreshed PNAs needed to be signed-off and published by 31 March 2018.

The report explained that the Berkshire Shared Public Health Team would lead on the development and delivery of the PNAs on behalf of the Berkshire Health and Wellbeing Boards, using the results of two surveys – one survey of residents using local pharmacy services and the other of pharmacy staff in each borough, to be carried out in 2017 in June, July and August. They would be electronic and managed through the Health and Wellbeing Board partner organisations' usual dissemination channels for a public survey.

The report also gave details of actions which needed to be undertaken at a local level to ensure success of the project, including promotion to local residents, explaining that the draft PNA would need to be signed off in October 2017 for public consultation between October and December 2017. HWBB members were asked to add this to their corporate consultation schedule for this period and to identify any processes that needed to be completed to ensure this consultation occurred.

Mandeep Sira noted that Healthwatch Reading had a number of communication channels which were available to be used for public consultation.

**Resolved -**

(1) That the report be noted;

(2) That a report on the draft PNA be submitted to the next meeting.

## 18. DATE OF NEXT MEETING

**Resolved –** That the next meeting be held at 2.00pm on Friday 6 October 2017.

(The meeting started at 2.10pm and closed at 4.30pm)

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

# Update on Progress Towards Promoting Positive MH & Wellbeing in Children & Young People (Priority 3 in HWBS)

JOINT REPORT FROM SOUTH READING CLINICAL COMMISSIONING GROUP, NORTH & WEST READING CLINICAL COMMISSIONING GROUP & READING BOROUGH COUNCIL

Sally Murray (CCG), Elaine Redding (Reading Borough Council) September 2017

## 1. PURPOSE OF REPORT AND EXECUTIVE SUMMARY

To provide a brief update on service development and improvement across the comprehensive Child and Adolescent Mental Health Service (CAMHS) system, responding to the national Future in Mind requirements.

For the Board to note that the Future in Mind Local Transformation Plan (LTP) is due to be refreshed in October 2017. It is recommended that the refreshed Future in Mind Local Transformation Plan is taken to the January 2018 Board with a fuller report for approval.

The current 16/17 Local Transformation Plan is referenced in point 2.2 below through the web-link.

## 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 original plan in October 2015 and the refreshed plan in March 2017. The current 16/17 plan can be found at: http://www.southreadingccg.nhs.uk/component/edocman/refreshed-local-transformaion-plan-for-children-and-young-peoples-mental-health-and-wellbeing-january-2017/download

An easy read version suitable for young people is also available http://www.southreadingccg.nhs.uk/component/edocman/refresh-local-transformation-plan-for-children-and-young-people-s-mental-health-and-wellbeing-yp-version/download

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 and the University of Reading.
Working Together for Children with Autism is a subgroup that reports to the Future In Mind group.

## 3. PROGRESS

**Areas of Progress Since last H&W board report (March 2017) are as follows.**
**More detail will be provided in the October 2017 refresh of the plans.**

3.1 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. As well as a reduction in the number of minors admitted to the Place of Safety at Prospect Park Hospital.
The service has been recommissioned for 17/18 in partnership with Berkshire East CCGs. Recurrent funding is being sought.

3.2 The Berkshire CAMHs Community Eating Disorders Service is now fully established and providing a more timely highly specialised community service in accordance with national requirements. National targets are routine referrals to be seen within 4 weeks and urgent referrals to be seen within 1 week.

3.3 A successful bid to NHS England Health and Justice commissioning has resulted in some additional CAMHs resource and new speech and language therapy resource being available to the Reading Youth Offending Team. Posts are currently in recruitment. NHS England Health and Justice commissioning have also commissioned an all age Liaison and Diversion scheme for people who are in touch with the criminal justice service. This extends the previous scheme which was for people aged 18 years and over.

3.4 The Reading School Link project is in year 2 of operation, providing training, help and supervision to teaching staff and pupils. The outcomes of the service will be evaluated in 17/18 with a view to review impact, effectiveness and sustainability of provision which also captures the voice of children and young people in terms of how they feel about key issues affecting their emotional and mental health well-being

3.5 61 PPEPCare (Psychological Perspectives in Education and Primary Care) training sessions were delivered to 1424 staff plus over 200 young people across Berkshire West in 16/17. PPEPCare supports the School Link project. Evaluations have been consistently very strong.

3.6 Parenting Special Children and Autism Berkshire have continued to deliver training sessions and support to families whose children have been referred or assessed for ASD and ADHD. Pre assessment and post assessment support is provided as part of the wider neurodevelopmental care pathways.

3.7 The multiagency Together for Children with Autism group continues to work to improve whole system working for children and young people at home, in education and in settings. More work is required to embed recommendations into a clear multiagency care pathway in each LA area with better accountability to ensure that standards are met in all settings. This work is closely aligned to the Special Educational Needs and Disabilities work as well as the Transforming Care work.

3.8 An outcomes framework has been agreed for all providers of emotional health and wellbeing services for children and young people. Providers are now reporting against an agreed set of outcomes as well as providing numerical data.

3.9 At a Reading HWB, young people told us that they wanted a single reliable source of emotional/ mental health information and advice available as a discrete blazer pocket sized booklet, distributed universally to pupils prior to exam season, as well as available online. They also wanted a bus and social media campaign. The Little Blue Book of Sunshine was then developed aimed at young people in years 10 and above. #littlebluebookofsunshine. Young people co-produced the Little Blue Book of Sunshine with clinicians and designers. They wanted a slightly cheeky campaign with messages appealing to all genders. 25,000 booklets were distributed to schools and clinics by the School Link project, CCG staff , Healthwatch and experts by experience. Looked After Children and the Youth Offending Teams requested additional copies. Instagram, Twitter and Facebook campaigns ran for 4 weeks around exam season along with a bus shelter and bus advertising campaign. The response has been very good but difficult to quantify. The campaign has been cited by Young Minds and the Youth Justice Board as examples of good practice.

3.10 The University of Reading has trialled a new evidence based low intensity approach to children and young people with anxiety and depression (AnDY clinic) using a skill mixed workers. Outcomes have been good and opportunities to commission this service are being sought.

3.11 An integrated BHFT Children, Young people and Families Health Hub went live in May 2017. Each referral is triaged and an appropriate decision made according to individual needs. The response might be CAMHs, children and young people's integrated therapies (CYPIT) public health nursing (universal services) specialist children's services or other community service depending on the need of the individual. Families can now self- refer.

3.12 An on line CAMHs toolkit for families is in development and is due to be launched in Autumn 2017.

3.13 Total referrals into BHFT CAMHs increased by 12.8% in 2016/17 compared to the previous year. Demand continues to rise with referrals up 23% in Quarter 1 compared to the same Quarter in 16/17.

3.14 Total BHFT CAMHs caseloads have increased for the last 3 Quarters

3.15 The current average BHFT CAMHs waiting times are

**Common Point of Entry**
Initial triage- 1 working day
Urgent -2 weeks
Routine- within 6 weeks
**Waiting times for treatment**
Specialist community teams- 6 weeks
ADHD 13 weeks (NB this care pathway has the greatest non attendance rate which drives up average waiting times because non attenders remain on the list)
Eating disorders- urgent- within 1 week
Eating disorders- routine- within 4 weeks.

3.16 Berkshire West waiting times for autism assessment remain lower than the national average (Berkshire West average is 44 weeks, the national average according to National Autistic Society is 3 and a half years). However waits remain longer that both the commissioner and

provider want locally. Additional non recurrent funding was made available to expedite reduction in autism assessment waiting times for children under the age of 5 years by running additional weekend clinics. CCGs continue to work with BHFT to reduce waiting times but recognise that demand for autism assessment continues to rise.

3.17 Reading continues to offer a good Primary Mental Health Worker (PMHW) and Education Psychology (EP) service.

3.18 Youth Counselling is jointly commissioned between the Local Authority and CCG. The provider is now No5. The majority of schools offer on-site access to trained counsellors.

## 4. NEXT STEPS

4.1 The Berkshire West Transformation Plan is due to be refreshed by the end of October 2017.It is recommended that the refreshed Local Transformation Plan is taken to the January HWB for approval.

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 continues to be on supporting and strengthening collaborative working from these and other developments in integrating mental health into children social care to ensure Reading children thrive and grow up to be confident and resilient individuals. This will be endorsed by :

- Joining up the system to engineer a new model of delivery that tackles access and prevents young people being lost in the system.
- Sustaining a culture of evidence based services improvement delivered by a workforce with the right mix of skills, competences and experience.
- 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.
- Improve transparency and accountability across the whole system, including resource allocation and ensuring collaborative decision making.

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. BACKGROUND PAPERS

5.1 Future in Mind paper:
https://www.gov.uk/government/publications/improving-mental-health-services-for-young-people

5.2 Transformation plan guidance;
http://www.england.nhs.uk/wp-content/uploads/2015/07/local-transformation-plans-cyp-mh-guidance.pdf

5.3 Links to Local Transformation Plans on the CCG websites (includes and easy read version and Frequently Asked Questions section)

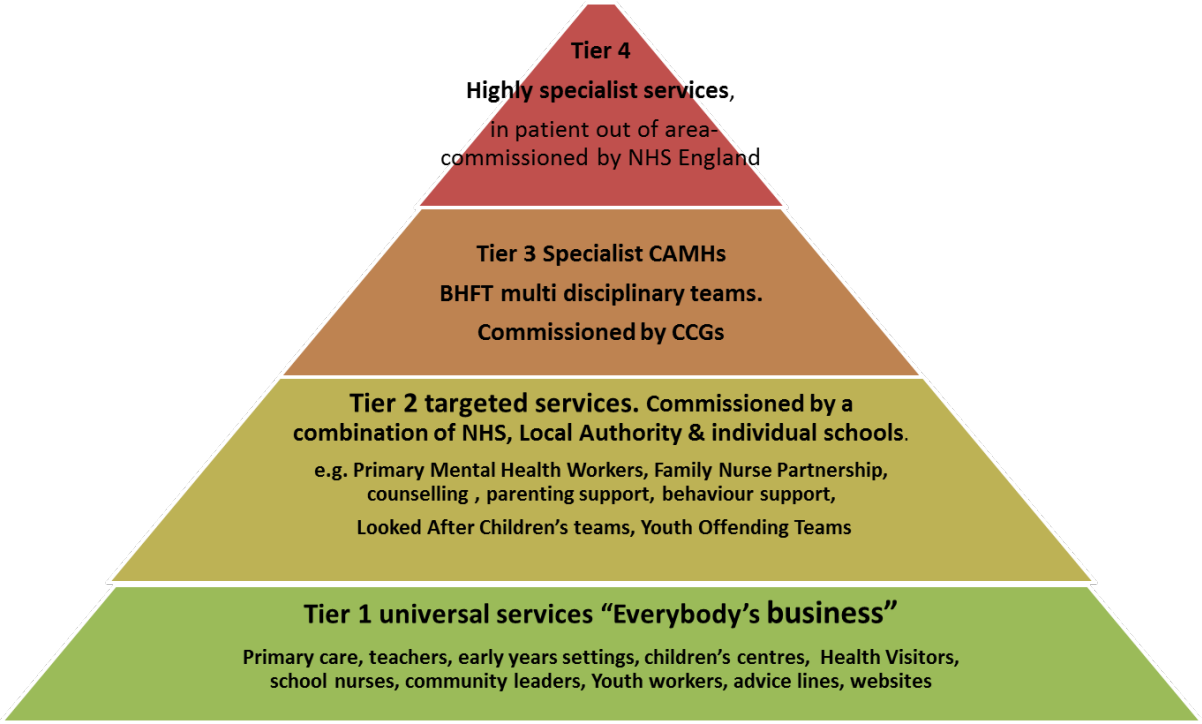
**http://www.southreadingccg.nhs.uk/our-work/children/camhs-transformation**

**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 |

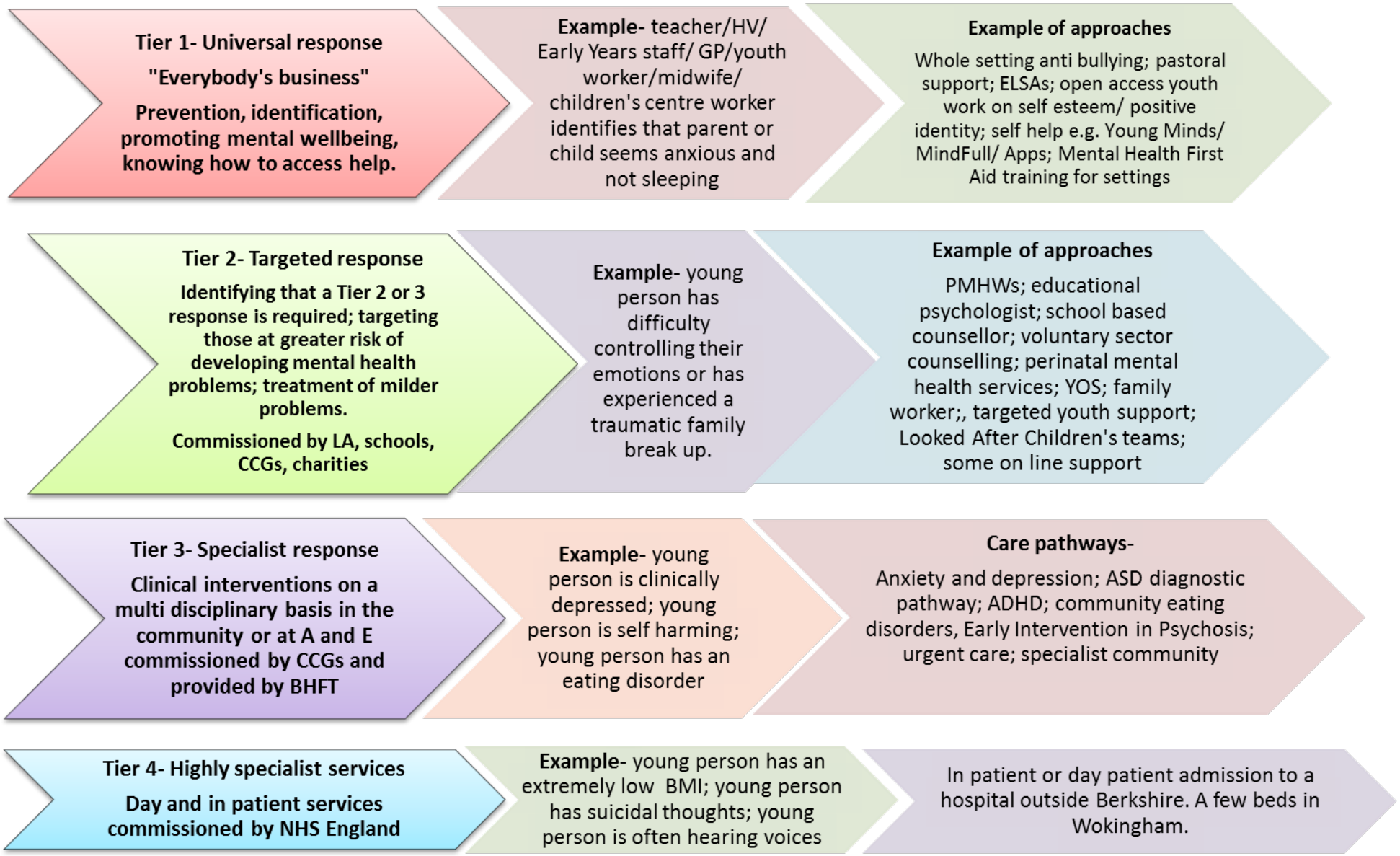
**Appendix 2**

**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



**READING BOROUGH COUNCIL**

**REPORT BY DIRECTOR OF ADULT CARE & HEALTH SERVICES**

| | | | |
|---|---|---|---|
| **TO:** | **HEALTH & WELLBEING BOARD** | | |
| **DATE:** | **6 OCTOBER 2017** | **AGENDA ITEM:** | **6** |
| **TITLE:** | **REDUCING LONELINESS & SOCIAL ISOLATION: READING DEVELOPMENTS** | | |
| **LEAD COUNCILLOR:** | **COUNCILLOR HOSKIN** | **PORTFOLIO:** | **HEALTH** |
| **SERVICE:** | **ALL** | **WARDS:** | **BOROUGHWIDE** |
| **LEAD OFFICER:** | **SARAH MORLAND / JANETTE SEARLE** | **TEL:** | **0118 937 2103 / 3753** |
| **JOB TITLE:** | **PARTNERSHIP MANAGER, READING VOLUNTARY ACTION / PREVENTATIVE SERVICES MANAGER, RBC** | **E-MAIL:** | **Sarah.Morland@rva.org.uk Janette.Searle@reading.gov.uk** |

## 1. PURPOSE OF REPORT AND EXECUTIVE SUMMARY

1.1 This report presents an update on recent developments to reduce loneliness and social isolation in Reading, in particular to improve understanding of the local issue and of which groups of Reading residents are at greatest risk of experiencing health inequalities as a result of being lonely and/or isolated.

1.2 This is one of several progress reports presented to this meeting by way of addressing the meeting's theme of 'emotional wellbeing'. This theme has been selected by the Board to facilitate a review of local plans against the Prevention Concordat for Better Mental Health, and in recognition of World Mental Health Day on 10th October.

1.3 A Loneliness and Social Isolation Steering Group has been formed to deliver on priority (2) of the Reading Health and Wellbeing Action Plan 2017-20. Voluntary and community sector partners are key members of that group, and the sector's approach within the Steering Group and beyond is being galvanised by Reading Voluntary Action.

1.4 A report on the findings of a Reading-wide survey of loneliness and isolation appears at Appendix 1 (*Loneliness and Social Isolation in Reading* – Reading Voluntary Action – July 2017) together with a summary presentation at Appendix 2.

## 2. RECOMMENDED ACTION

**2.1 That the Health and Wellbeing Board:**

**(a) Adopts the Prevention Concordat for Better Mental Health as a set of guiding principles for the Board, particularly in overseeing the delivery of the Health and Wellbeing Strategy 2017-20; and**

**(b) Endorses and supports the Champions to End Loneliness programme.**

## 3. THE PREVENTION CONCORDAT FOR BETTER MENTAL HEALTH

3.1 On 30 August 2017, Public Health England published the Prevention Concordat for Better Mental Health. This describes a shared commitment to work together to prevent mental health problems and to promote good mental health. The Concordat's signatories include NHS England, the Local Government Association, NICE, the Faculty of Public Health and Association of Directors of Public Health together with eleven national voluntary community and social enterprise organisations.

3.2 The commitments in the Concordat are as set out below.

i. To transform the health system, we must increase the focus on prevention and the wider determinants of mental health. We recognise the need for a shift towards prevention-focused leadership and action throughout the mental health system; and into the wider system. In turn, this will impact positively on the NHS and social care system by enabling early help through the use of upstream interventions.

ii. There must be joint cross-sectoral action to deliver an increased focus on the prevention of mental health problems and the promotion of good mental health at local level. This should draw on the expertise of people with lived experience of mental health problems, and the wider community, to identify solutions and promote equality.

iii. We will promote a prevention-focused approach towards improving the public's mental health, as all our organisations have a role to play.

iv. We will work collaboratively across organisational boundaries and disciplines to secure place-based improvements that are tailored to local needs and assets, in turn increasing sustainability and the effective use of limited resources.

v. We will build the capacity and capability across our workforce to prevent mental health problems and promote good mental health, as outlined in the Public Mental Health Leadership and Workforce Development Framework Call to Action.

vi. We believe local areas will benefit from adopting the Prevention Concordat for Better Mental Health.

vii. We are committed to supporting local authorities, policy makers, NHS clinical commissioning groups and other commissioners, service providers,

employers and the voluntary and community sector to adopt this Concordat and its approach.

3.3 The Concordat comes with a suite of tools to help identify how to target resources effectively in moving towards a more prevention focused approach to mental health – helping those who are experiencing challenges to their mental health and also helping to build more supportive and resilient communities. The tools are intended to drive improvements in health, social care and public health practice and also within the voluntary and community sector. All partners are encouraged to give more attention to the wider causes of mental health problems, including health inequalities and wider social determinants.

## 4. REDUCING LONELINESS AND SOCIAL ISOLATION AS A READING PRIORITY

4.1 The need to reduce loneliness and social isolation increasingly features as a health protection issue in national policy, with specific measures now included in both the Public Health Outcomes Framework and the Adult Social Care Outcomes Framework. National initiatives with a specific focus on loneliness are also very prominent currently, such as the Campaign to End Loneliness and the Jo Cox Commission on Loneliness.

4.2 'Social isolation' and 'loneliness' are not identical, although the terms are used interchangeably in many reports. 'Social isolation' describes an inadequate level of meaningful human interaction, and is something which can be measured objectively, taking into account both the quality and quantity of contacts. 'Loneliness', on the other hand, describes an emotional state, and can be experienced by people who may seem to others to have a good range of social connections. Teasing out the different impacts of isolation and loneliness, and so how best to address the wellbeing risk, is one of the challenges in this area.

4.3 Even with the need to understand better the interplay between social isolation and loneliness, there is a growing body of evidence supporting the economic case for reducing isolation because of the health risks. For example, reducing loneliness and/or social isolation has been shown to lead to:

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

4.4 The Prevention Concordat toolkit (see above) includes an evaluation of a signposting service aimed at reducing social isolation and loneliness amongst older people. This demonstrated a Return on Investment of £1.26 from every £1 invested in the service, which was considered to be a very conservative estimate as it focused on mental health improvements and did not take account of additional health benefits, such as improved physical health, as well as potential benefits for the protection of cognitive health.

4.5 When reducing loneliness and social isolation was first proposed as a Reading priority, this proved to have great resonance with local residents and organisations. Statutory care providers, voluntary organisations, community groups and individuals responded to a consultation on a new draft health and wellbeing strategy describing how lack of social connection seemed to be the underlying factor in a wide range of presentations of poor health. This feedback encouraged the Board to recognise loneliness and social isolation as risk factors for ill health – both mental and physical – by making it one of the eight health and wellbeing priorities for 2017-20.

4.6 As presented to the Health and Wellbeing Board in July, Reading now has a Loneliness and Social Isolation Steering Group. This is a cross sector partnership of individuals committed to developing understanding, raising awareness, and to promoting services, opportunities, community assets and an evidence-based approach. The Steering Group recognises the underpinning principles of the 2017-20 Health and Wellbeing strategy by including carers as a key interest group, making it a collective priority to raise awareness of services and opportunities, and considering the safeguarding implications of any approach considered.

4.7 The Group is overseeing the development of a local loneliness and isolation needs analysis to help target interventions in line with our strategic commitment to reducing isolation and loneliness across all ages. However, the majority of national research on loneliness and social isolation focuses on older people, and in developing a local needs analysis we recognise the need to redress this as well as improving our understanding of the particular issues for Reading residents. Reading Voluntary Action's 'social activity' survey has enabled us to make significant progress with this.

## 5. LONELINESS AND SOCIAL ISOLATION IN READING

5.1 *Loneliness and Social Isolation in Reading,* a report based on findings from a Reading-wide questionnaire into loneliness and isolation in April and May 2017, is appended to this report. Findings challenge some assumptions about who is most likely to be lonely. Respondents aged 65-74 had the highest proportion of people who reported feeling *mostly or always lonely.* Length of time living in Reading has a considerable impact on loneliness.

5.2 The key barriers to people being more socially activity were identified as lack of confidence, lack of knowledge about what is going on and where, and transport issues. Access to the internet can appear as a way to find out more about community events and activities to increase social connections; the research shows that 81% of respondents indicating lack of information as a barrier were aged 18 – 49 years.

5.3 The next step of the research is to carry out focus groups with targeted beneficiary groups. The purpose of this is to test the results and also to get more in-depth information about how people can be supported to overcome the barriers they face. This will help inform local organisations how they can respond to these issues. Initially, the focus groups will work with people who

are new to Reading, people with physical disabilities and chronic ill-health and people with mental ill-health. Members of the Loneliness and Social Isolation Steering Group have been recruited to help facilitate these focus groups. Depending on capacity, the focus groups could be rolled out to work with other groups.

5.4 A local development on the back of the survey findings to date is the *Champions to End Loneliness* campaign to enable local residents to take action on loneliness. The campaign includes a series of neighbourhood based public workshops to share information, encourage discussion and support action that will help reduce loneliness. Participants will be encouraged to make pledges through pledge cards and an online pledge board and will be provided with information on local organisations they can get involved with as well as ideas of small personal acts of kindness they can take.

5.5 Reading Borough Council is currently consulting on a new framework for commissioning community services from 2018 (*Narrowing the Gap II*), including proposals for jointly commissioning some of these services with the Reading clinical commissioning groups. Reducing loneliness and developing peer support mechanisms feature strongly in the draft framework, which will be finalised in the autumn in the light of feedback from potential providers, primarily voluntary and community groups. The consultation has been widely advertised, including through RVA's newsletters, and there have been two provider engagement events as well as opportunities to respond online to a dedicated mailbox.

5.6 The draft framework proposes that services are commissioned to help overcome the barriers to social connection experienced by adults with a learning disability, physical disability, hearing impairment, visual impairment, autism, experience of mental health difficulties, or who are in older age and/or frail. Further services are proposed to support unpaid carers, and families specifically affected by dementia, multiple sclerosis, or Parkinsons Disease. The framework also includes a proposal that the local authority and clinical commissioning groups in Reading jointly commission a social prescribing service to support people with social emotional and practical needs.

## 6. COMMUNITY & STAKEHOLDER ENGAGEMENT

6.1 The 'Loneliness and Social Isolation in Reading' report represents the views of 437 residents, who were supported to participate by 12 partner organisations.

6.2 The Champions to End Loneliness programme invites and supports Reading residents to come together at a neighbourhood level to reach those at risk of isolation or loneliness. To date, 2 workshops have been arranged.

6.3 The Reading Loneliness and Social Isolation Steering Group was formed on the back of an open workshop attended by 50 local residents and organisational representatives. The Steering Group brings together those who have agreed to play a role in delivering on the Loneliness and Social Isolation Action Plan and

to represent particular interest groups, and currently has 34 active members, some job-sharing a representation role. The Steering Group is supported by a wider Reference Group of 47 members.

## 7. APPENDICES

Appendix 1 report: *Loneliness and Social Isolation in Reading* – Reading Voluntary Action – July 2017

Appendix 2 summary presentation: *Loneliness and Social Isolation in Reading* – Reading Voluntary Action – September 2017

## 8. BACKGROUND PAPERS

Reading Health and Wellbeing Strategy 2017-20
Reading Health and Wellbeing Action Plan 2017-20
Reading Health and Wellbeing Action Plan 2017-20: Progress Report July 2017

READING VOLUNTARY ACTION

# Loneliness and Social Isolation in Reading

A report based on findings from a Reading-wide questionnaire into loneliness and isolation in April and May 2017.

Report funded by The Earley Charity
by hook or by crook

# Contents

# Forward

## By Cllr Graeme Hoskin

I'm delighted to have been asked to provide a forward to this important and extremely timely report. I won't repeat the startling evidence about how loneliness and isolation has a major impact on people's health and wellbeing. That evidence is laid out below.

We know Reading is no different to the rest of the country and this is a major issue for our town. That is why addressing loneliness and isolation is one of our key priorities in Reading's new Health and Wellbeing Strategy.

The survey and this report is a great piece of partnership work giving us real insight into the nature of social isolation in Reading. I was particularly interested in the evidence around the greater incidence amongst new residents and not just the problem of isolated older people that we have sometimes assumed.

The only way we will make a real positive change and reduce levels of isolation and loneliness is through the whole town, public bodies, the voluntary and community sector, and neighbourhoods all making sure we improve the connections and support we give each other. Reading is a fantastic town. Full of life, diversity and a vibrant community life. Our job is to make sure everyone is welcomed and included in that.

Thanks,

Graeme
Cllr Graeme Hoskin
**Lead Councillor for Health and Chair of Health & Wellbeing Board**

# Executive Summary

The survey has highlighted who is most likely to be experiencing loneliness and isolation, how it impacts on different groups of people, what barriers they face to reducing their loneliness and what they would like to be doing if those barriers could be overcome.

The survey underrepresented young people, ethnic minorities and men. The respondent group was not random and mostly relied on involvement in social groups or support services, or access online through social media channels, driven mainly by Reading Voluntary Action. Therefore, although insightful, the results do not represent the population as a whole.

## Barriers to social activity

1) The main barriers to people being more socially active are
    a) Lack of information about what / when / where things are happening
    b) Lack of confidence
    c) Difficulties with transport
2) Lack of knowledge about when / where / what is going on affects people who are new to Reading most of all, and consequently affects younger people more.
3) Lack of confidence affects people of working age more than older people
4) Transport problems particularly affect those with health issues, financial issues, in unstable / temporary accommodation, are unemployed and over 85 years old.

## Who is lonely?

5) Many people automatically assume older people are most lonely, but the questionnaire did not entirely reflect this assumption. Respondents aged 65-74 had the highest proportion of people who were *mostly to always lonely*. People aged 85+ were far more likely to feel lonely than any other age group at some point each week.
6) The survey was more likely to reach isolated younger people than isolated older people as the survey was available online. Older respondents are more likely to have accessed the survey by being involved in social groups or support services, which indicates they are already socially active.
7) Lack of social contact does not always correlate to loneliness, but twice as many respondents with limited social contact are *moderately to always lonely* than others.
8) People who are mostly to always lonely tend to face multiple barriers to being more socially active (eg physical health, mental ill health, financial, lack of knowledge).
9) Length of time living in Reading has a considerable impact on loneliness.

## What sort of activity did respondents want?

Over half of all respondents were interested in accessing more small group activities and social events, and over one third of respondents wanted opportunities to meet for lunch, coffee or one-to-one.

We also looked specifically at respondents who were lonely and lacking confidence. They had a much greater interest in one-to-one activities (23% higher than all respondents), walking groups (10% higher), meeting neighbours (15% higher) and volunteering (15% higher) than all respondents.

# Partner organisations

This report is based on a questionnaire to inform a partnership of local charities and Reading Borough Council how they can work together better, to address issues of social isolation and loneliness in Reading. The questionnaire can be found as an appendix to the report.

Reading Voluntary Action led on the survey with the support of Reading Borough Council to develop the survey and to analyse the data. The following organisations supported the completion of the questionnaires:

Reading Voluntary Action
Reading Borough Council Wellbeing Team and 50+ Social Groups
Reading Community Learning Centre
Launchpad Reading
Reading and West Berkshire Carers' Hub
A number of local churches
IRIS Partnership
Kennet Surgery
Tilehurst Surgery
University Medical Practice
Whitley Researchers
Engage Befriending
Reading Libraries
Age UK Reading

Many others supported by sharing on social media or directing people to the questionnaire.

# Acknowledgements

As well as all partner organisations, I would like to offer special thanks to Sarah Hunneman (Reading Borough Council) for help with the development of the questionnaire and Kim McCall (Reading Borough Council) who helped with the data analysis.

The quality of the report was also greatly improved thanks to Dr Steve Hendry (RVA), Sarah Morland (RVA), Lillian King (RVA trustee), Karen Morton (RVA trustee), Cathy Hills (RVA volunteer) Stephanie Schenkelberg (RVA intern), Adam Halford (RVA Intern), Katherine Shepherd (Mustard Tree Foundation), Fiona Price (Age UK Berkshire), Matt Taylor (Age UK Reading) and Dr Sophie Bowlby (Readibus trustee) for reviewing, proofreading and providing essential feedback on content, format and style.

Special thanks also go to the Earley Charity who funded the research for this report.

# Aims and approach

The need for the survey came from a recognition that local organisations must work together more collaboratively to address loneliness and social isolation. Organisations currently working with beneficiaries recognised this as an issue, and national research has revealed what the issues are nationwide. However there was not coherent Reading-wide understanding of what the issues looked like locally.

The purpose of conducting this research was to identify:
1.Who is affected by loneliness and isolation in Reading?
2.What barriers do they face to being socially active?
3.What would enable people feel less lonely and socially isolated?

The questions were formulated by Reading Voluntary Action and Reading Borough Council and reviewed by Engage Befriending, MacMillan Cancer Support, Sue Ryder Care, Age UK Berkshire, Age UK Reading and Reading and West Berkshire Carers Hub.

## Defining *Loneliness* and *Social Isolation*

The terms loneliness and social isolation are, at times, used interchangeably, however there is a distinct difference between the two, though they can go hand-in-hand. When the terms are referred to in this report, the following definitions have been adopted:

**Loneliness** is characterised by a negative feeling which occurs as a result of the gap between desired and actual quality of relationships or social contacts. Loneliness can be situational / transient or chronic.[1]

**Social isolation** is generally agreed to be more objective than loneliness and relates to the extent to which an individual is isolated from social contacts including friends, family members, neighbours or the wider community.[2]

[1] De Jong Gierveld and Van Tilburg *'A 6-Item Scale for Overall, Emotional, and Social Loneliness' Research on Aging 28* pp. 582-598, 2006
[2] As above

# Methodology and response sources

The survey was made available in hardcopy and online. Local organisations helped to distribute the survey and encouraged or supported their beneficiaries to fill it out. The survey was available in public venues such as GPs surgeries (Kennet Surgery, Tilehurst Surgery and University Practice participated) and libraries.

Reading Voluntary Action held a stall in Broad Street Mall inviting shoppers to fill out the survey and the Whitley Researchers[3] actively engaged with residents in Whitley to gather responses in that area.

The survey was accessed online through information on the Reading Voluntary Action website and through social media, led by Reading Voluntary Action but widely shared by others.

Here is the breakdown of survey response sources:
94 Reading Borough Council supported 50+ social groups
77 Reading Community Learning Centre
38 GPs surgeries
27 Whitley Researchers
14 Launchpad Reading
13 IRIS Partnership
12 Broad Street Mall
11 Befriending organisations
11 Libraries
9 Caversham Wellbeing Fair
7 Central Library Games Club

| | |
|---|---|
| Hard copies (from specific groups / places) | 313 |
| Other sources | 11 |
| Online | 113 |
| Total | 437 |

74% of all respondents (324) completed the questionnaire on hard copy forms and 26% of respondents (113) filled out the survey online. 66% of 18-29 year olds filled the questionnaire out online as opposed to just 6% of all respondents over 75 years.

As we read the results, it is important to note that, due to the methods of accessing survey respondents, we were most likely to reach people who are able to get out and about and those who are connected online. Additionally, 209 respondents (48%) filled out the survey through an organisation so we know they are accessing support services. This will impact on the results as we were more likely to reach local residents who are already connected somehow in the community.

[3] Whitley Researchers are a group of resident researchers, supported by the University to carry out high quality, locally relevant research in their community. https://blogs.reading.ac.uk/participation-lab/the-whitley-researchers-action-research-project-in-reading

# Background and existing research

Loneliness and isolation are issues that can affect people at any stage in life. In recent years, the issue has been widely covered in the media thanks to high profile campaigns such as the *Campaign to End Loneliness*[4] and the *Jo Cox Commission on Loneliness*[5]. Both campaigns aim to reduce the stigma related to loneliness and to engage everyone in the conversation about, and in action to reduce loneliness.

One study identified that individuals lacking social connections are 26% more likely to die prematurely than those who do not report as lonely[6] and is comparable to the risks associated with obesity and smoking 15 cigarettes per day.[7]

Loneliness is also understood to have an impact on cognitive decline and 64% increased chance of developing clinical dementia.[8] A number of studies have identified loneliness as a predictor of depression.[9]

This insight highlights the role that reducing the prevalence of loneliness in our communities can have on people's physical and mental health. Reading Borough Council identified through its Narrowing the Gap programme[10] that reducing loneliness results in:

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

Reducing the risks loneliness and social isolation is a priority of the Reading's Health and Wellbeing Strategy 2017-2020.

It is clear that reducing the prevalence of loneliness and isolation does not only have an effect on wellbeing, but also on physical, cognitive and mental health.. In light of this wider research into loneliness and isolation, this report focuses on the local, Reading context.

[4] Campaign to End Loneliness, https://www.campaigntoendloneliness.org/
[5] Jo Cox Commission on Loneliness, www.jocoxloneliness.org
[6] Holt-Lunstad, *Loneliness and Social Isolation as Risk Factors for Mortality*, 2015
[7] Holt-Lunstad, *Social Relationships and Mortality Risk*, 2010
[8] Holwerda, *Feelings of loneliness, but not social isolation, predict dementia onset: results from the Amsterdam Study of the Elderly*, British Medical Journal, 2012
[9] Roberts, *A Summary of Recent Research Evidence about Loneliness and Social Isolation, their Health Effects and the Potential Role of Befriending,* Befriending Networks, 2015
[10] Reading Borough Council, *Narrowing the Gap*, 2015

# Who responded to the questionnaire?

The survey was filled out by 445 people, but 8 identified as living at a postcode outside of the Reading Borough area. Therefore the research is based on responses from 437 local residents. This represents 0.27% of the Reading population (161,739).

## Gender

The response rate was heavily weighted towards females, with 308 female respondents (70.5%) compared to 124 male respondents (28.4%). The survey collection techniques may have played a role in creating this imbalance; a) many were filled at older people's social groups, where more females attend; b) there is some research to suggest women are more likely to fill out online surveys than males[11]. Five respondents did not provide information on gender.

## Age range of respondents

The survey was targeted at adults only and attracted responses from all ages. Figure 1 highlights where there is disparity between the proportion of specific age groups of the Reading population versus the proportion of survey respondents in each age bracket. The age band 18-29 year olds were heavily underrepresented in survey responses whereas ages 65+ were overrepresented in survey results.

| Age Band | Survey Population | | Reading Population | |
|---|---|---|---|---|
| | No. | % | No. | % |
| 18-29 | 39 | 9 | 32729 | 26 |
| 30-49 | 156 | 36 | 49764 | 40 |
| 50-64 | 79 | 18 | 23380 | 19 |
| 65-74 | 64 | 15 | 10209 | 8 |
| 75-84 | 65 | 15 | 6360 | 5 |
| *85+* | *33* | *8* | *2864* | *2* |

= Significantly lower proportion of respondents than the general population

= Significantly higher proportion of respondents than the general population

*Fig 1*

The disparity of results could be for a number of reasons, in particular, the more targeted approaches to having questionnaires filled out were most likely to reach older age groups. This included 50+ social groups, befriending organisations and carers' organisations.

[11] Smith, Grinell, Does gender influence online survey participation?: A record-linkage analysis of university faculty online survey response behavior, http://scholarworks.sjsu.edu/cgi/viewcontent.cgi?article=1003&context=elementary_ed_pub

## Ethnicity of respondents

Residents from a wide range of ethnic backgrounds responded. Overall, the survey reached 73% of survey respondents who identify as White British/English/Welsh/Scottish/Northern Irish (here on in: White British), although the proportion of the Reading population as a whole who identify as White British is 65%. Respondents who reported an ethnic group other than White British were more likely to be aged 30-49 years (60% of respondents compared to 26% of respondents with White British ethnicity) and less likely to have lived in the area for four years or more (60% compared to 84% of respondents with White British ethnicity). The survey reached proportionately higher numbers of people aged 65 plus, and this demographic is less ethnically diverse than younger age groups.

A high sample number selected 'other' and some then described an ethnicity that may have in many cases fitted into 'any other white background' or 'any other mixed'. These have not been re-assigned.

= Proportionately higher than the general population

= Proportionately lower than the general population

| Ethnic/National Identity | Survey Population | | Reading Population | |
|---|---|---|---|---|
| | No. | % | No. | % |
| White British | 317 | 73 | 101725 | 65 |
| Pakistani | 23 | 5 | 6967 | 5 |
| Indian | 22 | 5 | 6514 | 4 |
| Irish | 11 | 3 | 2269 | 2 |
| Arab | 9 | 2 | 680 | <1 |
| Any other White background | 6 | 1 | 12303 | 8 |
| African | 5 | 1 | 6087 | 4 |
| Caribbean | 5 | 1 | 3279 | 2 |
| Any other Black/African/Caribbean | 4 | 1 | 1104 | <1 |
| Any other mixed | 7 | 2 | 1232 | <1 |
| Bangladeshi | 3 | 1 | 695 | <1 |
| Chinese | 2 | <1 | 1603 | 1 |
| Mixed White and Asian | 2 | <1 | 1428 | 1 |
| Mixed White and Black African | 2 | <1 | 802 | <1 |
| Mixed White and Black Caribbean | 2 | <1 | 2718 | 2 |
| Any other Asian background | 5 | 1 | 5382 | 4 |
| Gypsy or Irish Traveller | 0 | 0 | 90 | <1 |
| Other Ethnic Group | 8 | 2 | 820 | <1 |

*Fig 2*

Due to the sample size of under 500 for the survey, the numbers are not sufficiently high to draw statistically significant conclusions from within specific ethnic groups. In several categories of question we tested how responses from any minority background compared against White British respondents and in all cases there was no significant difference. Therefore there is no comparative analysis by ethnicity in this report.

# Who is experiencing loneliness in Reading?

Just over 10% of respondents experience loneliness most or all of the time. This figure reflect the national picture for over 65s, which is also 10%.[12] We used recommended question categories from The Campaign to End Loneliness *Loneliness Measurement Guide*.[13] The very recent UK wide research by British Red Cross and Co-op[14] have identified 18% of people as often or always lonely, however there are possibly two reasons for this. Their categorisations are different, with more options, and secondly they targeted their research towards people at specific life transition points (eg new parents, recently bereaved, divorced) so it is likely to be less representative of the population as a whole.

Our results are also not fully representative of the population of Reading. The high proportion of results from older people and from females means that comparisons between any particular group and the 'all respondents', do not allow us to compare that group with the general population.

We asked two questions which are related to social isolation and loneliness respectively.[15]

> *How many times in the past 2 weeks have you spent time with other people?*
> and
> *During the past week I have felt lonely:*
> - *most or all of the time (5-7 days)*
> - *a moderate amount of the time (3-4 days)*
> - *some of the time (1-2 days)*
> - *rarely or never (less than one day)*

Loneliness is not solely about the number of social interactions one has, but about the quality of those interactions, whether the relationship is superficial or meaningful, and how one feels during the times you are not with people. Therefore the question of frequency of interactions is not insightful in its own right, but helps to paint a picture especially with those who report being lonely most of the time. It helps identify whether people are lonely and isolated or lonely due to other contributing factors.

[12] Victor, C. 'Loneliness in older age: the UK perspective' in Age UK Oxfordshire (2011) Safeguarding the Convoy: a call to action from the Campaign to End Loneliness
[13] Measuring your impact on loneliness in later life. p20: Center for Epidemiologic Studies Depression Scale (CES-D)
https://www.campaigntoendloneliness.org/wp-content/uploads/Loneliness-Measurement-Guidance1.pdf
[14] Kantar Public, Trapped in a Bubble: An investigation into triggers for loneliness in the UK, December 2016, p18
[15] See appendix (p31) for the full list of questions

Figure 3 shows that one quarter of all people feel lonely 3 or more days in the week and half of all respondents feel lonely at some point every week.

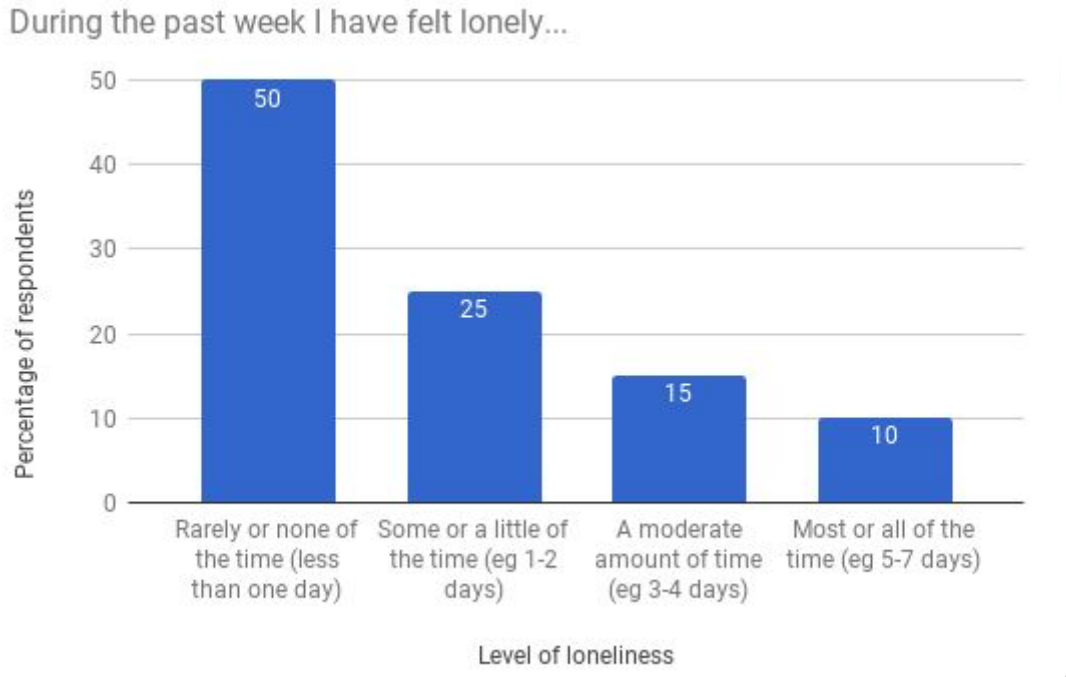



*Fig 3*

## Loneliness by age

It is a common perception that older people are more likely to be lonely, but from the responses we received this does not appear to be the case.

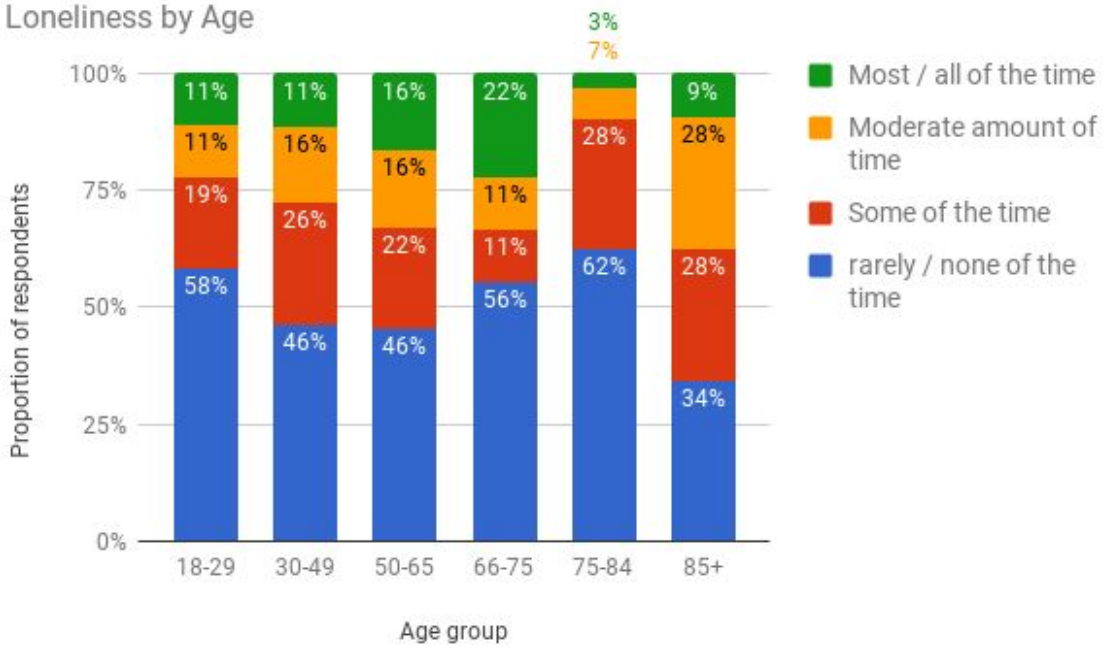



*Fig 4*

The depth of the green line represents the proportion of people by age group who feel lonely most or all of the time.

Those in early retirement appear to be the most *mostly or always* lonely, followed by those of working age from 50 years old upwards. When considering those who are *moderately to always lonely*, people aged 50-65 and 66-75 are similarly lonely (32% and 33% of people respectively). However, when considering people who are lonely at some point every week, those aged 85+ are considerably more affected than any other age group, with 66% of people lonely at least some of the time. In comparison, 44% of respondents aged 66-75 feel lonely at least some of the time.

The national research from British Red Cross also concluded that older people are not the most lonely group of people[16], however, similar to the Reading survey, it is probable that the survey did not reach the most isolated people in the older age categories due the the methods of data collection. It is important not to underestimate the issue of loneliness among the older population in Reading. Around 10% of all over 65s are lonely[17], and consequently, there are over 2000 lonely pensioners in Reading.[18]

Younger respondents who were not connected to services that promoted the survey, accessed it through online promotion and social media. In the older age groups, individuals who are not linked into existing support, visiting social groups or public spaces where the survey was available were less likely to have been reached. Therefore there is high likelihood that the most isolated older people were not reached by the survey and it cannot be assumed the issue is not more prevalent among older people.

## The impact of social media on feelings of loneliness

Younger people may be more prone to feeling more left-out, and consequently more lonely, as a result of social media. An increasing body of research recognises the negative impact social media can have on young people's wellbeing. An article in the Guardian newspaper reports on a poll around the mental health impact of social media on 14 to 24 year olds (our study only examines ages 18+) reports,

> "[Facebook, Snapchat, Twitter and Instagram] have a negative effect because they can exacerbate children's and young people's body image worries, and worsen bullying, sleep problems and feelings of anxiety, depression and loneliness, the participants said."[19]

Social media, in particular Instagram and Snapchat enable young people to compare themselves with others in a way that less regular / non users of social media do not experience. This impacts on people's expectations of what they 'should' be doing and therefore may also impact on the results around loneliness in younger age categories.

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[16] Kantar Public, *Trapped in a Bubble: An investigation into triggers for loneliness in the UK,* December 2016

[17] Victor, C, *Loneliness in older age: the UK perspective* in Age UK Oxfordshire (2011) *Safeguarding the Convoy: a call to action from the Campaign to End Loneliness*

[18] 2011 Census – Population and Household Estimates for England and Wales, March 2011 from Campaign to End Loneliness Constituency Campaign Pack

[19] Campbell, D, *Facebook and Twitter 'harm young people's mental health'*, The Guardian, May 2017, https://www.theguardian.com/society/2017/may/19/popular-social-media-sites-harm-young-peoples-mental-health

## Loneliness by length of time living in Reading

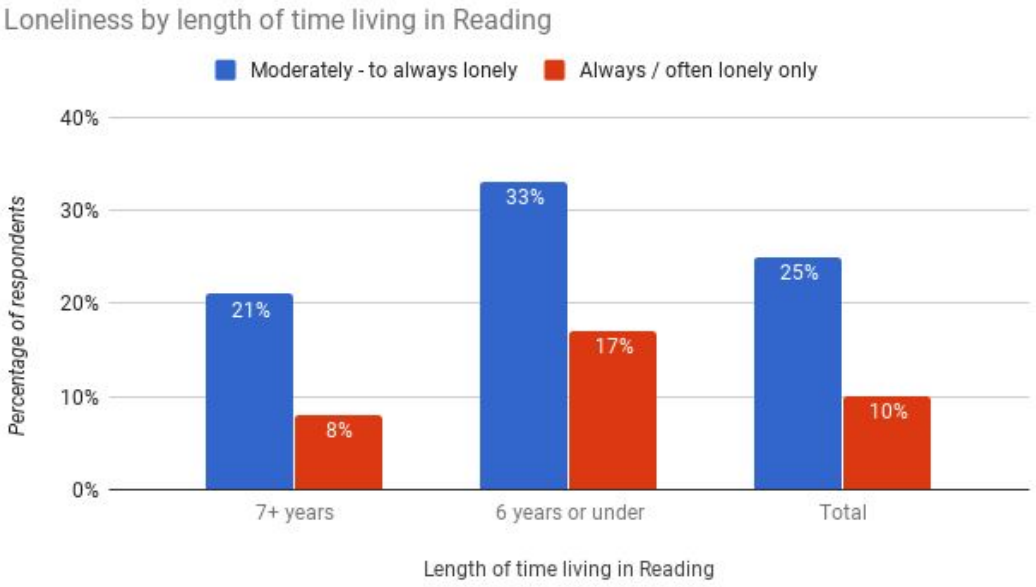


*Fig 5*

One of the factors protecting older people from loneliness may be their length of residence in Reading.

Figure 5 shows that more than double the number of people who have been in Reading less than 6 years feel mostly / always lonely (17%) compared to those who have lived in Reading more than 6 years (8%). How short a time under 6 years does not seem to be significant within the sample size of respondents.

## Loneliness and lack of social contact

Figure 6 displays frequency of social contact by age. This information helps us understand in which cases social contact correlates to loneliness.

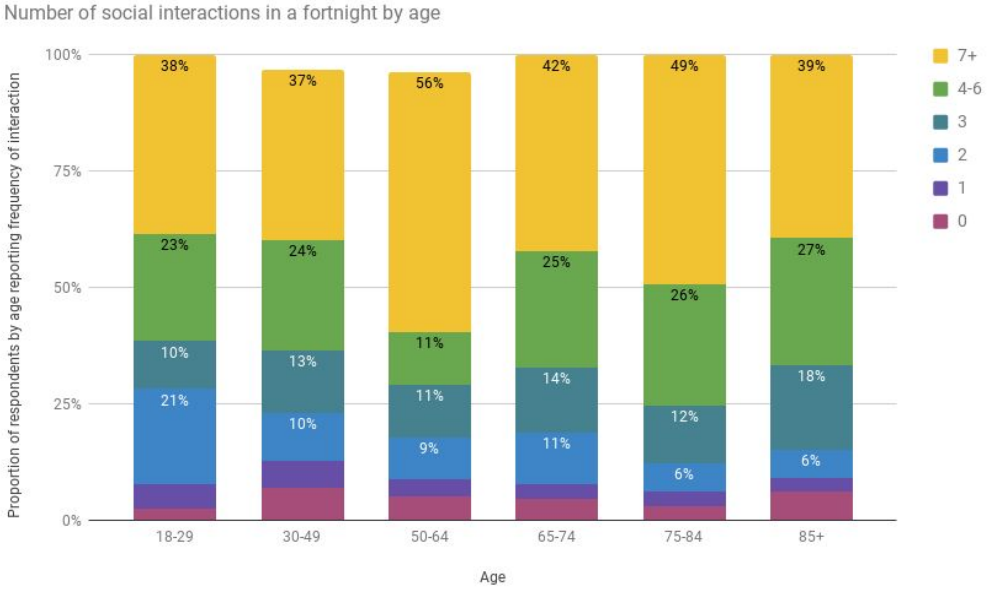


*Fig 6*

There are no strong trends by age and frequency of social interaction. The clearest trend can be seen among respondents who have very few social interactions (0-2 social interactions in the past fortnight). In the 18-29 age group, 29% of respondents report having very few social interactions. 12% of respondents in the 75-84 years age group report the same frequency of social interactions.

We also asked respondents where they met people. (see appendix, Q9) Responses were free text, but later categorised into ‘intentional’ and ‘incidental’. Incidental meetings included answers such as medical appointments, shop staff, CAB appointments and school drop-off. Intentional meetings were those where the social interaction was planned. In the age groups 18-49, 28% of respondents included incidental meetings. In the 75+ age groups, 36% of respondents included incidental meetings.

Loneliness cannot simply be attributed to regularity of social contact, however the results show it is a contributing factor. This is clearest when respondents are split into those who have seen people fewer than 4 times in the last fortnight and those who have seen people 4 or more times in the last fortnight (furthest right). Twice as many people who see others less often are moderately to always lonely compared to those who see people more often.

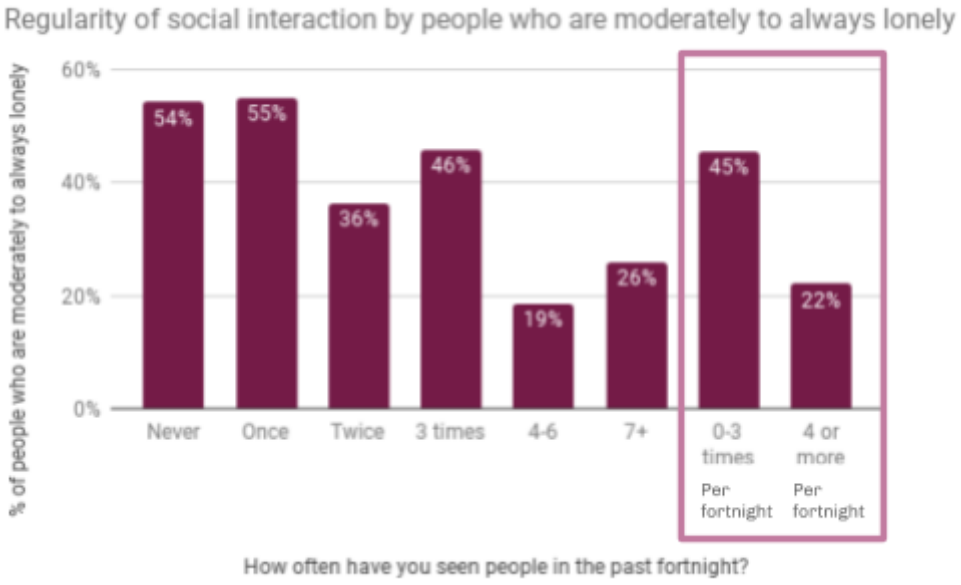


*Fig 7*

Lack of social contact also correlates to length of time living in Reading.

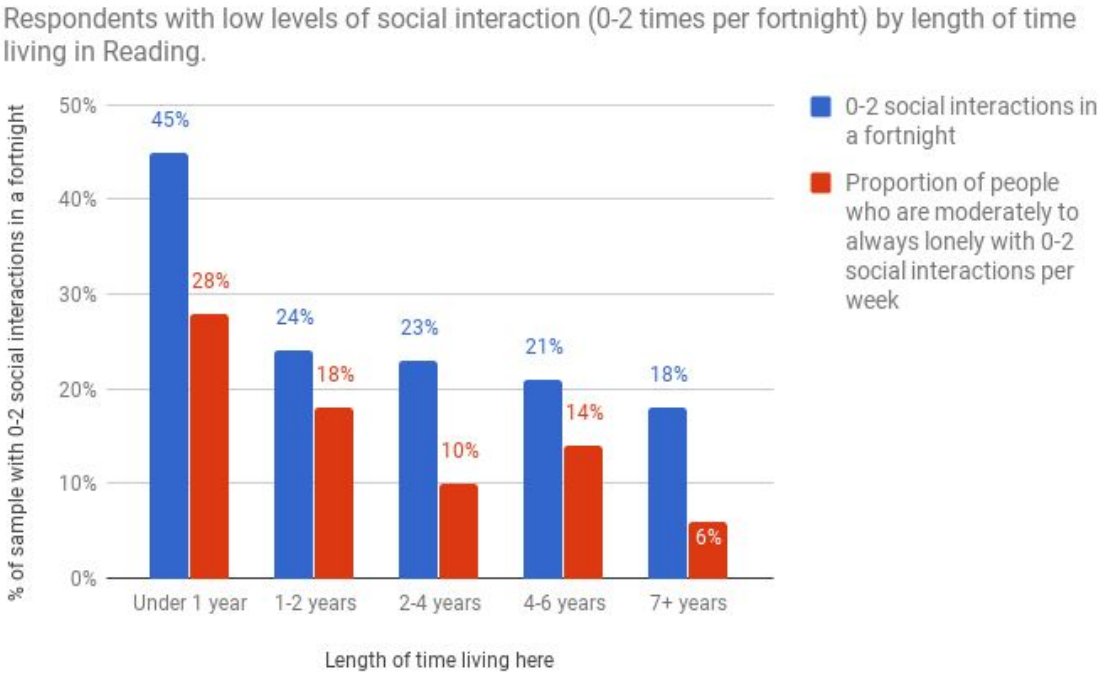


*Fig 8*

Figure 8 displays the proportion of people who have had fewest interactions in the past fortnight. (0-2 interactions). The red columns show those who have 0-2 interactions and identify as moderately to always lonely. Many services around loneliness in Reading focus on older people yet the majority of newcomers to Reading, who face high levels of loneliness, are people of working age. It is evident from the chart above that people tend to build a social circle fairly quickly as levels of social interaction increase considerably after the first year. However from the data on the previous page, this does not necessarily impact on loneliness until someone has lived here for a longer time period.

Evidence shows that a lack of sense of belonging correlates to a sense of loneliness.[20] These charts imply that although an increase in social interaction takes place after a short time living in Reading, the reduction in loneliness, and consequently, a sense of belonging, may take longer to develop. This is also reflected in many comments from survey respondents.

> *Having friends does not necessarily stop people feeling lonely. Loneliness is about belonging, disconnection, and not feeling supported.*
> (50-64 year old, female, moderately lonely despite having fairly busy social life)

[20] Watt, Susan, Badger, Alison, *Effects of Social Belonging on Homesickness: An Application of the Belongingness Hypothesis,* 22/01/2009

# Barriers people face being more socially active

The survey asked people what is stopping them being more socially active. (See appendix Q12) The three most common barriers are confidence, knowledge of what is going on, and transport. Figure 9 focuses only on those respondents who have stated they are lonely at some point every week (not including the answer “rarely to never lonely”).

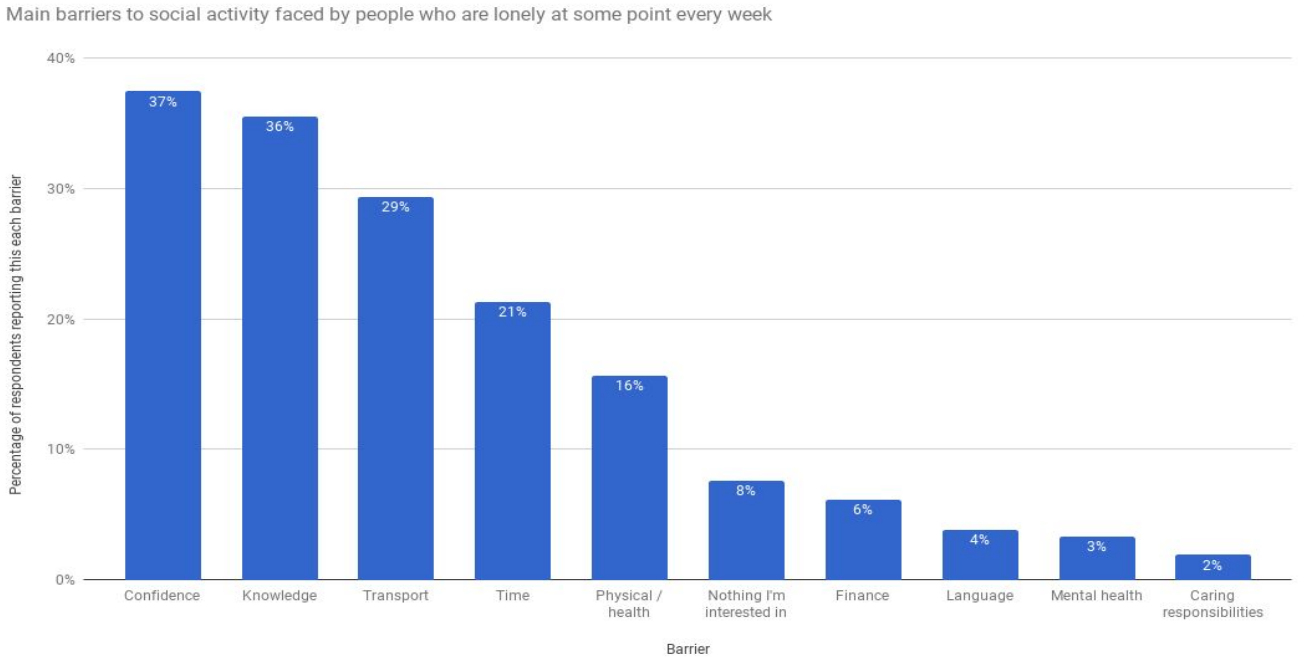


*Fig 9*

These three key barriers span all ages yet some are more prevalent among different age groups or life circumstances. It is worth looking in more detail at who is affected by these three barriers.[21]

## Confidence as a barrier to reducing loneliness

Figure 9 shows that 37% of people who are lonely at some point every week feel confidence is a barrier to being more socially active. This increases to 49% of those who are lonely at least 3 days per week (moderately to always lonely).

[21] It is important to note, that *finances*, *mental health* and *caring responsibilities* were free text answers and may have received higher responses rates if they had been check-box options.

Figure 10 shows that people of working age generally report confidence as more of an issue than those of retirement age.

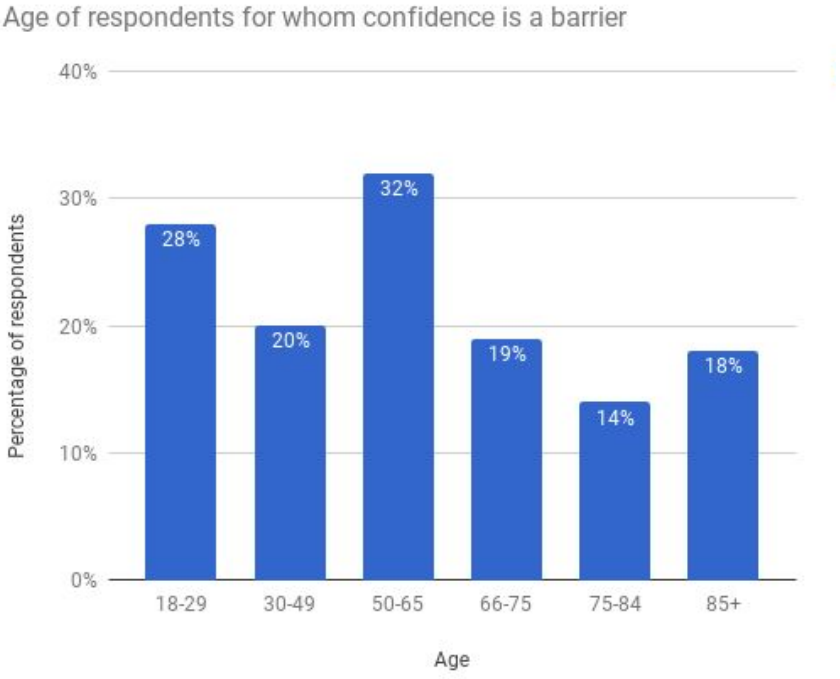


*Fig 10*

It is interesting to note the spike in issues of confidence for the 50-65 age group and that results of the survey also show one of the highest levels of loneliness for this age group. Many in this group may be 'empty nesters' whose children are leaving home for the first time. 'Empty nesters' are a target group within the Kantar Public 'Trapped in a Bubble' report into loneliness[22]. This could be a factor for the higher levels of loneliness and reduced confidence in this age group. This is also the age group that reports the highest number of social interactions in the past fortnight, but also the most intensely lonely age group (reporting 'mostly to always lonely').

The results for the 50-64 age group were checked against other risk factors for loneliness. This was to identify whether the spike in confidence issues and loneliness for this age range was due to other identifiable factors. It was found that there were no unusually high response rates from people in this age group in any of the following categories; unemployed, divorced, widowed, in unstable / temporary accommodation, carers, physical disability / health issues.

[22] Kantar Public, *Trapped in a Bubble: An investigation into triggers for loneliness in the UK,* December 2016, p13

## Lack of knowledge as a barrier to social activity

Lack of knowledge as a barrier to being more socially active versus age

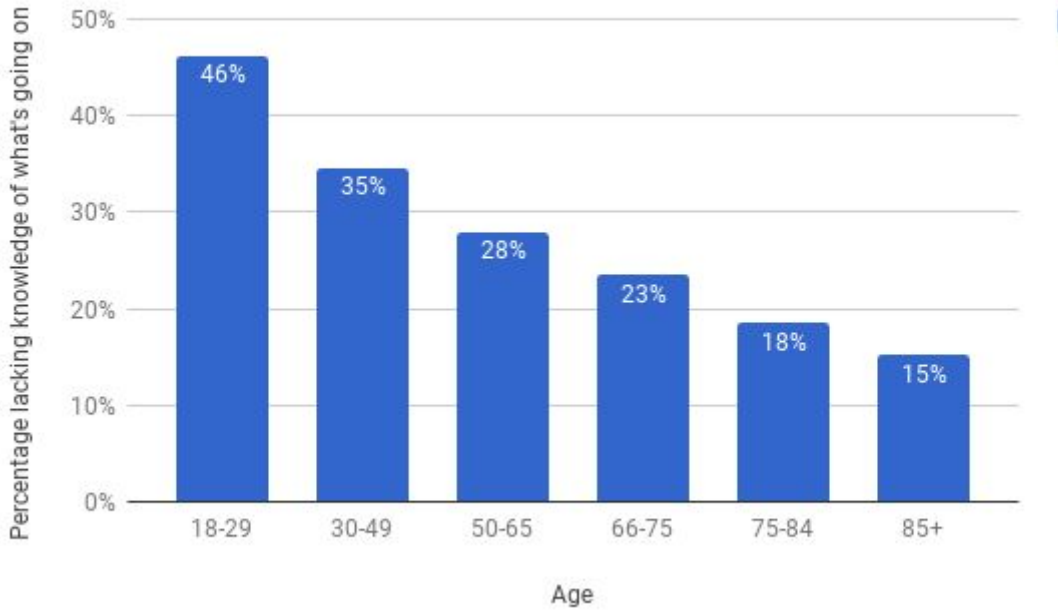


*Fig 11*

Lack of knowledge as a barrier to being more socially active vs Length of time in Reading

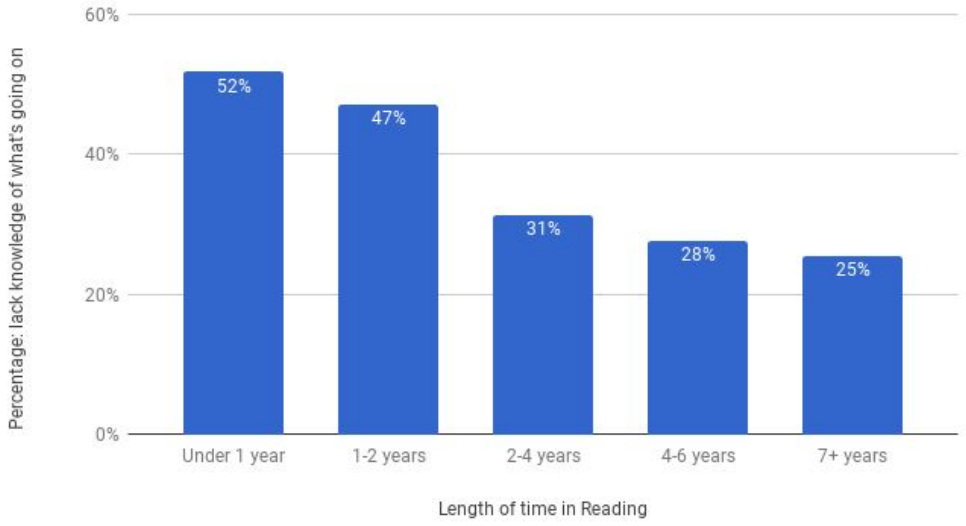


*Fig 12*

It is often thought that access to the internet helps to overcome significant barriers to knowing what is happening. Figure 11 suggests that the age groups most likely to make use of technology for their information are also the most likely to report lack of knowledge about what is available as a barrier to reducing loneliness. Figure 12, showing knowledge as a an issue and length of time living in Reading, also shows the same trajectory. As younger age groups are also more likely to have lived in Reading for less time, it may be that length of time in Reading is the contributing factor rather than age.

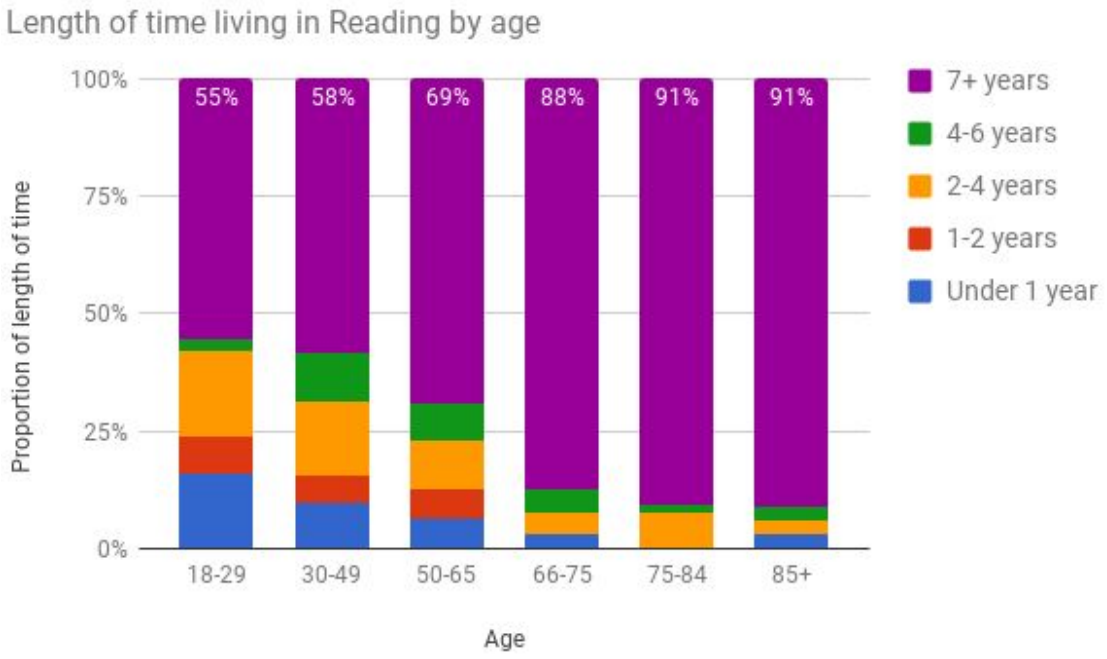


*Fig 13*

It is clear that length of time living in Reading is a key contributing factor to knowing what is going on and building social networks through those activities. The chart above highlights that a higher proportion of older adults have lived in the same place for a much longer period of time.This may be a contributing factor to why loneliness seems to affect a higher proportion of younger respondents highlighting lack of knowledge as a contributing factor.

As mentioned above, social media may play a role in these results; younger people, who are more regular users of social media, see what other people are doing and feel left out or feel they do not know what is going on because they are so much more aware of what other people are doing.

## Transport as a barrier to being more socially active

Transport as a barrier is a very broad category and so we asked people to specify in what way transport affected their ability to be more socially active.

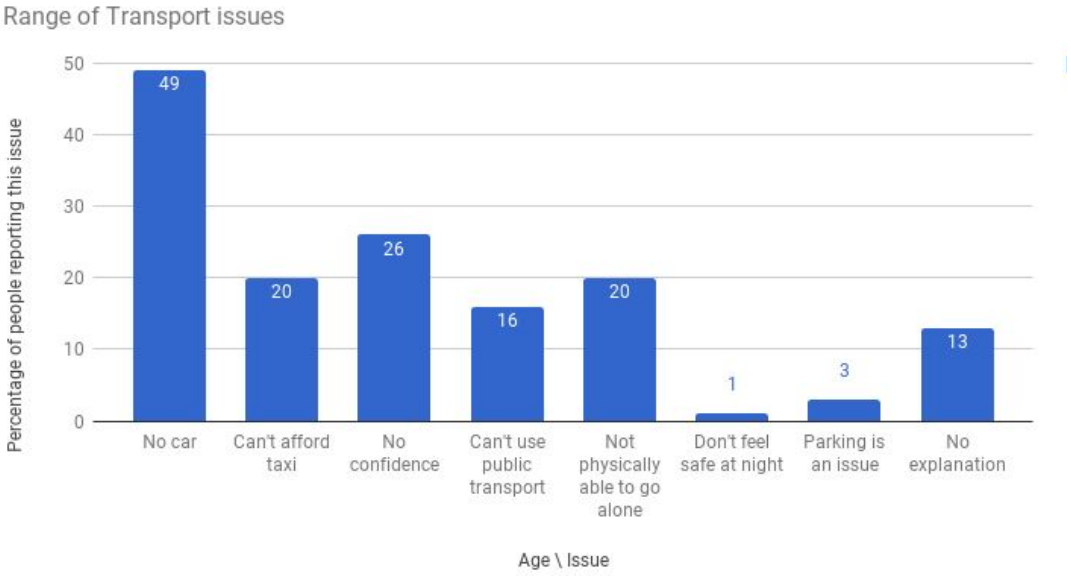


*Fig 14*

It can be assumed that the majority of respondents reporting transport as an issue have no car, although only 49% of this group reported having no car. 26% of people cited no confidence in relation to transport, therefore not necessarily as a practical barrier, but that being accompanied would make it easier to use transport. Mobility and physical difficulties in using transport, and financial constraints were an issue for 20% of respondents who responded to this question. 16% of those with transport difficulties feel unable to use public transport at all (either from a physical difficulty or confidence issue).

Figure 15 highlights certain groups who are more affected by transport issues than the general population. These groups represent people who may be less likely to have others in their household who drive if they don't (living alone, unstable accommodation), those who may have financial difficulties (in unstable accommodation, unemployed, full time parents) and those who may be less physically able or no longer be able to drive (85+).

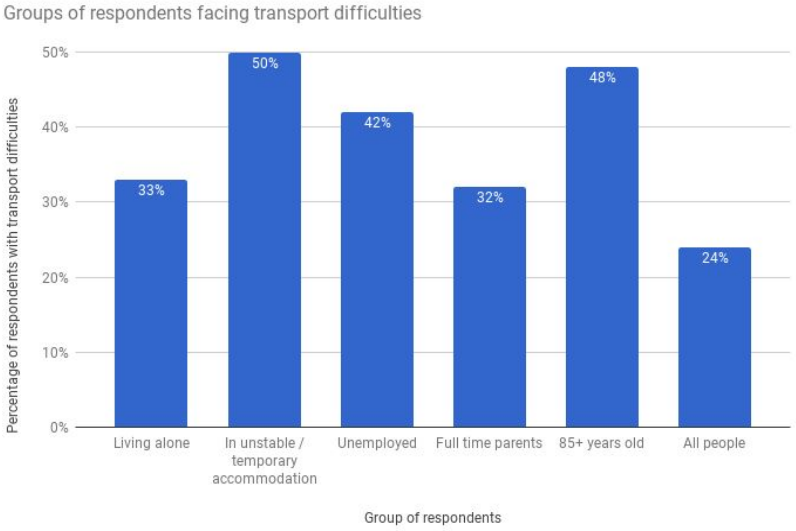


*Fig 15*

## Language skills and loneliness

16 respondents reported language skills as a barrier to being more socially active. Although the sample size is fairly small, some results are worth noting. Only one respondent had lived in the area for 7 or more years, so most are relative newcomers to Reading.

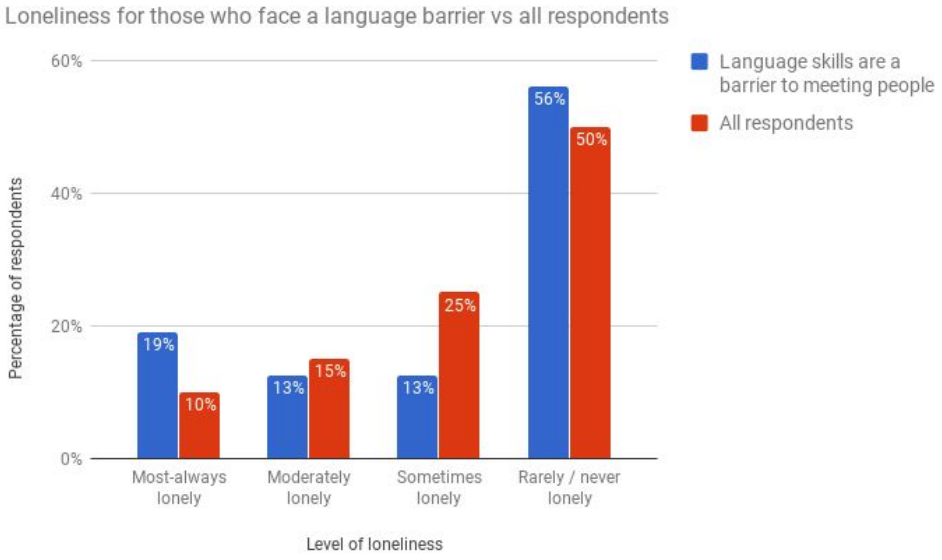


*Fig 16*

Almost double the proportion of people, for whom English was a barrier, reported feeling lonely most/all of the time compared to all respondents. However this is similar to that of all respondents who have lived in Reading for under 6 years (17%). The more noteworthy response within this group is that 100% of respondents (just 16 respondents) reported wanting more social contacts or friends.

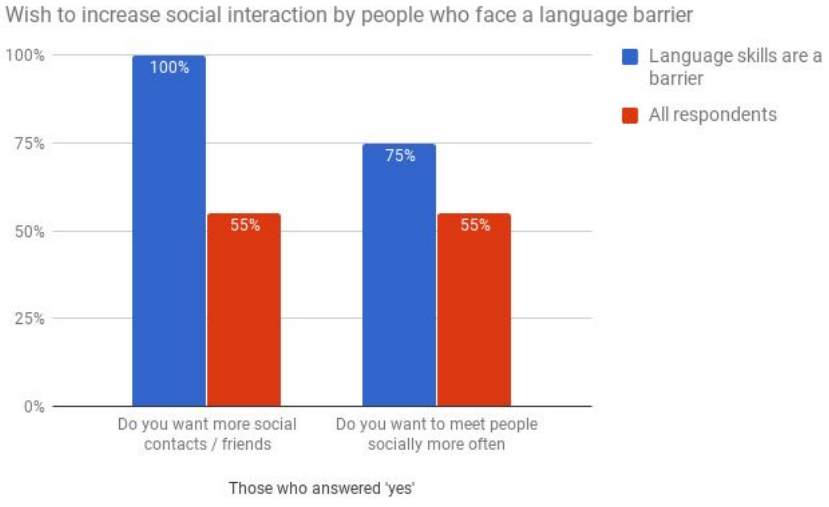


*Fig 17*

Similarly, 75% of these respondents want more regular social meetings. Although this group of people are not reporting as significantly more lonely than other groups, they are keen to widen their social network. This also reflects the observations of local organisation Reading Community Learning Centre[23] (RCLC). Staff have recognised a need for their learners to have opportunities to meet people outside of their families and RCLC itself.

[23] Reading Community Learning Centre reaches out and empowers isolated and vulnerable BAME women, whose first language is not English, to grow their skills, confidence and independence through learning, support and friendship across cultures. http://www.rclc.btck.co.uk/

# Specific groups and the barriers they may face

## Parents

This section focuses on parents living with children at home. 94 respondents (22%) reported living with children at home. For the purpose of this report, *'full time parents*' are those who have full time caring responsibility for their children. The term *'all parents*' also includes those who have other employment as well as child-caring responsibilities.

The results in figure 18 split *all parents* from *full time parents* as some of the issues differ. There are 19 'full time' parents (4% of respondents). Although parents cover a wide demographic, have lived in Reading for varying amounts of time and have varying life circumstances, there are some trends that affect parents differently to all respondents.

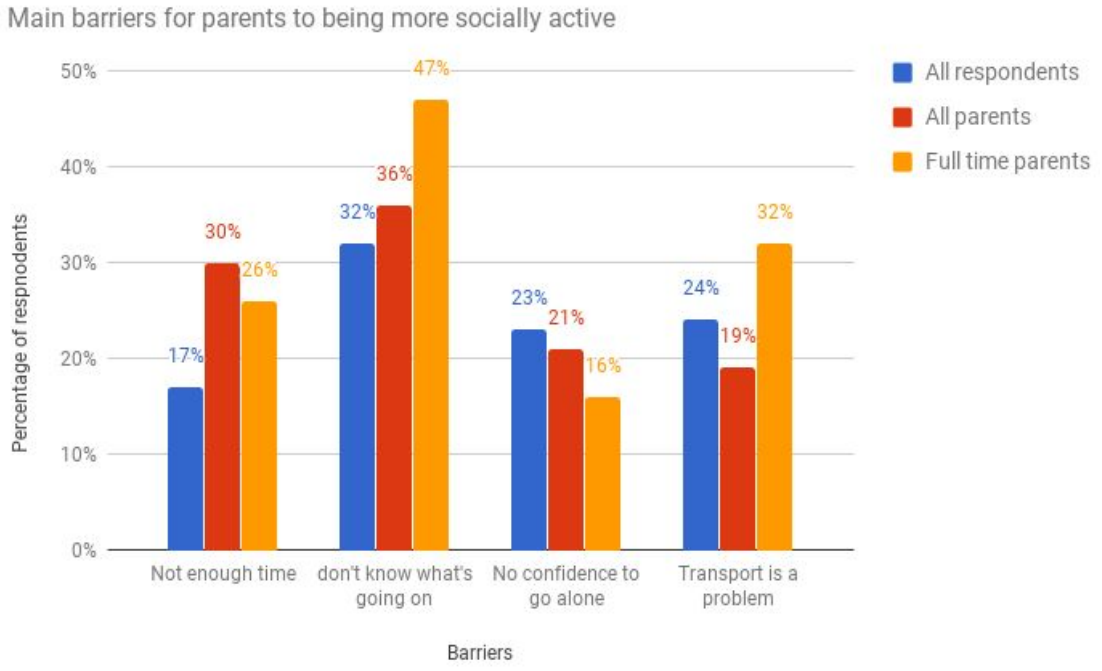


*Fig 18*

Figure 18 highlights the different issues parents face compared to all respondents. Lack of time is the biggest difference between all respondents and all parents. Full time parents are less likely to feel they know what is happening and more likely to find transport a problem. This is likely to indicate that the full time parents with transport problems have no/limited access to a car. Confidence is less of an issue among parents than the general population.

Loneliness in parenthood is an oft-discussed issue in both the media and in academic research.[24] This can be compounded by additional issues such as financial constraints, mental health difficulties or being new to the area as this parent describes:

> *[I'm] in a relationship where I do not have financial independence. I haven't spoken to anyone except my children and partner [in the past fortnight.]*
> (Parent who has had no social interaction in the past fortnight, mostly / always lonely)

[24] Woman's Hour, Radio 4, http://www.bbc.co.uk/programmes/p021ngb7, 25/6/2014

## People with physical disabilities, health issues and mobility impairments

Thirty seven respondents (8.5%) reported that a physical disability or health issue impacted on their ability to be more active socially. The questionnaire did not ask specifically whether respondents had a disability, so this may not reflect all respondents with a disability, only those for whom physical ability or health impacted on their social opportunities. (Identified from Q12, see annex.)

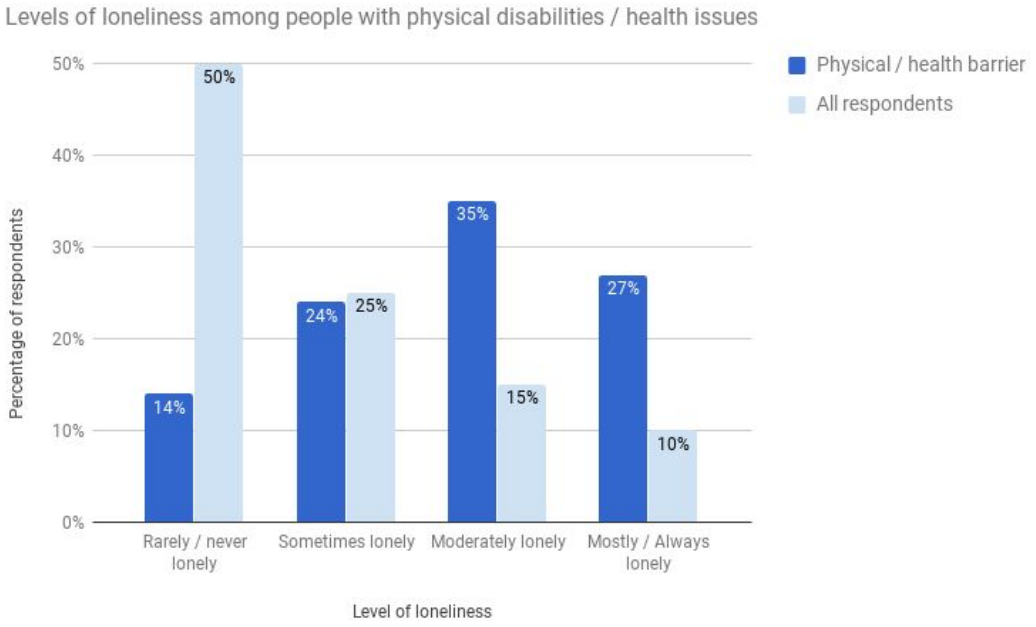


*Fig 19*

There is a stark contrast between all respondents and those who face physical or health barriers to being more socially active as figure 19 shows.

Frequency of social encounters cannot be used as a direct indicator of loneliness, yet the information helps us to understand why people are lonely. 38% of respondents in this group met people 7 or more times in the past fortnight. whereas 43% of all respondents reported having met people 7 or more times in the past fortnight. It would seem that respondents with physical and health difficulties are only slightly less socially active than all respondents. The significant difference however, is that 57% of respondents with a physical / health issue included incidental or practical encounters (eg on the bus, carers, GP surgery, visit to CAB) as opposed to just 13% of all respondents.

Where people have included additional information, it becomes apparent that very often, respondents face multiple challenges to being more socially active, especially where health and mobility are one aspect as shown below.

> *"I am fighting so many internal barriers to leading a fulfilling social life. Having the additional barrier of lack of access just makes it so much harder on those days when I do feel like I could talk to people and mix in and break down some walls."*
> (Female, 30-49, lonely most/all of the time, living with parents, disability, anxiety, lacks confidence, unable to use public transport, doesn't know where to go for support)

## Loss of a partner (divorce / separation and widowed)

Analysis of people who have lost a partner through divorce / separation and being widowed have been combined as neither group is sufficiently large to conduct thorough analysis and the groups face some shared issues. 3.4% of respondents(15 people) identified as divorced or widowed.

40% of respondents in this category (6 people) are moderately to always lonely, compared with 32% of all respondents. The main barriers for these people are time, transport and confidence. Time differs from the majority of respondents as a key barrier, which is understandable for people who are now managing a household on their own, when they formerly did so alongside a spouse.

## Mental ill-health

3.6% (16 people) identified mental ill-health as an issue. This was not a direct question. As the information was volunteered, it may not be representative of all respondents for whom mental health affected feelings of loneliness.

Eight people in this group (50%) are mostly or always lonely and fourteen people (88%) are lonely at some point every week. This is as opposed to 10% and 50% of all respondents respectively. The questionnaire does not identify cause or effect between mental illness and loneliness, but it does seem to demonstrate there is a correlation between the two.

> *"Drinking causes problems, anxiety, mental health, ADHD, aspergers, panic, no money, lateness, homeless, no phone"*
> (Male, newcomer to Reading 30-49 years, in temporary / unstable accommodation, mostly / always lonely)

Similarly to the respondent above, over half reported multiple issues (such as physical health, finances or caring responsibilities) as additional barriers to being more socially active and eleven people (69%) identified a lack of confidence as an issue.

## Unemployment

Figure 20 shows unemployment has an effect, but does not overwhelmingly impact on levels of loneliness among survey respondents. 24 people in the sample are unemployed.

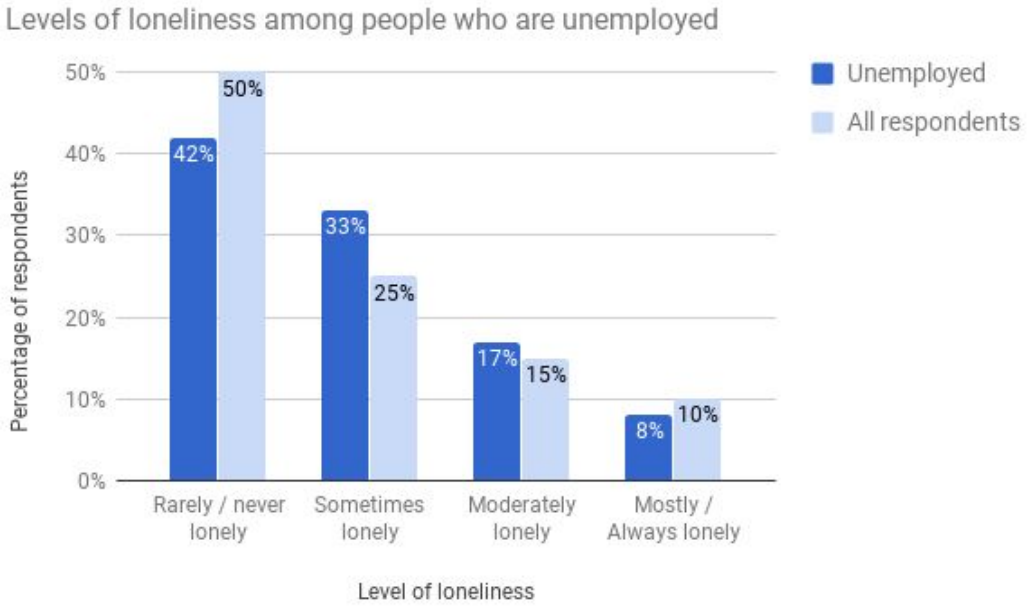


*Fig 20*

Levels of loneliness at some point every week (sometimes to always lonely) are slightly higher among people who are unemployed (58% as opposed to 50% of all respondents). However the main difference is in the 'sometimes lonely' category, with no difference when measuring moderately to always lonely together.

A more significant difference is identified in the questions that focus on a wish for more social interaction and more social contacts. 20 people (83%) responded either 'yes' or 'maybe' to wanting more regular social interactions and 22 people (92%) responded 'yes' or 'maybe' to wanting more social contacts / friends. This is in contrast with 58% and 68% respectively of all respondents.

One unemployed respondent expressed how important it was that community venues existed as a social meeting space.

> *"Reading is extremely lucky that it has places to meet which are [...] welcoming and not purely commercial enterprises eg Global Café, [Rising Sun Arts Centre] and facilities to enable voluntary [...] groups to easily meet[...]. Without these, I personally would be seriously lonely."* (Unemployed male, long term resident, aged 50-64)

Reading benefits from many community and social meeting spaces, both commercial and not for profit. The respondent above has found a network of people and places to socialise with financial constraints. However many people seem to struggle to find out where they can meet others, especially if they are new to the town.

# What social activity respondents would like

The chart below highlights the types of activities that people would most like to attend if they were able to overcome the barriers they face. The lighter blue reflects all respondents, whereas the darker blue colour represents respondents who are moderately to always lonely and lack confidence. While the trends are similar, certain activities are more popular among people who are lonely and lack confidence, namely small group activities, one-to-one activities, walking groups, meeting neighbours and volunteering.

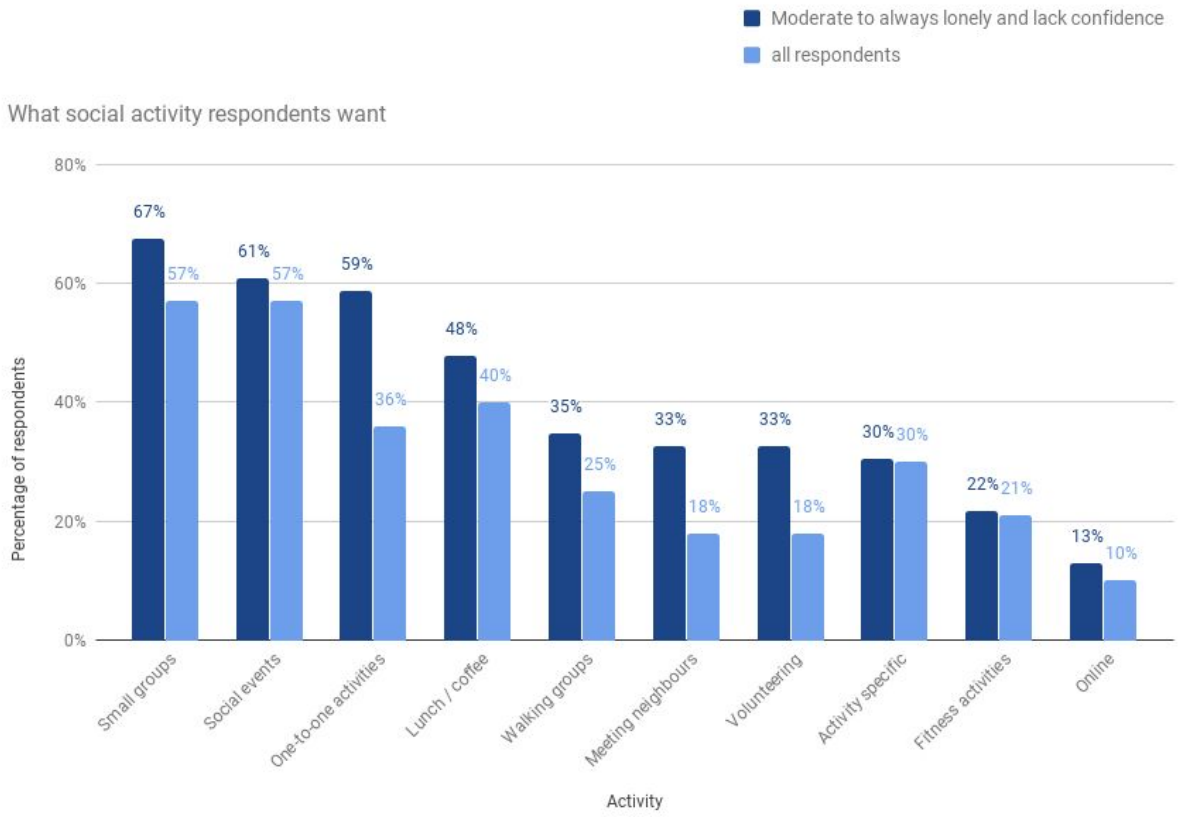


*Fig 21*

For people who are moderately to always lonely and lacking in confidence, the most striking difference between their responses and those of all respondents is in meeting neighbours and volunteering. For example, they identify volunteering 15% more than all respondents to reduce loneliness.

> *"There are too many conditions to be accepted for a volunteering job. [People] involved with volunteering seem not very accepting of the new volunteers."*
> (Newcomer to Reading, 55-64 years, mostly or always lonely)

Many people come into contact with Reading Voluntary Action to get support to find volunteering opportunities in order to meet people, but many people face barriers even once they have. One third of those who are lonely and lack confidence see volunteering as a means to reducing loneliness. Therefore it is important to ensure that support is available to those wishing to volunteer but lacking the confidence to do so.

## Meeting neighbours[25]

A sense of community can develop around a culture, a shared hobby or cause, or shared life situation, but often is thought of as the neighbourhood in which one lives.

> *"I suffer from depression and often feel sense of loneliness even when around others. I often have concerns that some of my elderly neighbours [...] are lonely but worry that if I try [to] befriend them it may come across as patronising or that [...] I'm trying to taking advantage of them."*
> (30-49 year old, long term resident)

Many approaches already exist that encourage people to be more neighbourly. Street parties, Play Streets[26], social gatherings through residents' associations, neighbourhood newsletters and social media tools to bring together neighbourhoods all exist in Reading which contribute to bringing groups of neighbours together.

The role of a strong social network in the neighbourhood where one lives cannot be underestimated as is clear in this example:

> *I'm quite happy as I have a large close family, two great friends and good neighbours"*
> (75-84 year old woman in RG2, long term resident, living alone, rarely/never lonely)

## Meeting in small groups, social events and one-to-one

These categories have a higher response rate as they are more general than some of the more specific options. It is worth noting the significant increase in the desire for small group and one-to-one social interaction for people who lack confidence and are lonely, a 23% more than for all respondents. A high number of comments reflected on why this is important.

> *I am able to meet people: at work, at events and in groups I volunteer with. But I find it very difficult to make friends, or connect further with people in Reading. Although I'm not physically alone, it feels very isolating to not be close or comfortable with people. I found this easier in my previous city [...] to find activities and groups that [didn't revolve] around drinking/working.*
> (Female, living alone, 30-49, relatively new to Reading)

Similar to this female resident, three other females of working age commented on having wide social circle or active social life, but not necessarily feeling close to people, and that it was hard to make those more meaningful connections.

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[25] *Meeting neighbours* was added as an option to the survey after the first 100 responses were in. Therefore the proportion of respondents who were able to and selected this response is 23% rather than 18% as noted in the chart above. Correspondingly, those who were lonely, lacking confidence, and wishing to meet neighbours, would be 42%.

[26] Play Streets give children the chance to play safely in their street without danger from traffic. www.reading.gov.uk/playstreets

# Further research opportunities

Although the questionnaire reached people from a range of minority backgrounds, the numbers were not statistically significant to draw any conclusions about any specific ethnic group. The 18-29 age group was also underrepresented. Both of these groups could be followed up with more targeted research.

Despite the low numbers, we did look at results specific to people who are divorced or widowed, parents, unemployed, suffer from mental ill-health and in temporary/unstable accommodation. We chose to look at these in more detail as they are known risk factors for loneliness. However the numbers in these groups were too low to be fully representative.

The questionnaire did not specifically ask about mental health, physical health or disability, except in relation to transport being a barrier to getting out. Therefore the numbers we know of are those who mentioned physical disability or health in relation to transport issues, or mentioned either physical or mental health in additional comments boxes. It is possible that the number of respondents with these specific issues may be higher than the number of responses that mention it, as the question was not directly asked.

We asked for the first half of respondents' postcodes, but did not provide any comparative analysis on geography as it was decided that this level of information (eg RG2, RG30) was not geographically specific enough to draw any conclusions about where people lived. This result however, did show us that results were gathered from all areas of Reading.

The research has provided information on who is lonely, what barriers they may face to being more socially active and what they would like to do. Further research through focus groups would be useful to understand what can be done about these problems and what would help people to overcome barriers they face.

It is evident from the questionnaire, that a large number of people who are very lonely face multiple barriers to being more socially active. These multiple barriers may be a mixture of practical, financial, physical and mental health issues. Complex combinations of issues cannot be solved through one intervention or organisation working in isolation, but require an holistic and collaborative approach across sectors and organisations to ensure individuals needs and concerns are addressed in order to have a significant impact on reducing isolation and loneliness.

# Appendix

### Social Activity Questionnaire

**Q1) My age is**

18-29 30-49 50-64 65-74 75-84 85+ Prefer not to say

**Q2) Where do you live?**

RG1 RG2 RG30 RG31 RG4 RG5 RG6 Other _____

**Q3) How long have you lived here?**

Less than 1 year 1-2 years 2-4 years 5-7 years 7+ years

**Q4) My gender is**

Female Male Trans _____ (other) Prefer not to say

**Q5) I identify as**

1. English / Welsh / Scottish / N Irish / British
2. Irish
3. Gypsy or Irish Traveller
4. Any other White background (add in other)
5. White and Black Caribbean
6. White and Black African
7. White and Asian
8. Other Mixed ethnic background (add in other)
9. Indian
10. Pakistani
11. Bangladeshi
12. Chinese
13. Other Asian background (add in other)
14. African
15. Caribbean
16. Other Black/African/Caribbean (add in other)
17. Arab
18. Other _____
19. Prefer not to say

**Q6) Please tell us a little about your home circumstances**

- ❑ Living alone
- ❑ Living in a house share
- ❑ Living with partner
- ❑ Living with children
- ❑ Recently divorced / separated
- ❑ Recently widowed
- ❑ A carer (for friend or relative)
- ❑ New to Reading
- ❑ Unemployed
- ❑ In temporary / unstable accommodation
- ❑ Full time parent
- ❑ Other_____

**Q7) How many times in the past 2 weeks have you met with people?**

0 1 2 3 4-6 7+ times

**Q8) Would you like this to increase?** Yes No

**Q9) Where have you met people in the past two weeks?**

**Q10) During the past week, have you felt lonely:**

- ❑ Rarely or none of the time (less than one day)
- ❑ Some or a little of the time (eg 1-2 days)
- ❑ A moderate amount of time (eg 3-4 days)
- ❑ Most or all of the time (eg 5-7 days)

**Q11) Do you want to increase your social contacts / make more friends?**

❑ Yes ❑ No ❑ Not sure

**Q12) How would you most like to meet more people? (tick as many as are relevant)**

- ❑ Meeting people one-to-one
- ❑ Opportunity to meet people in small groups (3-6 people)
- ❑ Social events (lunch clubs, day centres, Meetup groups)
- ❑ Activity specific If so, what type of activity?_____
- ❑ Over lunch or coffee
- ❑ Sports / fitness activities
- ❑ Walking groups
- ❑ Other _____
- ❑ Volunteering
- ❑ Online (Facebook, Skype / social media)
- ❑ Opportunities to meet neighbours

**Q12) What is stopping you access these activities already?**

- ❑ I don't know what / where / when things are happening
- ❑ There is nothing that I'm interested in
- ❑ I don't feel confident going on my own
- ❑ Language skills
- ❑ I'm not physically able / I don't feel well enough to access activities
- ❑ Activities don't happen at times that suit me
- ❑ Transport is a problem
  - ❑ No public transport
  - ❑ I don't have a car
  - ❑ I can't use public transport
  - ❑ I can't afford a taxi
  - ❑ I'm not confident using transport on my own
- ❑ Other _____

**Q13) Is there anything else you would like to add?**

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READING VOLUNTARY ACTION

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# Loneliness and Social Isolation in Reading

**Presentation to the Health and Wellbeing Board**
**6th October 2017**
**Sarah Morland, Partnership Manager**

# Presenting the findings from a Reading-wide questionnaire into loneliness and isolation in April and May 2017

# Aims and approach

➔ Local organisations working together to address loneliness and social isolation

➔ Understanding local issues

➔ Seeking to identify:

- who is affected by loneliness and isolation?
- what barriers do they face to being socially active?
- what would enable people feel less lonely and socially isolated?

# Methodology

- Jointly developed survey
- Accessible on-line and hard copy
- Distributed by local organisations, through libraries and surgeries
- 437 responses inc 74% hard copies and 26% on-line
- Most likely to have reached those who can get out and about or are connected on-line
- Not representative of population - work underway to address this

# Loneliness and Isolation

**Loneliness** is characterised by a negative feeling which occurs between desired and actual quality of relationships or social contacts - situational /transient or chronic

**Social isolation** is generally agreed to be more objective - relates to the extent to which an individual is isolated from social contacts including friends, family members , neighbours or the wider community

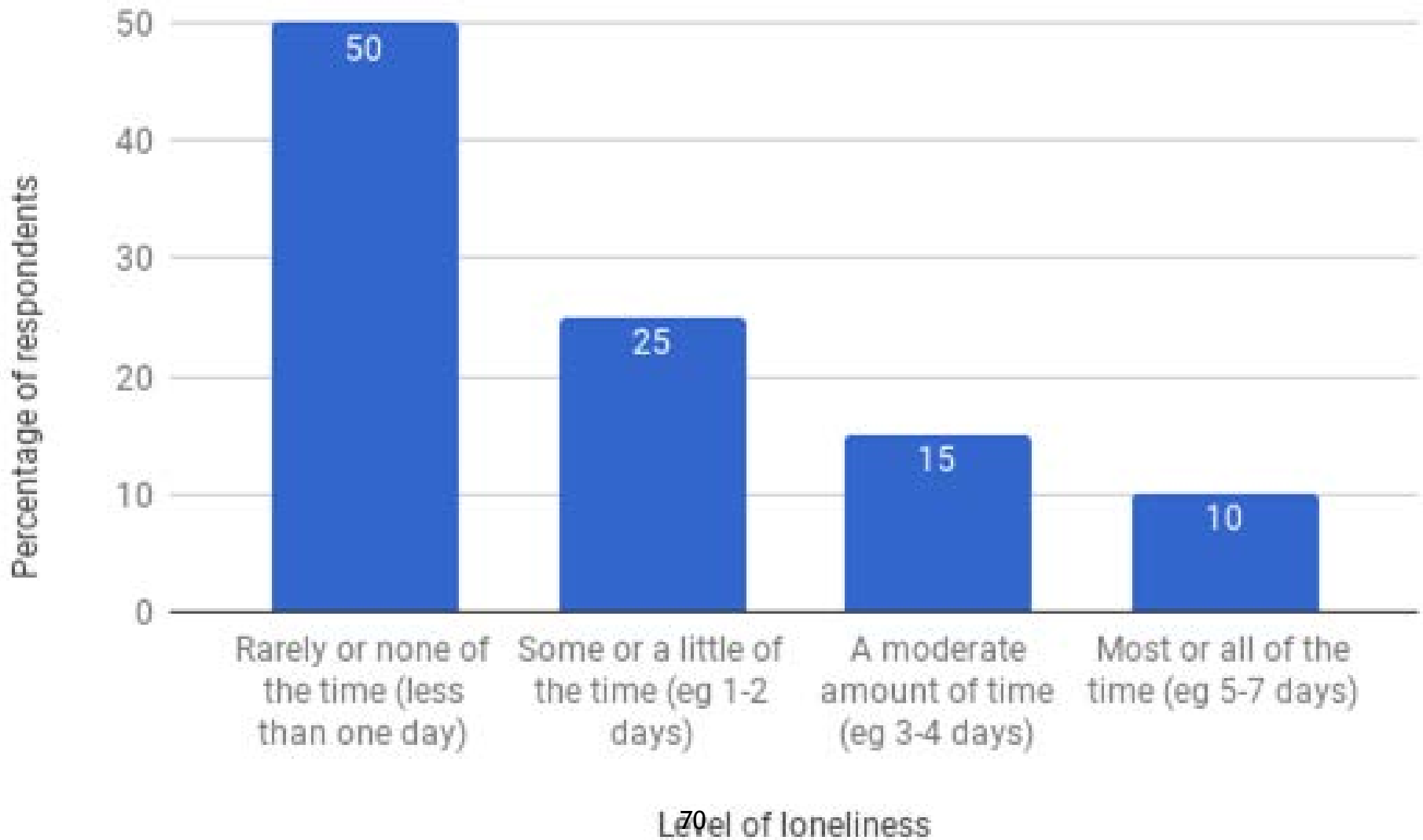
# Loneliness and Isolation

"Having friends does not necessarily stop people feeling lonely.  Loneliness is about belonging, disconnection and not feeling supported"

50-64 year old female, moderately lonely despite having a busy social life

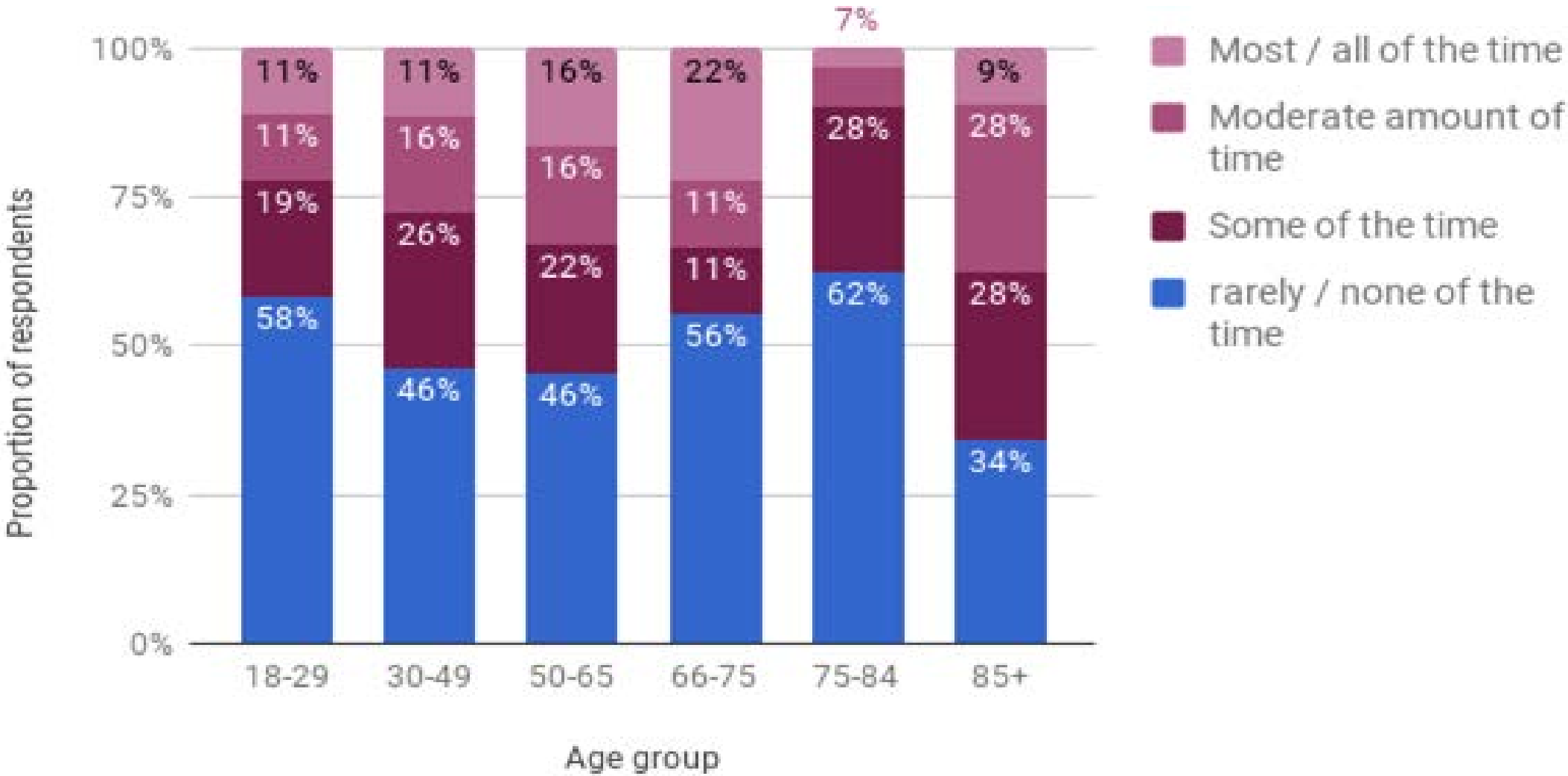
# Who is experiencing loneliness?

During the past week I have felt lonely...



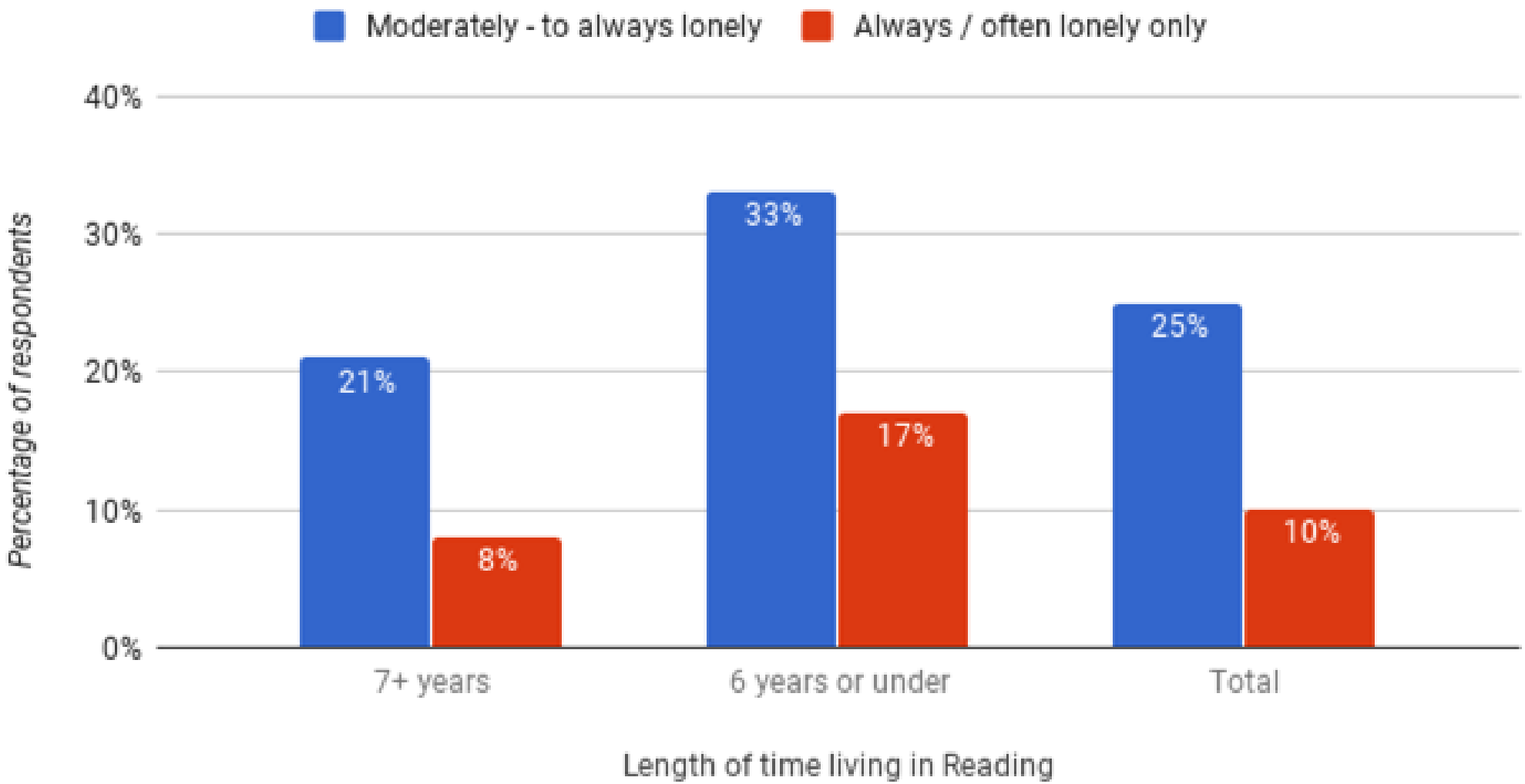
# Who is experiencing loneliness?

## Loneliness by age



# Who is experiencing loneliness?

## Loneliness by length of time in Reading



# Barriers to social activity

- Lack of information about what/when/where things are happening
- Lack of confidence
- Difficulties with transport

# How is voluntary sector responding?

## Lack of information about what/when/where things are happening

- Signposting (between organisations and groups)
- Social prescribing
- Reading Services Guide and RVA Directory

# How is voluntary sector responding?

## Lack of confidence

- Getting out and about - e.g. Age UK Berkshire
- Peer mentoring - e.g. Reading Your Way
- Befriending - e.g. Engage Befriending
- Groups - e.g. Tilehurst Together
- Volunteer buddies (being explored)

# How is voluntary sector responding?

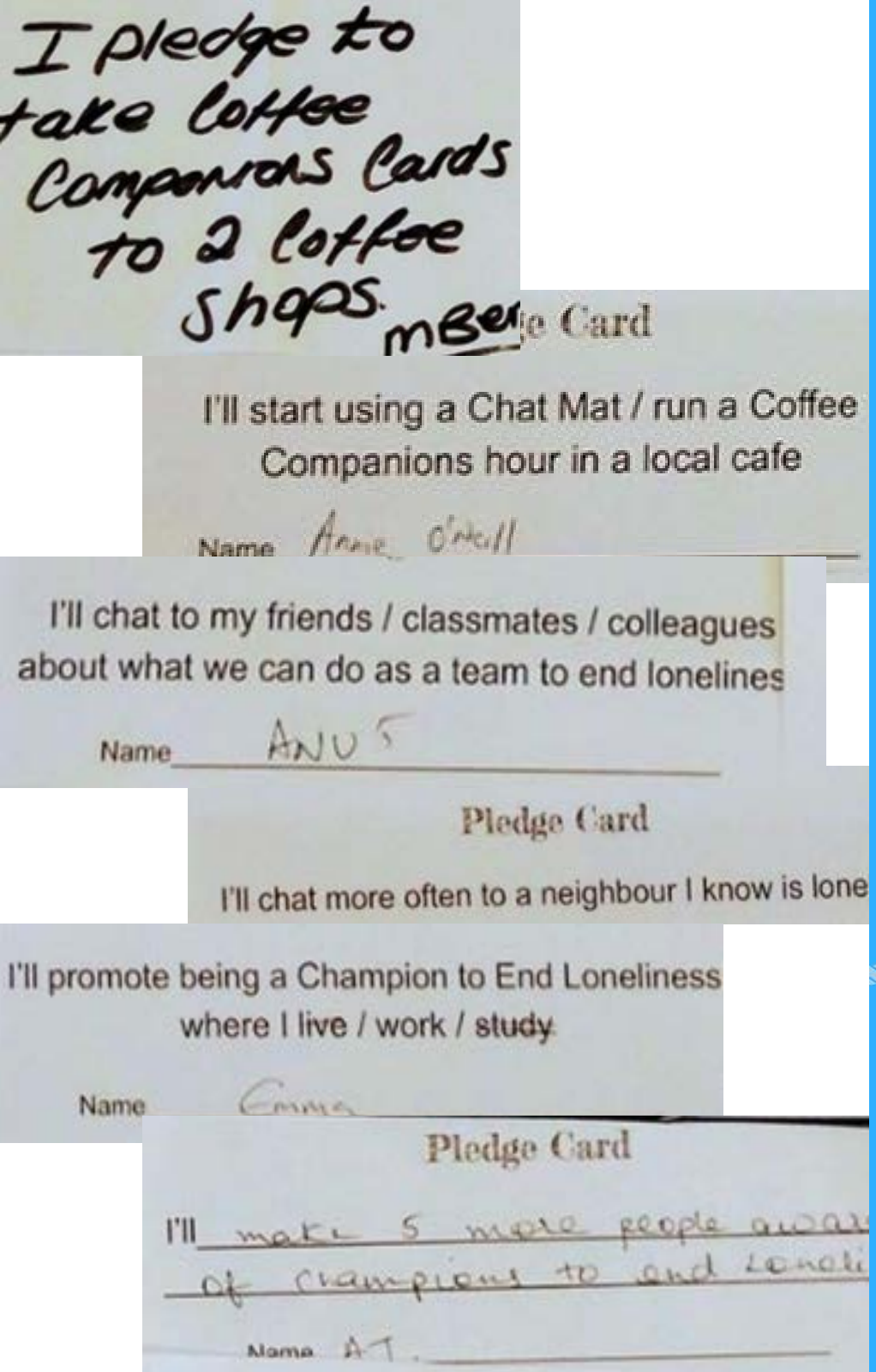
## Difficulties with transport

- Readibus
- Caversham Good Neighbours
- The Globe
- Volunteer buddies (being explored)
- Volunteer car driving schemes (being explored)

# Champions to End Loneliness

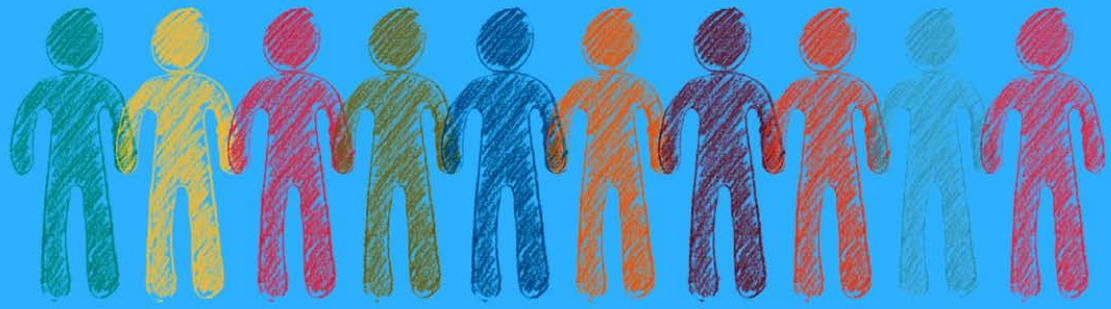
Engaging members of the public to take action on loneliness

- Workshops in partnership with local community groups to inform
- Pledge cards and online pledge board
- Signposting people to local organisations that need volunteers
- Support to take action through personal commitments or getting involved with existing organisations




Caversham needs

# Champions to End Loneliness



are you with us?

Join the workshop to find out how

Caversham Library

Tues 26 Sept, 5:30 pm - 7:30 pm

Book: bit.ly/CavershamChamps

READING VOLUNTARY ACTION

Free refreshments!

The Earley Charity
by hook or by crook

# Champions to End Loneliness

## Make a pledge to end loneliness

- 10.5% of people in Reading are lonely most or all of the time. That's around 16,000 people.
- 50% of people in Reading are lonely at some point every week. That's around 78,000 people.

Little actions can make a big difference. What could you do?

Name (required)

Email (required)

I pledge to... (required)

I'll chat more often to a neighbour I know is lonely

Customise your pledge (if you'd like to say something more specific / personal about what you'll do):

In order to carry out my pledge, I would like more information about...

Please sign me up to the Champions to End Loneliness mailing list.

Please do not include my name on the online pledge board.

Submit »

# How is the research being used?

- Already supporting individual funding bids
- Basis for future voluntary sector bids to address gaps
- Informing Reading's JSNA

# A role for statutory agencies?

- Nominate Champions to End Loneliness within services and practices
- Promote VCS services e.g. via Social Prescribing
- Invite RVA to brief on VCS services that can support patients and clients
- Consider joint funding opportunities to reduce the risks of loneliness and isolation (NTG draft framework out for consultation)
- Work with VCS to co-design services to address health and social care priorities

# Final comments from two people

‘It was good to meet with you today….It's actually quite a step to recognize that one is lonely, never mind acknowledging that one needs help to overcome it. I feel that today's meeting with you was a very positive first step.’

(Social Prescribing patient)

# Final comments from two people

“Reading is extremely lucky that it has places to meet which are welcoming and not purely commercial enterprises e.g. Global Cafe, Rising Sun Arts Centre and facilities to enable voluntary groups to easily meet.  Without these, I personally would be seriously lonely”

(Unemployed male; 50 - 64yrs; long-term resident)

# Questions?

Thank you

Sarah Morland, Partnership Manager
Reading Voluntary Action
sarah.morland@rva.org.uk
0118 9372273

**READING BOROUGH COUNCIL**

**REPORT BY THE DIRECTOR OF ADULT CARE AND HEALTH SERVICES**

| | | | |
|---|---|---|---|
| **TO:** | **HEALTH & WELLBEING BOARD** | | |
| **DATE:** | **6 OCTOBER 2017** | **AGENDA ITEM:** | **7** |
| **TITLE:** | **SUICIDE PREVENTION PROGRAMME UPDATE** | | |
| **LEAD COUNCILLOR:** | **COUNCILLOR HOSKIN** | **PORTFOLIO:** | **HEALTH** |
| **SERVICE:** | **MENTAL HEALTH** | **WARDS:** | **BOROUGHWIDE** |
| **LEAD OFFICER:** | **JANETTE SEARLE** | **TEL:** | **0118 937 3753** |
| **JOB TITLE:** | **PREVENTATIVE SERVICES MANAGER** | **E-MAIL:** | **Janette.Searle@reading.gov.uk /** |

## 1. PURPOSE OF REPORT AND EXECUTIVE SUMMARY

1.1 This report presents an update on delivery against the Health and Wellbeing Action Plan Priority 4 - Reducing Deaths by Suicide. It includes an overview of performance and progress towards achieving suicide prevention goals and upcoming activities to support suicide prevention strategy objectives.

1.2 This is one of several progress reports presented to this meeting by way of addressing the meeting's theme of 'emotional wellbeing'. This theme has been selected by the Board to facilitate a review of local plans against the Prevention Concordat for Better Mental Health, and in recognition of World Mental Health Day on 10th October.

## 2. RECOMMENDED ACTION

**2.1 That the Health and Wellbeing Board:**

**Notes the progress to date against the 2017-20 Reading Health and Wellbeing Strategy Action Plan, Priority 4.**

## 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 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. On 30 August 2017, Public Health England published the Prevention Concordat for Better Mental Health. This describes a shared commitment to work together to prevent mental health problems and to promote good mental health. The Concordat's signatories include NHS England, the Local Government Association, NICE, the Faculty of Public Health and Association of Directors of Public Health together with eleven national voluntary community and social enterprise organisations.

3.4 In Berkshire, the development of a strategic approach to suicide prevention has been coordinated by a multi-agency group which has overseen the preparation of a county-wide strategy and action plan, complemented by local action plans responding to the unique needs and circumstances of each of the six local authorities in Berkshire. The Berkshire strategy includes a 'stretch' target to reduce the suicide rate by 25% by 2020.

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. PROGRESS TO DATE AGAINST THE SUICIDE PREVENTION ACTION PLAN

4.1 A Reading Mental Wellbeing Group has been formed which is a multi-agency group that brings together stakeholders who oversee the local development of evidence-based support for mental wellbeing. This group provides strategic direction for the implementation of the Reading Suicide Prevention Plan.

4.2 Work is ongoing to raise public awareness on suicide risk and support available. The Wellbeing team has recently launched a Suicide Prevention Page on the Reading Services Guide which supports residents to make links with national and local support services for those at risk of death by suicide, including people bereaved through suicide.

4.3 The formal launch of the Berkshire Suicide Prevention Strategy – on 17th October – provides an opportunity to raise the profile of suicide risk and suicide support through media coverage and partner engagement. The launch event will take the form of a mini conference in the Town Hall, Wokingham, with guest speakers and workshop sessions. Reading's Wellbeing team is co-ordinating a local event on 9th October 2017 to mark Older People's Day with the theme of Emotional Wellbeing in Later Life. This year's guest speaker, Jean, suffered mental health problems and has now written a book on how to live well. The event will include a range of workshops, demonstrations and information stalls promoting mental health and wellbeing.

4.4 Prior experience of mental illness is a known risk factor for suicide, and the local suicide prevention action plan includes promoting services which support groups particularly vulnerable to mental ill health or those who need tailored approaches. This includes children and young people – as described in the separate 'Future in Mind' update presented to the Board today – as well as survivors of domestic abuse or sexual abuse. Trust House in Reading provides specialist support to those affected by rape and sexual abuse as well as training to other agencies and will be facilitating a workshop at the Suicide Prevention Strategy launch.

4.5 Reading's Recovery College (Compass) uses an educational approach to enable people with experience of mental health difficulties to become experts in their own healthcare. The College builds on people's strengths and helps them to develop skills and confidence to manage their recovery journey. Now in its second year, Compass's new website will be lunched on World Mental Health Day (10th October).

4.6 Reading Your Way offers peer led support for mental health recovery, including entering education, returning to work, finding new hobbies and social activities, solving housing issues, making friends, organising finances and helping people to avoid or manage crises. Reading Your Way will host an Open Coffee Morning to mark World Mental Health Day.

4.7 People suffering from substance misuse are also at higher risk of death by suicide and the Reading Drug and Alcohol commissioner has reviewed contracts to ensure suicide prevention strategy objectives are set up with all our providers.

4.8 Reading hosted a media event jointly organised by Public Health Berkshire, BBC Berkshire and the Samaritans on 11th September (the closest working day to World Suicide Prevention Day on 10th September 2017). The objectives of the session were to highlight the role of media in shaping public perception of suicide, to educate Berkshire's media community on responsible suicide reporting and to promote the forthcoming Suicide Prevention Strategy launch. The event covered sessions on the Strategy, an overview of the importance of sensitive reporting by the Samaritans and IPOS (Independent Press Standards Organisation). Participants included editors, journalists, feature writers and broadcasters who were informed about important suicide prevention work taking place across Berkshire and how they could work in partnership to address this issue.

4.9 In accordance with the local Suicide Prevention Action Plan, the Reading Joint Strategic Needs Assessment (JSNA) module on suicide and self-harm has also been updated. The Mental Health JSNA module is now in the process of being refreshed.

4.10 Delivery against all of the Health and Wellbeing strategic priorities is expected to take into account and be founded on the three 'foundation' issues, i.e. carer recognition, safeguarding and a co-ordinated approach to wellbeing information. Local suicide prevention work is grounded in keeping vulnerable people safe, and raising awareness of support. Carers are recognised as a group vulnerable to stress and ill health and so needing to have tailored support or access in order to maintain good mental health.

## 5. CONTRIBUTION TO STRATEGIC AIMS

5.1 The Berkshire Suicide Prevention Strategy, and complementary sections of the Reading Health and Wellbeing Strategy, support the Council's Corporate Plan priority to 'safeguard and protect those that are most vulnerable.' Similarly, these 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'.

5.2 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 & STAKEHOLDER ENGAGEMENT

6.1 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.

6.2 The Reading Mental Wellbeing Group, which oversees the local suicide prevention action plan, is a multi agency forum which bring together service users, carers and partners across sectors.

## 7. LEGAL IMPLICATIONS

7.1 There are no legal implications arising from this report.

## 8. EQUALITY IMPACT ASSESSMENT

8.1 The contents of this report do not trigger the need to complete an equality impact assessment.

## 9. FINANCIAL IMPLICATIONS

9.1 There are no new financial implications arising from this report.

## 10. BACKGROUND PAPERS

Reading Health and Wellbeing Strategy 2017-20
Reading Health and Wellbeing Action Plan 2017-20
Reading Health and Wellbeing Action Plan 2017-20: Progress Report July 2017

**Reading Health and Wellbeing Board: Mental Health Strategy**

| | |
|---|---|
| **Meeting Date** | 6th October 2017 |
| **Title** | Mental Health Strategy Progress Update |
| **Purpose** | To facilitate Health and Wellbeing Board discussion on the next steps regarding implementation of Mental Health Strategy, in order to inform future work. |
| **Author** | Bev Searle, Director of Corporate Affairs, Berkshire Healthcare, in liaison with Gabrielle Alford, Director of Joint Commissioning, Berkshire West CCGs |
| **SUMMARY** | The attached paper was provided to the Berkshire West Integration Board in February 2017, when the following recommendations were supported:<br>1. H&WB Board discussions on Mental Health should be undertaken in each Unitary Authority area to clarify local priorities, and approach to strategy implementation.<br>2. A Berkshire West Strategy Steering Group should be established with representatives linked to local governance arrangements appropriate to each area.<br>3. Key Berkshire West mental health projects should be included in Delivery Group monitoring, along with progress in reducing delayed transfers of care from MH Inpatient Services. N.B. this is not intended to duplicate existing reporting e.g. through the A&E Delivery Board.<br><br>Since February, a joint agency Mental Health Strategy Steering Group has been established to enable progress on the implementation of the Five Year Forward View for Mental Health. Progress has also been made with the establishment of a joint panel for planning support for people who are subject to section 117 of the mental health act (highlighted as an area of concern in the following paper).<br><br>The paper is being presented to the Reading Health and Wellbeing Board in line with recommendation 1, as part of the focus on mental health at this meeting. It is structured in line with the Integration Board request to look at what is going well, what are our challenges, and |

| | |
|---|---|
| | recommendations about the next steps we should take to ensure mental health is appropriately included within our overall approach to integration as a system.<br><br>There is good alignment between the priorities of the Reading Health and Wellbeing Strategy, and the attached Mental Health Strategy update. Our aim is to identify a small number of priority actions which need to be taken forward on a Berkshire-west basis, while achieving clarity about the specific pieces of work which are best addressed at a Unitary Authority level in line with local Health and Wellbeing Strategy priorities.<br><br>A summary of the requirements of the Five Year Forward View for Mental Health is provided for information. |
| **ACTION REQUIRED** | The Health and Wellbeing Board is asked to consider the information presented and provide direction regarding specific areas of concern/priority for the Reading population. (These will be collated with feedback from West Berkshire and Wokingham Health and Wellbeing Boards and brought forward into the work of the Berkshire West Strategy Steering Group.)<br>Guidance regarding frequency of ongoing reporting of progress is also requested from the Health and Wellbeing Board. ( It is suggested that this takes place twice yearly, and is aligned with local progress reporting on mental health initiatives) |

**Integration and Mental Health: Briefing for Berkshire West 10 Delivery Group 25.01.2017**

**Introduction**
This paper aims to support a discussion regarding the current position, what is going well, where we are experiencing difficulties, and what are our recommended next steps to communicate to the Integration Board.

**Background**
The Five Year Forward View for Mental Health (FYFV for MH) provides an important source of national guidance for evidence-based development of mental health services. It was informed by a significant national engagement exercise, which included over 20,000 responses, as well as an economic analysis by the Centre for Mental Health. This is an important document which provides guidance about the return on investment which can be achieved for a range of mental health initiatives.

Berkshire Healthcare has developed a local mental health strategy working with commissioners and partners for 2016 - 21. This was informed by:

- A literature review including national guidance – in particular the FYFV for MH, NICE and good practice evidence
- A review of what service users and carers have said about what is important to them (including the national engagement exercise to inform the development of the Five Year Forward View for Mental Health)
- Key public health messages about mental health problems and our local population
- The expertise and knowledge of clinicians and leaders.
- The vision and values of the organisation as a whole

The summary document outlining the Berkshire Healthcare MH Strategy (attached) was approved by the Trust Board and implementation plans for Child and Adolescent, Adults of Working Age and Older Adults are in development.

It is recognised that each Local Authority is at a different stage in terms of its own strategic priorities, and approach to development of local strategy, and the aim is to work in a way that makes sense in terms of local need, but maintains a coherent, Berkshire-wide approach.

**What is going well?**

- Strong foundation of good quality services, financial performance and governance (Berkshire Healthcare rated “good” by the Care Quality Commission and within segment 1 of the NHS Improvement Single Oversight Framework).
- Most priorities within the FYFV for MH have been supported by commissioner investment, which will facilitate achievement of performance targets.
- National investment has been secured for IAPT ( Increasing Access to Psychological Therapies)to increase access for MH and develop services for long term physical health problems, and Perinatal Services.
- Bids have been submitted for Transformation Funding for MH Liaison Services via the Sustainability and Transformation Partnership (in line with NHSE Guidance).
- Innovative use of technology to provide online access to treatment and support.
- Single point of access to mental health services now being developed to include social care.
- Specific services have a national reputation for quality and innovation ( including Early Intervention in Psychosis, IAPT, Community Teams for Older People etc)

**What are our difficulties?**

- Demand pressures, within finite funding available has caused an increase in out of area placements for people who need acute inpatient treatment, as well as those who need specialist treatment. This is not acceptable for patients and their families and also causes significant cost pressures.
- Local Authorities have been required to make significant savings, which inevitably impact on MH Services and people who use them.
- Meeting the needs of people presenting at RBH A&E with psychological problems is presenting a significant challenge: further analysis is needed to ensure that we understand the different cohorts of people needing help and address their needs appropriately.
- Delayed transfers of care from MH Inpatient services has a number of causes, including section 117 issues and difficulties securing accommodation.
- Street Triage and Individual Placement ( supporting people into employment)Services are not funded recurrently despite the evidence-based contribution they make in supporting people to move on from specialist mental health services
- Bed Occupancy levels at or over 100% have been reached regularly (85% is the recommended level)
- Workforce shortages – these are particularly challenging in Inpatient Services, but a Prospect Park Development Programme has been established and initial results being achieved are encouraging.
- Dual Diagnosis – the commissioner and provide landscape in Berkshire is complex, with different arrangements in each area for addressing the needs of people with combined substance misuse/alcohol problems and mental illness. Inpatient Services have experienced an increase in the number of people being admitted with dual diagnosis, and community based services for people with the most complex services are limited.
- Despite significant progress in reducing waiting times for CAMH Services, waits for people needing to access the Autistic Spectrum Disorder and Attention Deficit Hyperactivity Disorder Pathways are slower to improve.

**Potential Recommended Next Steps for approval by Delivery Group**

1. H&WB Board discussions on Mental Health in each area to clarify local priorities, and approach to strategy implementation.
2. Berkshire West Strategy Steering Group established with representatives linked to local governance arrangements appropriate to each area.
3. Inclusion of Berkshire West key projects in Delivery Group monitoring, along with progress in reducing delayed transfers of care from MH Inpatient Services. NB this is not intended to duplicate existing reporting e.g. through A&E Delivery Board.

Bev Searle, Director of Corporate Affairs, Berkshire Healthcare in liaison with Gabrielle Alford, Director of Joint Commissioning, Berkshire West CCGs

Berkshire Healthcare NHS
NHS Foundation Trust

# Mental Health Strategy 2016 – 21

## Summary Document December 2016

**Berkshire Healthcare NHS Foundation Trust**

Healthcare from the heart of your community

Berkshire Healthcare NHS
NHS Foundation Trust

# Our Mental Health Strategy – introduction

## Introduction

We are proud to be the main provider of mental health services to people in Berkshire – and this summary document outlines our key priorities for the next five years which will guide our work to enable us to achieve our vision:

**"To be recognised as the leading provider of community and mental health services by our staff, patients and partners."**

The development of our Mental Health Strategy for 2016 - 2021 has been informed by:

- A literature review including national guidance – in particular the Five Year Forward View for Mental Health - NICE and good practice evidence
- A review of what service users and carers have said about what is important to them (including the national engagement exercise to inform the development of the Five Year Forward View for Mental Health)
- Key public health messages about mental health problems and our local population
- The views and needs of our local commissioners
- The expertise and knowledge of our clinicians and leaders.
- Our vision and values as an organisation

## Engagement

To develop our approach and identification of key priorities, discussions have been held with commissioners, clinical leaders and managers, Trust Governors, service users and representatives within our Children and Young People's Services, Adults and Older Adults Services.

## Development of Strategic Intentions

The following slide shows the process that led to the identification of our six strategic intentions:


- Effective and compassionate help
- Working with service users and carers
- Straightforward access to services
- Supporting our staff
- Good experience of treatment and care
- Working with partners and communities

These are shown in more detail on page 8 and provide a summary of what we intend to do in terms of developmental objectives.

How we will achieve our vision for mental health services for 2021 requires a focus on key priorities to drive the required transformation of the way we work**.** We have summarised these within our overall aim to provide:

**Safer, improved services with better outcomes, supported by technology**

# Mental Health Strategy Summary 2016 - 2021

Berkshire Healthcare NHS
NHS Foundation Trust

## Effective and compassionate help

- Evidence-based pathways
- Safe, effective services achieving outcomes which are meaningful to service users
- Inpatient services represent a "centre of excellence"
- Suicide Prevention.

## Supporting our staff

- Recruiting and retaining skilled, compassionate staff
- Developing new roles
- Enabling creativity, innovation and effective delivery
- Building strong clinical and managerial leadership, a quality improvement and research culture.

## Working with service users and carers

- Guiding development of our services
- Supporting self management.

**Safer, improved services with better outcomes, supported by technology**

## Good experience of treatment and care

- Personalised care supporting recovery and quality of life
- Meeting both physical and mental health needs.

## Straightforward access to services

- Meeting national targets
- Effective and integrated urgent care
- Expanding online and telehealth services
- Tackling discrimination and stigma.

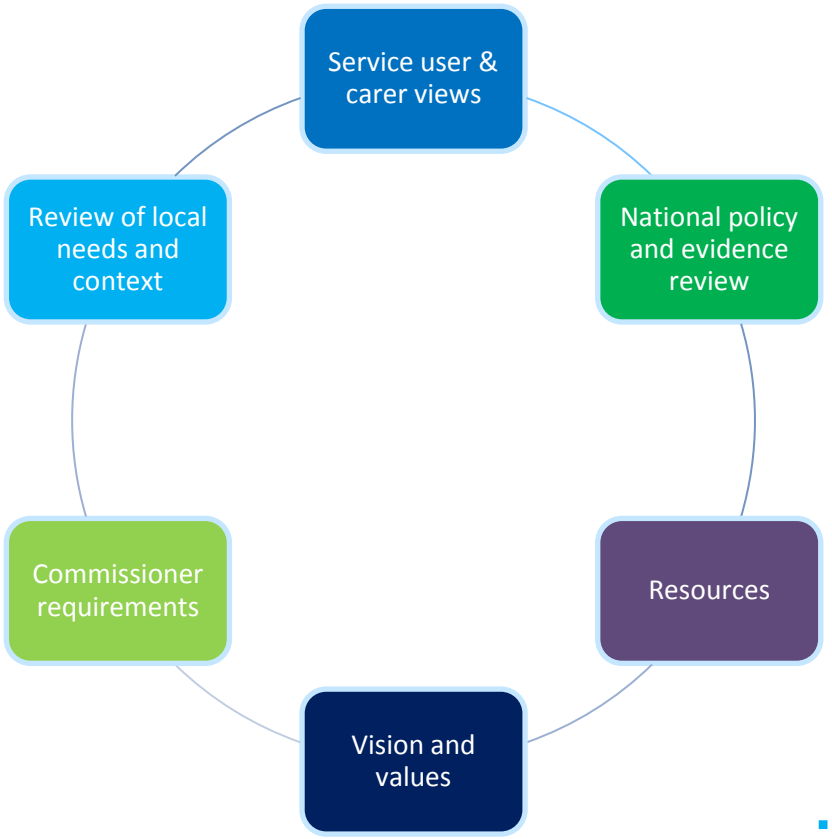
## Working with partners and communities

- Partnerships with primary care, social care and voluntary sector organisations
- Integrating mental health within locality services, and system sustainability and transformation plans
- Supporting prevention, early intervention and peer support.

# Our approach to the development of our strategy…

Berkshire Healthcare NHS
NHS Foundation Trust

- Reviewing national consultation result, local service user and carer feedback, friends and family test results.




- Being informed by Public Health analysis, activity assessment and stakeholder views.

- Analysing NICE guidance, national policy, research and best practice review and mental health benchmarking.
- Clinical views and quality priorities.

- Collaborating with commissioners.
- Reviewing commissioner and system priorities.

- Considering demand, workforce and financial pressures.
- Using the talent and capability of our staff.
- Maximising the opportunities presented by use of technology.

- To be recognised as the leading provider of community and mental health services by our patients, staff and partners.

## …led to the identification of our Strategic Intentions

(shown on page 8)

# Service user and carer views

Berkshire Healthcare NHS
NHS Foundation Trust

The **Five Year Forward View for Mental Health Taskforce : public engagement findings ( 2015)**, is an important document in supporting our understanding of what is important to service users and carers:

- 20,473 people participated in an online survey developed by Mind and Rethink Mental Illness
- 250 people with lived experience and carers who participated in intensive engagement events.

The key themes that emerged were:

- **Prevention and stigma -** 25% and 19% respectively said these were in their top 3 priorities for change
- **Access and choice -** timely access to effective, good quality evidence-based mental health treatment and therapies in response to need, always in the least restrictive setting, was a primary concern for the majority of survey respondents. 52% of people said access is one of their top three priorities, and 33% cited needing choice of treatment.
- **Quality and experience -** people said choice was a top priority, 13% described the importance of having the right information to make meaningful decisions about their treatment. 13% of people stated the need for wider diversity and skill mix in NHS staff, including the need for peer support and more staff with psychological support skills.

The Berkshire Mental Health User Group was consulted as part of the process of drafting this strategy, and their feedback was strongly aligned with that of the National Taskforce in terms of priority concerns. These findings have influenced the selection of our strategic priorities, as well as the related objectives and key tasks for our children and young people services, and our services for adults of working age, and older adults.

Our **Patient Leaders** programme has now been established, and we have recruited and trained our first candidates. They will work with us on our mental health service development initiatives, ensuring that the voice of service users and carers informs our decision making.

Involvement of **Children and Young People** in the development of our Child and Adolescent Mental Health (CAMH) service has progressed considerably over the last year. We have a dedicated Participation Lead and service user steering groups as well as participation events in the school holidays. Service users and their families have helped with communication about our services, including with the development of video clips.

Our CYP Integration Programme has been strongly influenced by service users and their families, who 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 and when it is needed most. Our CAMHs service is now part of our Children, Young People and Families programme and work will be continuing over the coming months to review the way we deliver care.

Our engagement with service users and carers in **adults and older adults services** is variable across specific services and localities. By including working with service users and carers within our strategy, we are signalling our intention to develop this further, and achieve consistency across all our mental health services. Wherever possible, we will work together with commissioners and partners to do this.

We have already established a number of carers initiatives including the “Triangle of Care”. Our Communication and Engagement Strategy outlines the key activities to be undertaken by our Patient Engagement and Marketing & Communications teams. Our Patient Experience reports, including summaries of our complaints and Friends and Family Test results, enable our Executive and Board to measure our progress in providing a good experience of treatment and care.

# Drivers - 1

Berkshire Healthcare NHS
NHS Foundation Trust

## Prevalence and therefore demand is increasing, but benchmarking shows we have performed well in terms of costs and key performance targets.

### Children and young people

In Berkshire, prevalence of common mental health disorders varies between 7.3% and 9.6%, against an England average of 9.3%.

Our services have experienced year on year increases in referrals and with this increase in demand there has also been an increase in activity and complexity, which is reflected in waiting times for some specialist services (though overall waiting times are now decreasing), as well as the increase in presentations to A&E over the past 5 years. There has also been a 40% increase in young people accepted into the service over the same timeframe.

### Adults

Referrals to our adult mental health services have increased by 17% over the last 2 years, from 23,155 during 2013/14 to 27,054 during 2015/16. Our Common Point of Entry provides easy access to advice, information and signposting, as well as to our mental health services. Prevalence of common mental disorder is predicted to continue to rise as shown below.

| Year | 2015 | 2020 |
|---|---|---|
| Bracknell Forest | 12,016 | 12,318 |
| Reading | 16,801 | 16,888 |
| RBWM | 14,170 | 14,465 |
| Slough | 14,955 | 15,669 |
| West Berkshire | 15,077 | 15,043 |
| Wokingham | 15,476 | 15,816 |

### Older Adults

All local authorities in Berkshire are at or below England prevalence levels, which is rising in line with, or slightly greater than, the rise in prevalence of England as a whole.

**National Benchmarking Information** shows that the overall **cost** of mental health adult and older adult services across Berkshire Healthcare's inpatient and community mental health services is **below average** in national and regional comparisons by weighted populations. We have an **above average bias towards community services** and away from hospital beds on financial, clinical activity and workforce measures.

We have **fewer adult acute beds** (13.9) per 100,000 weighted population than the national average (16.6) and the number of **older adult beds** (12) is **significantly lower** than the national average (37.2). Our specialist Crisis Resolution Home Treatment Teams are a key factor in enabling us to meet local need within very low inpatient bed numbers.

Our **rates of readmission within 28 days are within the top quartile** nationally, and we are achieving our target of under 9% readmissions.

Our **bed occupancy was very slightly below average** in 2014/15 benchmarking, but is now rising to the high 90%s. (Royal College of Psychiatrists recommends a rate of 85%).

**Adult and older adult community teams** appear overall to have an **average or higher than average caseload** and **below average contact rates** which is likely to be due to capacity constraints driven by available resources.

# Drivers - 2

Berkshire Healthcare NHS
NHS Foundation Trust

## National targets have informed commissioner investment; supply of key staff is a significant challenge, but we have strengths to build on.

### Meeting targets

There are a number of national documents setting out how mental health service should be provided in the future and include key targets to be met. These include:

- The Five Year Forward View (FYFV) for Mental Health and Implementing the FYFV for Mental Health, which set out ambitions to provide the right care in the right place, drive down variation in service quality, and improve outcomes.
- Future in Mind (2015), which provides the strategic framework for children and young people's mental health services
- The National Dementia Strategy (2009-2014), the Prime Ministers challenge on dementia 2020, and the implementation plan (2016) set out priorities for older people's mental health services

Specific FYFV targets have been reflected in planning guidance for 2017/18 and 2018/19. We are well positioned to meet these targets as a result of previous commissioner investment in areas such as child and adolescent mental health (CAMH), Crisis Response Home Treatment Team (CRHTT), Mental Health Liaison, Early Intervention in Psychosis (EIP) and Perinatal Services. However, additional investment is needed to achieve full compliance with guidance in all target areas. This also needs to be balanced with plans to meet rising demand within our core services.

### Supply side pressures

There are national shortages of a number of healthcare professional staff, including nurses and doctors, as well as some specialist staff. Berkshire Healthcare is competing for these scarce, highly mobile staff with acute trusts and other health providers (including the independent sector) within an area of high housing costs. This has led to difficulty in timely recruitment to services which have received new investment, as well as ensuring required levels of substantive staff for existing services. A number of initiatives are in progress to address these challenges, including a specific workforce project as part of our overall development programme for Prospect Park Hospital.

### Strengths to build on

**Our strengths we can build on include:**

- Our "good" Care Quality Commission rating, and consistent delivery of financial targets
- Our organisational reputation, and good relationships with commissioners
- Our high levels of staff engagement, reflected in our staff survey
- Our innovative use of technology to drive improved rates of access and choice for patients and carers in key service areas
- Our engagement with people who use our services and carers in specific geographies/service areas.

# Our Strategic Intentions - what we intend to do

Berkshire Healthcare NHS
NHS Foundation Trust

**Our vision:**
To be **recognised** as the **leading community** and **mental health service provider** by **our staff, patients** and **partners.**

## Effective and compassionate help

- Evidence-based and responsive care delivered through clearly described pathways
- Focussed on providing safe, effective services that consistently achieve outcomes which are meaningful to service users
- Inpatient services represent a "centre of excellence" in line with best practice
- Suicide prevention.

## Supporting our staff

- Recruiting and retaining skilled and compassionate staff
- Developing new roles and innovative approaches to workforce planning
- Valuing, training and engaging staff to enable creativity, innovation and effective service delivery
- Building strong clinical and managerial leadership, a quality improvement and research culture.

## Working with service users and carers

- Engagement with service users and carers guiding development of our services
- Developing supported self management models of care and support for carers.

## Good experience of treatment and care

- Personalised care supporting individual choice, independence, recovery and quality of life
- Both physical and mental health needs of service users are assessed and responded to in an integrated way.

## Straightforward access to services

- Meeting national targets
- People can access our services without discrimination or stigma where they live, learn and work
- Effective and integrated urgent care coordinated around service users and their families
- Using technology to provide more online and telehealth services where this makes sense.

## Working with partners and communities

- Effective partnerships with primary care, social care and voluntary sector organisations
- Ensuring mental health is a core part of integrated locality services and local system initiatives and wider sustainability and transformation plans
- Supporting development of prevention, early intervention, and peer support services.

# Resourcing and Governance

Berkshire Healthcare NHS
NHS Foundation Trust

The **2017/18 Planning Guidance for the NHS** includes targets for the next 2 years, along with the requirement for contract agreements to be reached in December 2016. Our required Operational Plan submissions will detail our financial, workforce and activity plans to meet our financial control total and performance targets – which include those set out in the Five Year Forward View for Mental Health.

**Agreed commissioner investment** for the achievement of key Five Year Forward View targets has been secured to establish services which are fully or partially compliant with guidance, and has been described on page 7.

Our mental health services represent approximately 50% of our income and expenditure as an organisation, and our **cost improvement plans** will necessarily apply to our mental health services. A significant focus is our plan to reduce expenditure on agency staff, which already has a dedicated programme and financial plan in place to achieve required targets

Our **IAPT Expansion and Long Term Conditions initiative** includes national and local CCG funding for the next 2 years. During this time, we will seek to evidence the projected return on investment that can be achieved as a result of providing enhanced access and specific evidence based treatment for long term physical health conditions. The rationale for this national initiative is based on evidence concerning the reduced use of secondary health services that can be achieved as a result of helping people recover from mental health problems which they experience alongside their long term conditions.

## Resourcing Risks

***Workforce***

Scarcity of key staff has been highlighted as a risk to delivery of performance targets in a number of areas of our strategy. We have identified a number of actions that are in progress, or planned which will help to mitigate this risk, and our Workforce Strategy will outline the means by which we will secure staff in the required numbers, with the necessary response to the needs of service users and their families.

***Growth in demand*** for our services has been highlighted on page 6. Within a block contract environment, meeting costs required to maintain safe services represents a significant challenge, particularly given the financial position of our commissioners. This provides a significant driver for the development of new ways of working reflected in the priorities of this strategy.

***Local Authority funding*** has been significantly reduced, which is likely to have a knock-on impact to our services in terms of joint services which we provide, as well reduced levels of social care and housing related support.

## Governance

Our **Mental Health Programme Board** will oversee the implementation of our Mental Health Strategy, our Pathways and Clustering Project and our Prospect Park development programme. It will report progress to the Trust Board via the Business and Strategy Executive. Our Quality Executive Group will oversee quality impact assessment of specific initiatives within implementation plans.

Our existing meetings with commissioners will be used to jointly monitor progress, and local Health and Wellbeing Boards will receive formal reports and progress updates as required.

# Implementation and measuring success

Berkshire Healthcare NHS
NHS Foundation Trust

## Implementation planning

This summary strategy document will be supported by implementation plans within our three major service areas of:

**Child and adolescent mental health**
**Adults of working age**
**Older adults**

These plans, including existing and new initiatives, will be completed by April 2017. They will reflect the importance of partnership planning with commissioners and other providers to achieve a joined up experience for people who use services, along with effective use of resources within our six localities and Berkshire-wide.

We will work with commissioners and partners to ensure **effective engagement of service users and carers** in our implementation, which will be supported by a **communication and engagement plan** to facilitate **engagement of our staff, commissioners and partner providers** within our six localities and across Berkshire.

Berkshire Healthcare is part of two **Sustainability and Transformation Plans** (STPs) (Berkshire West, Oxfordshire and Buckinghamshire (BOB) and Frimley Health and Care). We will continue to actively contribute to these plans, seeking to ensure that mental health is embedded throughout, that specific targets are included and achieved, and the needs of people with serious mental illness are addressed. This will also be taken forward in our **local Berkshire systems** (including the Berkshire West ACS initiative, BW10 Integration Programme and East Berkshire New Vision of Care programme) with health and social care partners, where we will be seeking the inclusion of mental health within local integration and Better Care Fund plans.

## Risks

Key risks and issues affecting implementation will be included in our plans.
A number of resourcing risks have been identified on page 9. In addition to these, specific attention will be paid to mitigating the risk posed by the **complexity of commissioning and partnerships** in Berkshire – given our 6 Unitary Authorities and 7 Clinical Commissioning Groups. Related to this is the risk presented by fragmented and limited response to the needs of people with ***dual diagnosis*** (co-existing mental health and substance misuse problems).

## Our targets

The implementation plans for this strategy will include targets set out in the national policy guidance described on page 7. Local commissioner targets contained within the quality schedule of our contract, along with CQUIN requirements will also be included.

In addition, our aspiration "to be recognised as the leading provider of community mental health service provider by our staff, patients and partners" means that we need to achieve at least top quartile performance in the following by 2021:

- National Staff & Patient Surveys
- Friends and Family Test
- CQC ratings
- Waiting Times
- Average Length of Stay
- Readmission rate within 28 days
- Acute and non-acute occupancy rates
- 7 day follow up
- Delayed transfers of care
- CR/HTT gate keeping of inpatient admissions
- Mental Health Services Dataset.

### We will also incorporate:

- PLACE – Patient Assessment of the Care Environment
- Safe staffing
- Local qualitative information reflecting service user and carer experience.

# Mental Health Strategy
## Implementation roadmap

Berkshire Healthcare NHS
NHS Foundation Trust

| | 2016 - 18 | 2018 - 19 | 2019 - 21 |
|---|---|---|---|
| PPH Development | Staffing, bed optimisation and centre of excellence projects established and meeting targets | Medium –term actions delivered, pathways and patient/carer engagement well established | Long term actions delivered. Strategy reviewed and future priorities confirmed |
| Pathways | Implementation of priority pathways – initial focus on people with personality disorder | All evidence based pathways established and tariff implications confirmed with commissioners | Outcomes reviewed and benchmarked to inform further work required |
| Zero suicide | Completion and implementation of strategy linked to system suicide prevention plan | Medium –term actions delivered | Long term actions delivered. Strategy reviewed and future priorities confirmed |
| Urgent Care | System reviewed including PMS, PoS, CRHTT and CMHT pathways | Alternatives to admission reviewed and priority actions confirmed and implemented | Long term actions delivered. Strategy reviewed and future priorities confirmed |
| IAPT | Early implementer programme: increasing access and delivering for priority long term conditions | Plans for future sustainability completed and agreed with commissioners | Services covering wide range of long term conditions and delivering positive outcomes |
| Longer term care | Priority actions for Out of Area Placement reduction confirmed and implemented | Partnership actions with UAs, Vol. sector & housing providers confirmed and implemented | Long term actions delivered. Strategy reviewed and future priorities confirmed |

**Technology enabled service delivery:** online programmes, skype and SHaRON expansion. Informatics development.

Quality Improvement methodology enabling safer, evidence-based services with better outcomes

# Glossary of terms

Berkshire Healthcare NHS
NHS Foundation Trust

| | |
|---|---|
| **ACS** | Accountable Care System<br>Partner organisations working together to provide services in response to population need through effective use of collective resources |
| **BCF** | Better Care Fund<br>Use of health and social care funding to promote integrated responses - in particular to reduce emergency admissions and delayed transfers of care |
| **BME** | Black Minority Ethnic |
| **BW10** | Berkshire West 10<br>Local Authorities, CCGs and Health Trusts in Berkshire West |
| **CAMHs** | Child and Adolescent Mental Health Services |
| **CCG** | Clinical Commissioning Group |
| **CQC** | Care Quality Commission |
| **CQuIN** | Commissioning for Quality and Innovation |
| **CRHTT** | Crisis Resolution and Home Treatment Team |
| **CYPF** | Children, Young People and Families (programme) |
| **FYFV** | Five Year Forward View |
| **IAPT** | Improving Access to Psychological Therapies |
| **MH** | Mental Health |
| **NICE** | National Institute for Health and Social Care Excellence |
| **NVC** | New Vision of Care<br>Local Authorities, CCGs and Health Trusts working together to provide integrated services which provide improved outcomes and experience for service users, as well as better use of resources. |
| **OAP** | Out of Area Placement<br>When patients need to receive inpatient care a way from their local hospital because of lack of available beds. |
| **QEG** | Quality Executive Group |
| **QIA** | Quality Impact Assessment |
| **SHaRON** | Support, hope and recovery online network |
| **STP** | Sustainability and Transformation Plan |
| **UA** | Unitary Authority<br>Our six Local Authority partners are all constituted as Unitary Authorities which means they each fulfil the full range of functions which are shared between district and county councils in two–tier systems. |

# Berkshire West
## Accountable Care System

Report to Reading Health & Wellbeing Board – September programme update

September 2017

# Berkshire West Accountable Care System - Recap

***Current position***

- A high performing system but increasingly under pressure: rising demand and expectations, extended access, workforce pressures, financially challenged
- Different parts of the health system funded differently: payment by result (PbR), block contract, GMS, PMS and APMS primary care contracts
- Commissioner/provider split creates unhelpful consequences for jointly planning patient care and managing the Berkshire West £

***What is an Accountable Care System?***

- A more collaborative approach to the planning and delivery of services with collective responsibility for resources and population health
- Organisations working more closely in partnership with system wide governance arrangements
- Underpinned by a single budget system financial model – manages risk and aligns incentives, for the whole health care system

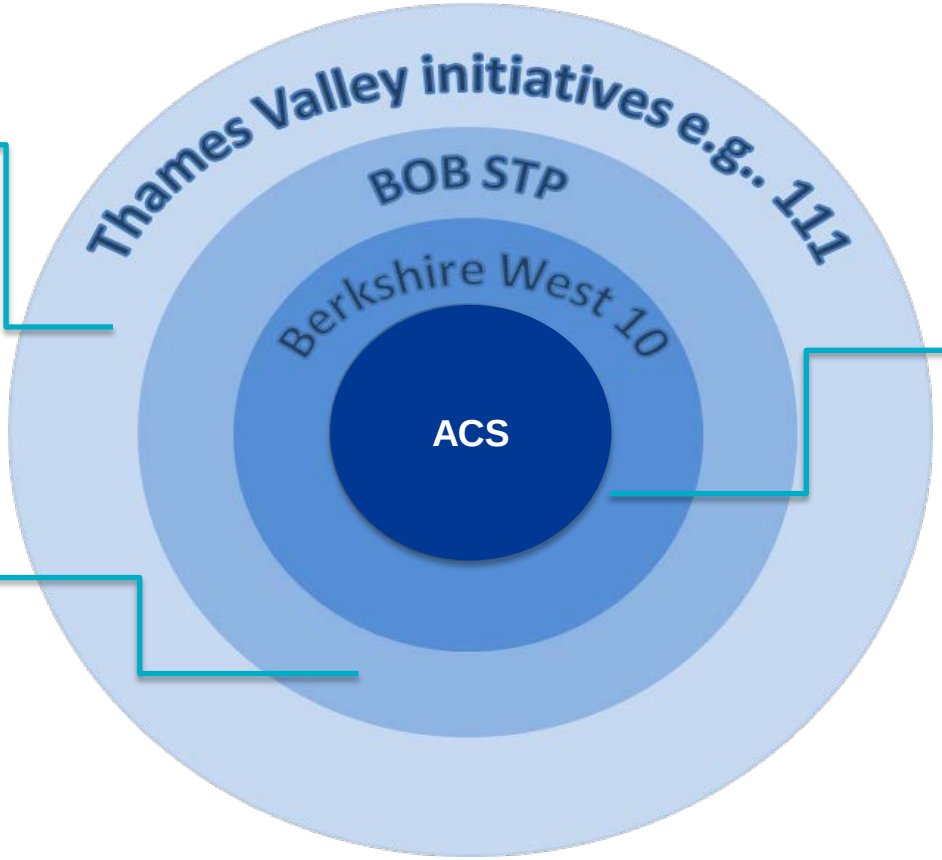


Berkshire West
Accountable Care System

# The ACS programmes fit with other initiatives in our region

We will continue our work with partner organisations to plan for and deliver services effectively at larger scales

Our individual ACS members are an engaged and active part of the Buckinghamshire, Oxfordshire and Berkshire West STP




The ACS compliments the well established health and social care integration programmes which oversees joint investments and improved system working



Berkshire West
Accountable Care System

# Key updates / next steps

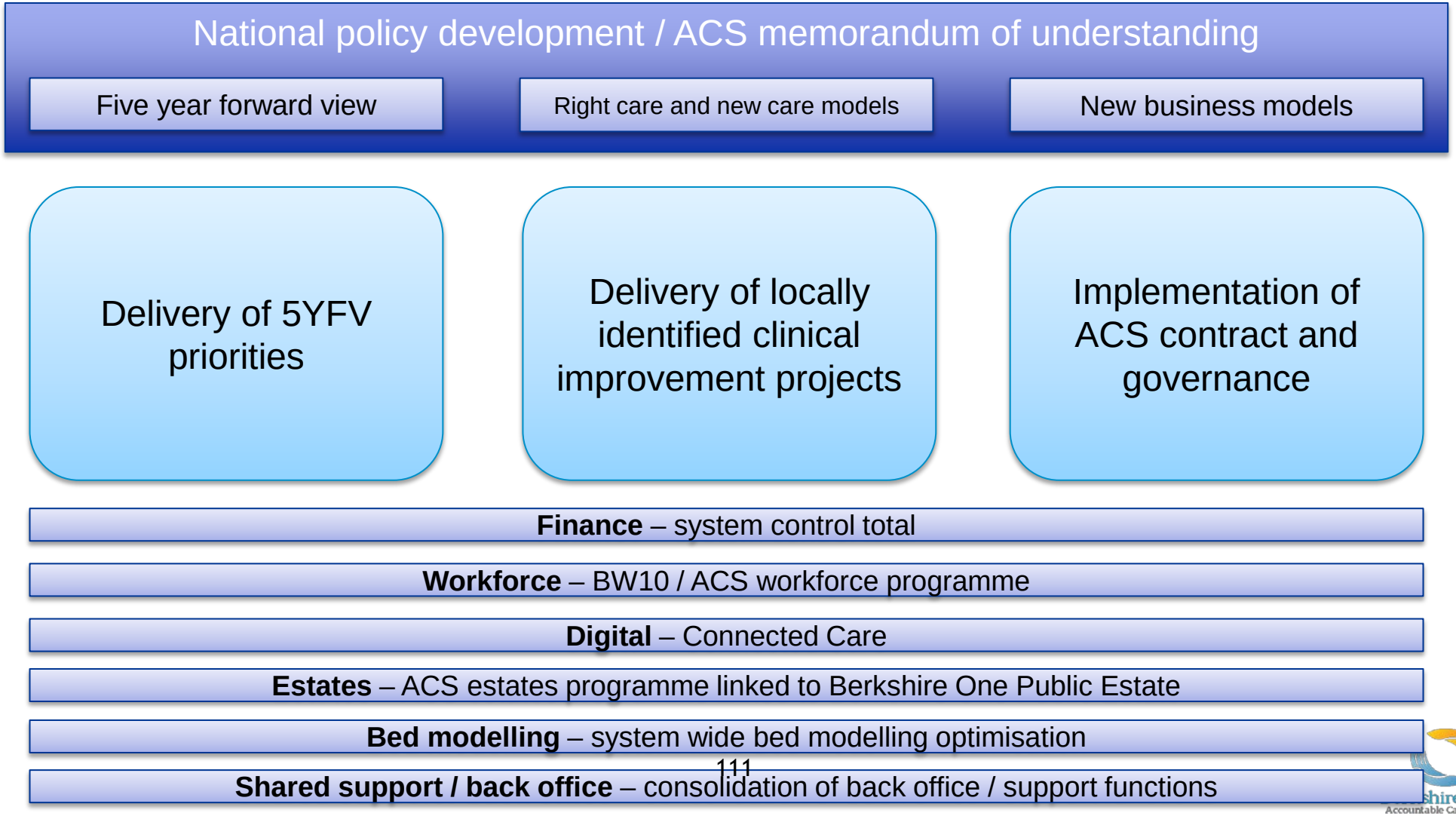
- **We have agreed a 'performance contract' with NHSE/I (to be formally signed by end October 17)**
  - *This will take the form of a memorandum of understanding (MOU) between the Berkshire West ACS and NHS England and describes what we need to achieve in 17/18 & 18/19.*
- **The ACS governance continues to evolve**
  - *Chair of the Berkshire West Integration Board now formally a member of the ACS Leadership Group – building links and mutual dependencies across programmes*
  - *ACS progress reported through BW Integration Board and to 3 Health & Wellbeing Boards*
  - *Primary Care alliance representation at both the ACS Leadership and Management group*
  - *Now looking at best mechanism to ensure effective resident engagement and the interfaces with existing joint health & social programme boards (e.g. A&E Delivery Board, Long Term Conditions Board)*

# Key updates / next steps

- **By December we will agree payment mechanism and contracts for 2018/19, establishing how the ACS organisations do business together**
  - A single capitated budget and financial plan which identifies and mitigates system risk
  - A single control total with clear risk share arrangements
  - Contracts which get the money to where it is needed – based on COST not PRICE
- **The ACS transformation programme continues focusing on the delivery of the 5YFV priorities, delivery of locally identified clinical improvement opportunities and the implementation of ACS contracts and governance** *(see following slides)*

# Programme approach

Fig 1. The Berkshire West ACS Programme takes a three-pillar approach to implementation



# New care models

***High intensity users***

- This project has identify the most prevalent A&E attendees and design and implement a community based intervention to proactively manage and support this cohort to reduce the workload on unscheduled care services and the wider health economy, resulting from reduced 999 calls, which otherwise would have attended A&E and resulted in an admission.
- Learning from Blackpool and Fyfe demonstrated that an approach of empathy and coaching rather than enforcement had the potential to reduce both the number of 999 calls and subsequent attendances and admissions.

***MSK transformation***

- A new MSK integrated service model for the ACS will be based on a contract with a single point of responsibility (*Prime Provider*), for the identified cohort of patients, with the associated budget and responsibility for clinical quality, patient safety and the efficient management of the patient pathway of care. The prime provider would deliver the totality of the pathway of care for MSK services that currently reside within both the community and secondary care setting.
- A ‘structured collaboration’ approach is underway with providers / clinicians with a view to agreeing the new service model in December ready fro April 2018 implementation.

# New care models

***Outpatients transformation***

- This major transformation programme will be phased over 2-3 years embracing a patient centric approach to the delivery of outpatient services closer to the patients' home, utilising new technologies and pathways, maximising the right clinicians to provide patients with consultations in Primary Care, Secondary Care and community based services.

***Respiratory care***

- The project will change the management of respiratory disease and deliver more care in primary care / the community and in the way services are delivered to patients with symptoms of sleep apnoea or chronic cough (linking with outpatient programme), supporting care closer to home; reducing avoidable referrals to secondary care and unnecessary follow ups.

# New business models

***Bed modelling***

- The project aims to ensure our 'bed base' is fit to meet our current and anticipated demographic and that it supports the new care model and system changes as they are identified via the ACS programmes.
- Undertaking demand – capacity modelling as a test bed to explore the consequences of different 'behaviours' and bed configurations, the project aims to inform the feasibility of different models of care delivery and identify opportunities and areas for improvement for the long term care requirements of the population.

***Estates***

- This project aims to maximise effective utilisation (clinical and non-clinical) of NHS Estate portfolio across West Berkshire and identify opportunities to deliver cash receipts through disposals and reduced annual revenue costs across the system.
- The project will support and be shaped by the emerging estates requirements of the new care model and system changes identified via the ACS change programmes.

***Support services / Back office functions***

- Undertaking a review of the current structure and cost of support services this project will explore alternative models of provision and consolidate functions intelligently. Options for phase 1 functions (finance) being evaluated in October with implementation planned for April 2018.

# Summary Report for Reading Health and Wellbeing Board

6th October 2017

| | |
|---|---|
| Name of Report | Merger of the four Berkshire West CCGs |
| Author of Report | Dr Cathy Winfield, Chief Officer |
| Organisation | Berkshire West CCGs |
| Date of Report | 14th September 2017 |
| Date of Meeting | 6th October 2017 |
| Subject Information | To brief the HWB on the proposal to merge the four Berkshire West CCGs into a single CCG with four localities. |

**PURPOSE OF REPORT**

1. The purpose of this paper is to brief the HWB on the proposal to merge the four Berkshire West CCGs into a single CCG with four localities, effective from April 2018. Further to the letter of 31st July from the CCGs to the Leader, the Health and Well Being Board are invited to comment on the proposals.

**BACKGROUND**

2. In July and August of this year, the GP membership of the four Berkshire West CCGs voted to merge to create a single CCG with four strong localities.

3. The key rationale was to reduce the duplication and inefficiency created by running four separate organisations so that clinical and managerial effort could be focused on developing primary care Alliances and supporting the Accountable Care System.

4. In accordance with this vote, the CCGs have submitted an application to merge to NHSE, and the NHS E National Commissioning Committee will consider this and make a decision at the end of September.

5. The CCGs will begin to work in new ways in shadow form during the current year and, subject to NHSE approval, the new CCG will be established on April 1st 2018.

6. The attached Merger Proposal paper articulates in more detail the rationale, benefits, risks and some elements of an operating model for a single CCG.

NHS North and West Reading Clinical Commissioning Group

NHS Newbury and District Clinical Commissioning Group

NHS Wokingham Clinical Commissioning Group

NHS South Reading Clinical Commissioning Group

# Berkshire West CCG Configuration: A proposal to merge the 4 CCGs into 1, with four localities (from 1 April 2018)

# 1. Introduction

The 4 CCGs in Berkshire West were established with a unique model of governance, working in a federated way. CCGs are clinically led organisations made up member GP practices. The CCG configuration was primarily driven by the GP practices who comprise the membership and the need to engage closely with local practices. It also supported the establishment of closer working relationships with local government and the three Health and Well Being Boards in Berkshire West, especially important in view of the emerging agenda of integration between health and social care.

The CCGs share the majority of the management team and run joint committees and joint programmes of clinical transformation. The model allows for locally sensitive commissioning to meet the needs of particular populations whilst providing some opportunity to work across Berkshire West where required. The CCGs have operated this way for four years but a number of factors have now prompted them to reconsider this arrangement

A number of key changes have taken place since the CCGs were established in 2013 which merit review of the current configuration:

- **Changing NHS landscape:** The NHS is now in a period of transition from the structures established by the Lansley Reforms to new emerging concepts of Accountable Care Systems and Primary Care Provider organisations that bring groups of practices together. Whilst no plans to make changes to statutory organisations have been announced, CCGs must respond flexibly to the new landscape and consider where best to focus clinical and managerial leadership.
- The successful Berkshire West drive to develop an **Accountable Care System (ACS)** along with the ambitious programme of reform outlined in the NHS Five Year Forward View requires a shift in focus for senior management and clinical leaders and it is felt that in this context, a proposal for a merger of 4 CCGs into 1 should now be explored.
- We are seeing the emergence of **new primary care provider organisations** across the patch and they require managerial resource and support. This can only be provided by refocusing the current management team and it is reminiscent of the period when PCTs assigned resource to shadow CCGs. The CCGs need to review their own configuration in the context of these changes.
- **Financial position.** The financial challenge facing the 4 CCGs is unprecedented with a £25m QIPP target in 17/18. In this context it is necessary to make the best use of every pound and there is a responsibility to hand on a strong financial legacy to new organisational forms. One of the duties of CCGs, where the Accountable Officer must specifically ensure compliance, is the duty regarding effectiveness and efficiency. "Each CCG must exercise its functions effectively, efficiently and economically." The CCGs have invested in a team to support primary care as part of the delegation of commissioning responsibility from NHS England without any transfer of resource. This has put pressure on the CCGs' running cost budget and a merger would alleviate that.
- The **integration of health and social care.** In the period since CCGs were established there has been good progress in joint working with our three local authority partners. In addition to strong locality working, the system also works on a Berkshire West footprint through the BW10 Delivery Group and Integration Board.

In the light of these factors a case for change to the CCG configuration was considered by the four Councils of Member Practices to whom decisions on CCG configuration are reserved. The fifty member practices of the four CCGs were asked to vote on the proposal to create a single CCG with four localities and the proposal was supported.

## 2. Merger Benefits

- **Strategic:** A merger will support the development of the Berkshire West Accountable Care System and enable sharing of commissioner and provider clinical input into pathway redesign and service transformation. As the focus of primary care leadership moves towards **primary care sustainability and delivery of the 5 Year GP View**, the merger will limit the duplicated committee work and allow some resource to be directed to supporting provider alliances and clusters.
- **Operational:** There is duplication of effort across the 4 CCGs e.g. servicing of 4 Governing Body meetings, production of 4 sets of plans, monitoring returns and accounts and annual reports. This is seen across many functions including those outsourced to the Commissioning Support Service e.g. IG Toolkit production. Operating 4 CCGs places a considerable additional workload on the team that work across all 4 CCGs at a time when there is an increasing workload required around ACS development and primary care sustainability.

  A single CCG with four localities would enable the GP led locality teams to meet as often as they do now but to be liberated from the responsibility of organisational governance and focus instead on the development of clinical services and improving outcomes and experience for patients in their locality.
- **Quality:** By merging the 4 CCGs, there will be a reduced focus on assurance on small numbers of outliers against constitutional targets at individual CCG level. This will enable the CCG Quality and Operational teams to have more time to focus on the important issues for the CCG and localities with overall compliance at a Berkshire West level.

  **Financial**: It has been estimated that the cost of the current duplication is between £150k and £200k per annum. Although only a small amount of the resource reduction would be cash releasing, there would be an opportunity to secure better value for money through the redeployment of expensive resource.

  Some cash releasing savings can be made to support the CCGs' £25m QIPP target and to prepare for NHS England's plan to reduce NHSE/CCG running cost funding by £150m by 2020/21 (potentially £600k for Berkshire West). A shared back office function is already part of the ACS work programme and the CCGs have already in housed some CSU functions to increase quality and reduce cost with further in housing planned. Furthermore, the work associated with the CCG programme boards has grown significantly and these are now major transformation programmes supporting delivery of the Five Year Forward View and underpinning the ACS programme. As the CCGs move forward with the ACS and an ambitious programme of transformation, the work of the programme boards will gain further importance.

## 3. The proposed operating model for a single CCG:

The proposed operating model has been designed to retain the features that support close working with member practices, patients and partners in each locality whilst providing efficiency gains and supporting the emerging ACS and primary care providers.

- **A single Governing Body** with four localities: A structure that retains optimal engagement with GP practices and patients to ensure responsiveness to local health needs, whilst reducing the bureaucratic burden of being 4 separate organisations and ensures a robust separation of duties in order to avoid any Conflicts of Interest as the ACS develops.
- **Four localities based on the current CCGs**: A structure that maintains and builds on effective working relationships with local government and Health and Well Being Boards and supports the integration of health and social care
- **Four Councils**: Under the scheme of delegation they would have devolved responsibilities for local decision making and devolved budgets. This model would preserve the levels of engagement that are required for success and is one that is seen operating effectively in some neighbouring CCGs and likely to be adopted by others as CCGs review effectiveness and efficiency.
- **Retains PMS funding in the localities that will replace current CCGs**: This ensures that commitments made in 2015-2016 are met. With a merger there will be an opportunity to invest differentiall in the other localities to achieve **parity of primary care funding for PMS and GMS practices** across Berkshire West.
- **The shared management structure will be supported by local operational teams** as is currently the case and there will continue to be Clinical Management Team/Organisational Leadership Team meetings. It is anticipated that these meetings may have a part B focussing on primary care provider development, but it is essential that the localities continue to help meet the commissioning obligations of the CCG as they evolve over the next years. The locality groups would retain responsibility for:
  - Key decisions and financial management of agreed budgets
  - Locality strategy and vision, bearing in mind the need relate to the Berkshire West ACS
  - Local operating plans that feed into the a single Operating Plan for the CCG in line with NHSE Planning Guidance
  - Development of QIPP ideas, service redesign and quality improvement
  - Development of primary care including the implementation of the GP5YFV
  - Ensuring that services are sensitive to the needs of the local population
  - Prescribing budget and incentive schemes
  - One of the ACS programme boards e.g. urgent care
  - BCF budgets and management of associated locality projects
  - Performance reported at Locality level where it is amenable to influence by GPs e.g. immunisations, screening, GP survey, radiology, pathology, NEL referrals per 1,000, quality premium etc.
  - Actively participating in their Health and Well Being Boards and electing a representative to attend HWB meetings (likely to be the Locality Board Chair)
  - Working with their Healthwatch (they are likely to attend the statutory Board)
  - Participating in Board committees e.g. Quality, QIPP and Finance, but with a focus on avoiding duplication where it does not add value.

### 4.2 Councils

- There would be a statutory requirement for a single GP council but to retain engagement the proposal is to retain 4 Councils working with the relevant locality group.
- At locality level differential voting could be locally agreed to reflect practice size if required.
- The four locality Councils would come together (possibly twice a year) to share good practice, provide input to the planning process and take those decisions that are reserved to them such as signing off the Operational and Strategic Plan.

### 4.3 CCG Governing Body

The proposed Governing Body structure ensures that a clinical majority is maintained and is suggested below but this is not yet finalised:

- Accountable Officer
- Chief Finance Officer
- Nurse Director
- Secondary Care Consultant
- 3 or 4 lay members (one for each locality, with one non-voting)
- 1 GP for each of the 4 localities (one being the Chair)
- 1 Operational Director for each of the localities (non-voting)
- Director of Strategy (non-voting)
- Director of Joint Commissioning (non-voting)

The member practices have made a number of proposals with regard to the constitution of the new CCG and the CCGs will work them through a period of co-production to develop the new constitution.

**Our key stakeholders should not notice any change in the way we do business but the statutory entity will change to reduce the bureaucratic burden and maximise managerial and clinical capacity**

## 4. Process

The CCGs must obtain approval from NHS England to change their configuration.

The CCGs submission will need to demonstrate that member practices support this change and show that the views of Health and Well Being Boards have been taken into account. Due to the tight timelines some of these processes will need to happen in parallel.

## 5. Timeline

The proposed timeline for the merger is as follows

| Action | Date |
|---|---|
| Review of draft business case by Clinical Commissioning Committee | April 2017 |
| Council of Member Practices to be briefed on the Merger Option | May 2017 |
| Approval of the final business case by Clinical Commissioning Committee | May 2017 |
| Practices to vote on the Merger proposal | 27 July 2017 |
| Submission of expression of interest to NHS England | 31 July 2017 |
| Engagement with partners | 31 July – 18th August 2017 |
| Submission to NHSE | 18th August 2017 |
| NHSE Commissioning Committee decision | 27th September 2017 |
| Berkshire West CCG to operate in shadow form | 1 October 2017 |
| Merged CCG fully operational | 1 April 2018 |

## Annex 1: The Five Legal Factors

Whilst there are provisions under section 14G of the NHS Act 2006 (as amended) allowing for mergers of CCGs, there are specific legal factors that NHS England must consider when deciding whether or not to agree the merger. Each of the five factors has been considered below:

**1. Coterminosity with local authorities**

There will be no changes to the overall boundary, with the merged CCG having coterminosity with the 3 Local Authorities in Berkshire West.

**2. Clinically-led: the new CCG should demonstrate that it will remain a clinically-led organisation, and that members of the new CCG will participate in decision-making in the new CCG.**

Strong clinical leadership has been an important feature of the CCGs during the 4 years to date and will have even greater importance over years ahead given the levels of transformational change required across the health and social care system in Berkshire West. The Accountable Care System and the development of sustainable primary care providers involves change supported by high levels of leadership and engagement at all levels throughout the organisations involved. It is proposed that the only reduction in clinician time is as a result of reducing the number of governing body meetings and committees that clinical leads attend and in fact some of the time saved will be reinvested in the transformation programme.

**3. Financial management: NHS England will consider whether the new CCG will have financial arrangements and controls for proper stewardship and accountability for public funds.**

The individual CCGs currently maintain separate ledgers. However, the overall financial position is managed on a Berkshire West basis with risk sharing agreements in place between the CCGs. The controls and procedures operate in the same way across all CCGs and consolidated reports are produced for key meetings e.g. QIPP and Finance Committee. A move to a single ledger and set of reports should not result in any significant change to the control environment and it will facilitate the management of the position across Berkshire West. It is anticipated that finance resource will be released to support key developments. However, an important piece of work to undertake quickly is to ensure that reports are available at locality level, something that is achieved by local CCGs that operate multiple localities.

**4. Arrangements with other CCGs: the new CCG will have appropriate arrangements with others, for example lead commissioning arrangements.**

None of the current arrangements will be changed as a result of the merger. It is anticipated that arrangements will develop further under the STP arrangements.

**5. Commissioning support: NHS England can take into account whether the new CCG has good arrangements for commissioning support services.**

The CCGs share their CSU support and are currently procuring jointly their future support services through the Lead Provider Framework. It is anticipated that the merger would significantly reduce duplication of tasks and the CCG would expect to see a reduced price for support.

**READING BOROUGH COUNCIL**

**REPORT BY DIRECTOR OF ADULT CARE & HEALTH SERVICES**

**TO:** Health & Wellbeing Board

**DATE:** 6 October 2017 **AGENDA ITEM: 11**

**TITLE: Update on BOB STP Prevention Workstream**

**LEAD COUNCILLOR:** Councillor Graeme 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** This report is intended to give the Health and Wellbeing Board an information update on the work of the Prevention Workstream that is part of the Buckinghamshire, Oxfordshire and Berkshire West Sustainability Transformation Plan (BOB STP). The report sets out the 6 themes that are the focus of this work, giving the vision, deliverables and progress to date. The 6 themes are: obesity, physical activity, tobacco, Making Every Contact Count, Digital solutions and Healthy Workforce. The work going on in the BOB STP Prevention Workstream is variable across the themes and is evolving continuously. Progress has been made and collaboration continues across the 3 geographical areas within BOB and the different disciplines. The Prevention Workstream group continues to have good buy-in from Directors of PH and their representatives from Buckinghamshire, Oxfordshire and Berkshire West.

**1.2** Appendix 1 – BOB STP Prevention Programme Status Update - July 17

## 2. RECOMMENDED ACTION

**2.1 The Board to note progress against delivery of the six STP themes within the BOB STP Prevention Workstream**

## 3. POLICY CONTEXT

**3.1** Sustainability and transformation partnerships build on collaborative work that began under the NHS Shared Planning Guidance for 2016/17 – 2020/21, to support implementation of the Five Year Forward View. They are supported by six national health and care bodies: NHS England; NHS Improvement; the Care Quality Commission (CQC); Health Education England (HEE); Public Health England (PHE) and the National Institute for Health and Care Excellence (NICE).

- The development of STPs is driven by Joint Strategic Needs assessments and Health and Wellbeing Strategies. Reading is part of the Buckinghamshire, Oxfordshire and Berkshire West STP footprint (BOB STP). *The agreed Council strategy and/or policy within which the decision is being made:*
  **Health and Wellbeing Strategy, Joint Strategic Needs Assessment**

## 4. THE PROPOSAL

**4.1** The challenges and opportunities facing NHS and care services across Buckinghamshire, Oxfordshire and Berkshire West (BOB) are set out in a five-year Sustainability and Transformation Plan (STP). The plan demonstrates how the NHS will work to improve health and wellbeing within the funds available and also highlights how it will work in partnership with the Local Authorities to address the many challenges that exist including growing populations, higher proportion of older people, inequalities in health, increase in complex and costly treatments etc.

The BOB STP has as its focus the following areas:

- Shifting the focus of care from treatment to **prevention**
- **Ensuring Access** to the highest quality primary, community and urgent care
- Facilitating collaboration of the three acute trusts to deliver **quality and efficiency**
- Maximising value and patient outcomes from **specialised commissioning**
- **Developing Mental health services** to improve the overall value of care provided
- Establishing a flexible and collaborative approach to **workforce**
- **Developing Digital interoperability** to improve information flow and efficiency

### 4.2 The BOB STP Prevention Workstream

**Vision**

***A proactive approach to disease prevention within all that we do, shifting the focus of care from treatment to prevention , addressing unhealthy behaviours that may lead to serious conditions further down the line and thus reducing the burden on the healthcare system. We will take action to motivate people to take ownership of their own health and encourage healthy environments to enhance the quality of life for our population.***

There are a wide range of programmes that support the aim of shifting the focus of care from treatment to prevention in all settings. The programmes that have been identified for the BOB STP are:

- Obesity
- Physical activity
- Making Every Contact Count
- Tobacco
- Improving Workforce Health
- Digital self care

The overall objectives for all of these areas of work are twofold:

1. To embed prevention within the local transformation programmes
2. To collaborate across BOB on areas where there is benefit of working at scale. There is also an aim to continue working together to identify other BOB wide opportunities, that may include alcohol and social prescribing.

The most appropriate level at which each programme should be led and delivered within the health and care system has been agreed through the STP. This has been based on the partnerships and scale required to best implement the specific programmes. A stocktake of all initiatives was undertaken and schemes were chosen based on the following principles:

1. There is a clear opportunity/ benefit in doing it jointly, to deliver improvement in terms of finance, quality and/or capacity
2. Doing something once is more efficient and offers scale and pace
3. Collective system leadership is required to make the change happen

### 4.3 The case for change in Buckinghamshire, Oxfordshire and Berkshire West

The overall health and wellbeing of the populations across the BOB STP footprint is generally good however areas of deprivation and poor health are often masked. Inequalities in health exist across all three localities. Higher levels of obesity and smoking are more prevalent in certain groups including those on low incomes and living in deprived areas. There is a commitment in the BOB STP Prevention Workstream to focus on developing system wide initiatives to reduce the burden of ill health due to physical inactivity, poor diet and smoking as well as a recognition that this needs to be done in partnership with CCGs, Local Authorities, Public Health, NHS Trusts and The Academic Health Sciences Network (AHSN).

There is a strong evidence base showing that the health and wellbeing of residents can be improved and demand on health and social care services reduced though people changing to healthier lifestyle behaviours, including being more physically active, eating a healthier diet, maintaining a healthy weight and not smoking. Return on investment tools have shown that for the BOB footprint the savings could be as much as £9 million over a 4 year period.

There are already examples of joint commissioning in prevention across Berkshire West for smoking cessation and tier 2 weight management services and these demonstrate the advantages of commissioning at a wider level with multiple partners. There are also examples of joint commissioning with CCGs and Las through the Better Care Fund. All this can be built upon and extended across the BOB STP.

### 4.4 Update on Progress to date in the six areas of work of the BOB STP Prevention Workstream

Throughout 2017/18 the work is being further developed and plans implemented. Appendix 1 shows a summary of milestones for each workstream that is RAG rated.

### 4.4 (a) Obesity

**Vision: To agree and develop a pathway for commissioning obesity prevention and treatment services which is consistent across the BOB area.**

- **milestone status is green.**

A joint workshop was held at Reading Civic Centre bringing together Clinical Commissioning Group (CCG) and Public Health obesity leads from Berkshire West, Oxfordshire and Buckinghamshire. In addition there were clinicians from the main hospital trusts who deliver tier 4 bariatric services and providers of a community based tier 4 service in Buckinghamshire. This was a very productive meeting with the following aims:

1. To inform commissioning for Tier 3 and 4 weight management services in Buckinghamshire, Oxfordshire and Berkshire West, exploring any opportunities for collaborative commissioning.
2. To discuss current positive practice and learn from local and national experiences (good or bad) including how CCG commissioned services dovetail with local authority commissioned tier 1 and tier 2 services.
3. To provide a safe and informative environment to discuss and seek ‘buy in’ to vision and direction.

The workshop identified a number of key issues: that a clear pathway was needed across BOB linking all tiers of weight management and that LAs, CCGs and major providers must work collaboratively to provide this; that current tier 4 bariatric surgery includes an element of tier 3 whereby patients are helped to lose weight to prepare for their surgery but that a new focus for tier 3 services could also be helping

bariatric patients to lose weight thus eliminating the need for surgery; any tier 3 service would have to be accessible to patients so a degree of local delivery would be needed; an addition to tier 3 services could be the use of apps, skype etc to improve accessibility.

A further meeting has been held to discuss the outcomes of the workshop and agree a way forward. The development of a business case for tier 3 weight management services across BOB is being carried out. CCGs will commission this service and it will be part of a clear weight management pathway that includes all tiers of service.

### 4.4 (b) Physical inactivity

**Vision: To maximise the use of the IT patient portal, identify through consultations, patients who are physically inactive and use technology and social media approaches to improve their activity levels. To incorporate Physical Activity as a treatment prescription for condition pathways.**

- **milestone status is amber and this group is in the pre-implementation phase**.

A suggested focus for this group is to work with the cancer and diabetes clinical networks to develop model pathways showing where physical activity can be incorporated into disease pathways. Front line staff will be encouraged to get more proactive about including advice on physical activity as part of their advice to patients. This approach links in with the Public Health England (PHE) Physical Activity Champions initiative.

In addition a pilot is starting PHE is starting a pilot project, the Physical Activity Clinical Advice Pad pilot, whereby five local authority-Clinical Commissioning Group partnerships will test out the use of a clinical advice pad to aid clinicians in promoting physical activity as part of routine care in Primary Care.

The investigation of the use of physical activity apps and on-line advice and support to help people be more active is ongoing.

### 4.4 (c) Tobacco

**Vision: To reduce significantly the number of smokers who have surgical interventions.**

- **milestone status is green.**

The importance of addressing tobacco has been recognised by the BOB STP Prevention Group and this fits with the focus on reducing smoking prevalence of the Thames Valley Cancer Alliance. As the lead commissioners of smoking cessation services the LAs will be required to work with the CCGs to decrease smoking prevalence in routine and manual workers, where there is still a relatively high rate of smoking in comparison with the rest of the population. In addition there will also be a focus on further decreasing smoking in pregnancy as a key outcome. Further joint plans for smoking cessation and tobacco control are under development.

In addition the CCGs are considering limiting elective surgery for patients who continue to smoke. This approach is being refined and a policy statement that will be consulted on is under development. Again it will be vital for the LA commissioners to work together with the CCGs to ensure that the required smoking cessation services are in place to support patients who are trying to give up before their operation. A pilot project was trialled in Berkshire West – Stop B4 The Op – whereby GPs referred patients who needed elective surgery and were smokers directly to the Stop Smoking Service on a rapid access basis. This will be relaunched in the first instance.

### 4.4 (d) Making Every Contact Count (MECC)

**Vision: The programme of work aims to embed MECC across organisations to enable the workforce to recognise their role in prevention and reducing inequalities to support the sustainability of the health and social care system; building on existing initiatives in place across the BOB STP footprint.**

- **milestone status amber.**

A project approach has been agreed by the BOB STP Prevention Group and a Project lead has been appointed. Jackie Prosser is developing the final project plan and amalgamating intelligence gathered through the use of a MECC stocktake sent to NHS and LA organisations on the status of MECC for each. The model includes determining the number of MECC trainers that will be needed across BOB, setting up a train the trainer cascade for sustainability, employing MECC Co-ordinators in each locality and developing MECC Champions in all sectors. The MECC approach will be widely used and it is envisaged that front line workers in the NHS, LAs, police, fire service and voluntary and third sector organisations will all undergo MECC training and see it is part of their everyday role. MECC training could be included in staff induction programmes and this approach will be seen as the norm for front line staff.

The two health behaviours that can be identified and addressed through MECC in the first instance are smoking and obesity. MECC will also be a clear plank in the workforce health workstream.

### 4.4 (e) Digital self care

**Vision:**
**To Support the general wellbeing of service users and carers through the use of digital, supporting patients with managing their conditions. To use digital technology to lead prioritisation of care by clinical and social care professionals. To make a joined up and informed investment around patient facing technology (opposite of as is state)**

- **Digital self-care – milestone status is amber**

This work continues however a complete detailed review and specification of services has been deemed to be in scope of an Accountable Care System (ACS) corporate service. It will be of paramount importance as ACSs evolve that prevention is included within digital specifications across the board.

The work of the 12 month pilot project being developed in Berkshire involving the NHS and Microsoft is continuing, involving 400 volunteers who are NHS staff wearing a digital device (Fitbit) 24 hours a day for the period of one year. A number of parameters will be monitored including BP, HR, activity levels and sleep and the aim is to understand if the wearing of an electronic monitoring device can in fact have a positive effect on health and wellbeing.

The use of digital technology is a focus of all of the prevention workstreams.

### 4.4 (f) Workforce health

**Vision: To improve and sustain workforce health and wellbeing and employee confidence to promote healthy lifestyles to others**

- **milestone status is green**

BOB Healthy workforce group has reviewed membership and now has higher level representation. A benchmarking exercise has been done and is being analysed to get a full understanding of how public sector organisations are caring for the health and wellbeing of their staff. Links have been made with the MECC lead, the work of the STP Workforce stream and with Occupational Health Services.

One focus of the group has been mental health and wellbeing in the workplace. Berkshire Healthcare Foundation Trust (BHFT) has employed a dedicated mental health practitioner for staff wellbeing. The impact is being evaluated. In addition BHFT have action plans that incentivise staff health and wellbeing through their CQUIN programme and staff have been provided with resilience training in Frimley to support the launch of their staff wellbeing strategy.

Wherever innovative and effective workforce health strategies and initiatives are being implemented, these examples will be used to inform and encourage other organisations to utilise similar approaches. In this way we can embed good practice already in place to encourage consistency of wellbeing offer across BOB, through disseminating case studies, success and evaluation measures and offering peer support. In this way a culture is created where staff Health and Wellbeing is used proactively within organisations e.g. during organisational change and is considered in conjunction with other organisational activities e.g. Education and Training, retention programmes etc.workforce health

## 5 CONTRIBUTION TO STRATEGIC AIMS

5.1 The work being undertaken as part of the BOB STP Prevention Workstream contributes to the following Corporate Plan priority:

Providing the best start in life through education, early help and healthy living;

*5.2* The Preventative work within BOB STP contributes to the following Council Strategic Aim:

To promote equality, social inclusion and a safe and healthy environment for all

*5.3* There is also contribution to the aims of the Health and Social Care Act (2012) and the Public health Outcomes Framework

- Under The Health and Social Care Act (2012) local authorities now have a much stronger role in shaping services, and have taken over responsibility for local population health improvement. The Health and wellbeing boards have brought together local commissioners of health and social care, elected representatives and representatives of Healthwatch to agree an integrated way to improving local health and well-being. The aims for each LA are set out in the Health and Wellbeing Strategy that is based on the local JSNA.
- The Public Health Outcomes Framework (PHOF) *Healthy lives, healthy people: Improving outcomes and supporting transparency* sets out a vision for public health, desired outcomes and the indicators that will help us understand how well public health is being improved and protected
- The BOB STP Prevention workstream will help to improve the health and wellbeing of residents by preventing many long term conditions including diabetes, coronary heart disease, stroke, Chronic obstructive pulmonary disease (COPD), osteoporosis, and some cancers. This will be achieved through helping residents to take responsibility for their own health and wellbeing and adopt healthier lifestyles including being more physically active, not smoking, eating a healthier diet and maintaining a healthy weight. In addition workforce health and digital solutions can also help to improve mental and emotional health and wellbeing of those who live and work in Reading.

## 6. COMMUNITY ENGAGEMENT AND INFORMATION

*6.1* *Section 138 of the Local Government and Public Involvement in Health Act 2007 places a duty on local authorities to involve local representatives when carrying out "any of its functions" by providing information, consulting or "involving in another way".*

*6.2* The Berkshire West CCGs have presented the concept of the BOB STP to their residents at a Public Consultation meeting. For North and West Reading and South Reading CCGs these meetings took place in March 2017 in local venues. Details of the Prevention workstream were touched upon only in general terms without details of the work planned.

## 7. EQUALITY IMPACT ASSESSMENT

*7.1* The work of the BOB STP Prevention Workstream will continue to be developed with an awareness of inequalities of health identified through robust local data sets.

## 8. LEGAL IMPLICATIONS

8.1 We do not anticipate there to be any legal implications at this stage.

## 9. FINANCIAL IMPLICATIONS

9.1 The work being undertaken by the BOB STP Prevention Workstream is being delivered within existing resources. Some funding may be made available from a variety of sources for specific pieces of work for example the Making Every Contact Count project has been funded through the STP process.

## 10. BACKGROUND PAPERS

10.1 BOB STP Prevention Workstream Update April 2017.

# BOB STP Prevention Dashboard – Delivery Summary

26th July 2017

## OBJECTIVES(1)

1.To embed prevention within our local transformation programmes and NHS organisation culture
2. To continue working together to identify other BOB wide opportunities, which may include alcohol and social prescribing

(1) source: Prevention PID

## STATUS (against objectives)

**Objective 1: Red -** a programme of work has been established to close our anticipated financial gap for the next two years however there is currently no indication we will do so
**Objective 2: Amber** – The priority projects which have now been established for clinical improvement are aligned to this objective but have not yet been implemented
**Objective 3: Amber** – the clinical improvement priority projects identified are preventative in nature. However, the detail of how this will be delivered is still to be defined.

**Red**

## ITEMS FOR BOB OPERATION TEAM ATTENTION

1. ***The financial savings opportunities of each of the priority projects require urgent quantification and attribution (see Risk 1)***
2. ***Finance support to consider investment to save on Obesity pathway***
3. ***Focus on Tobacco to be on a) safe surgery and b) Manual workers and maternity inequalities (see – milestones) – Business Case refresh being undertaken***
4. ***PHE working on Health inequalities for BOB to target services***
5. ***MECC***

## DELIVERY STATUS

| # | Project / Scheme | Phase | Milestone Status(2) | Benefits Status(2) | Notes |
|---|---|---|---|---|---|
| 1. | Obesity | Pre-implementation | A | A | Workshop held on 12 July, - outputs agreed – Further meet of CCGs and LA planned in August – joint proposal to commission a Tier 3 service – locality based.. |
| 2. | MECC | Design | A | A | Stocktake to establish baseline measure of MECC Trainer, number of conversations, and approach in process., Project approach to be considered at the July Operational Group. HEE supporting in the identification of benefit of MECC for BOB |
| 3. | Workforce Health | Design | G | A | Outline project plan being drafted covering key engagement and decision points. Link with STP worksroce. |
| 4. | Physical Inactivity | Pre – implementation | A | A | Prevention group agreeing ‘design principles. Operational group to agree approach. |
| 6. | Digital Self Care | Design | R | A | Outline project plan being drafted with the CIO group. |
| 7. | Tobacco | Pre – Implementation | G | A | Berkshire West safe surgery draft statement shared with Bucks and Oxford, Further consideration required on the policy statement, link with locality smoking cessation services.<br>Revised business case to be developed |

**R/A/G KEY:** = complete = on track, no issues = some challenges = major challenges

## KEY MILESTONE STATUS – NEXT 3 MONTHS

| Project | Milestone | Baseline Date | Forecast/ RAG | Notes |
|---|---|---|---|---|
| **Obesity** | *Workshop for scoping tier 3 services* | *17 May 17* | **G** | *12th July workshop held . Agreed to work up a case for a tier 3 service, see notes* |
| | *BOB Obesity Specification* | *01 Dec 17* | **G** | *Business case in development require Finance support for the review* |
| **Tobacco** | *Revised business case on opportunities* | *Aug 17* | **G** | *Clarification of opportunities required. Finance support for the review required* |
| | *Inequality focus* | | **G** | *PHE confirmation BOB STP demonstrates smoking inequality in manual workers* |
| **MECC** | Baseline stocktake | *15 May 17* | **A** | *Stocktake sent to CEO, COO for BOB NHS organisations and LA Public Health Teams, deadline for extended to the End of July. Establish baseline, to design training and set trajectory for number of trainers and number of conversation - leading to BOB MOU* |
| | Approval of Project approach | *July 17* | **G** | *Approach approved by prevention group. Engamgmnent commenced with NHS England Pharmacy to leverage Pharmacy contract on MECC. Paper to be sign up by operational group in August 17 .*<br><br>*Focus on MECC to around tobacco (esp in manual workers, and obesity)* |
| **Workforce health** | Link with BOB Workforce programme | *May 17* | **Complete** | |
| | Approval of project approach to Prevention group and Operational Group | *Aug 17* | **A** | *Approach reviewed by prevention group. Further clarification on objectives required* |
| **Physical Inactivity** | Workshop to identify opportunities with physical inactivity | By end May 17 | **Complete** | *Project group to agree re-model following unsuccessful recruitment of community consultant.* |
| | Approval of project approach to Operational Group | Aug17 | **A** | *Paper review Apps and uses across STP tp be agreed by opeartional group in August. Delayed by to Annual leave* |
| **Digital Self care** | Complete detailed review and specification of services deemed in scope of an ACS corporate service | *By end May 17* | **A** | *progress will depend on availability of relevant people to participate and contribute* |

**R/A/G KEY:** = complete = on track, no issues = some challenges = major challenges

## KEY RISKS & ISSUES (5)

| Ref | Aggregate risk score | Source / Date | Risk / issue | Owner | Actions requested / Actions Agreed |
|---|---|---|---|---|---|
| 1. | | June 17 – SRO | There is a risk that BOB Prevention priority projects will not deliver sufficient cost reductions to achieve financial sustainability. (£3m)<br><br>This would lead to an impact / effect on partner financial positions | STP Operational Group & Finance Group | - The financial savings opportunities of each of the priority projects require urgent quantification and attribution |
| 2. | | April 17 – PMO | There is a risk that there is insufficient resource to deliver on the Prevention priority projects and achieve BOB ambitions.<br><br>This would impact programme deliverables, outcomes | STP Operational Group | -Operational Group group to review programme resource schedule to ensure appropriate level of programme / project resources |
| 3. | | | | | |
| 4. | | | | | |
| 5. | | | | | |

(5) Addition project risks raised by project managers that do not meet the escalation criteria below and that are deemed to be in the scope of the project to manage and mitigate remain on the respective projects RAID log

## PROJECT RISK ESCALATION CRITERIA

Project and/or identified process risks that meet one or more of the following criteria will be escalated to the Management Team as a programme risk:

- Any risk that is likely to impact on the delivery/achievement of one or more other partners milestones and/or benefits
- Any risk scored '5' for either likelihood or Impact
- The Operational Group Chair, a project SRO or the CFO Group Chair may escalate risks to the Leadership Team for inclusion on the Programme Risk register, following initial escalation and discussion with the PMO.

## BENEFITS TRACKING – SYSTEM WIDE

| Reductions in Activity compared to Forecast Improvement | | | | | | |
|---|---|---|---|---|---|---|
| Scheme | Baseline - 16/17 FY performance | 2017/18 | | | | Notes |
| | | Q1 | Q2 | Q3 | Q4 | |
| Obesity | | | | | | |
| MECC | | | | | | |
| Workforce Health | | | | | | |
| Physical Inactivity | | | | | | |

| Reductions in £Spend compared to Forecast Improvement | | | | | | |
|---|---|---|---|---|---|---|
| Scheme | Baseline - 16/17 FY performance | 2016/17 | | | | Notes |
| | | Q1 | Q2 | Q3* | Q4 | |
| Obesity | | | | | | |
| MECC | | | | | | |
| Workforce Health | | | | | | |
| Physical Inactivity | | | | | | |

## BENEFITS – PROJECT SPECIFIC - alignment to BOB STP

| # | Project | | | | | | | Other Notes |
|---|---|---|---|---|---|---|---|---|
| | | | | | | | | |
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TO BE COMPLETED WHEN DATA AVAILABLE

**KEY:** **X** = aligned to BOB STP **II** = aligned to Locality Oxford, Berkshire West, Bucks

## Smoking Inequalities

So whilst we have low prevalence, in most cases over a ¼ of the smokers are routine and manual workers

Source:
http://www.tobaccoprofiles.info/profile/tobacco-control/data#page/0/gid/1938132885/pat/104/par/E45000019/ati/102/are/E06000036

| Indicator | Period | England | South East PHE centre | Bracknell Forest | Brighton and Hove | Buckinghamshire | East Sussex | Hampshire | Isle of Wight | Kent | Medway | Oxfordshire | Portsmouth | Reading | Slough | Southampton | Surrey | West Berkshire | West Sussex | Windsor and Maidenhead | Wokingham |
|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|
| Smoking Prevalence in adults - current smokers (APS) | 2016 | 15.5 | 14.6 | 16.1 | 19.9 | 11.2 | 17.1 | 13.6 | 15.3 | 15.2 | 19.0 | 11.9 | 20.1 | 15.8 | 18.0 | 17.8 | 12.4 | 12.8 | 15.4 | 12.2 | 8.8 |
| Smoking Prevalence in adults in routine and manual occupations - current smokers (APS) | 2016 | 26.5 | 28.2 | 28.4 | 33.1 | 26.8 | 34.3 | 25.9 | 26.9 | 29.0 | 34.2 | 24.6 | 25.3 | 30.4 | 24.9 | 29.5 | 23.6 | 21.9 | 33.7 | 22.0 | 20.5 |

# Summary Report for Health and Wellbeing Board

September 2017

| | |
|---|---|
| **Name of Report** | Establishing Clinical Response for Adults who have suffered Female Genital Mutilation (FGM) |
| **Author of Report** | Liz Stead |
| **Organisation** | Berkshire West Federation of CCGs |
| **Date of Report** | September 2017 |
| **Date of Meeting** | 6 October 2017 |
| **Subject Information** | Summary update report on the clinical response to adults who have experienced FGM.<br><br>**<u>Previously</u>**<br><br>The bid to the Home Office Violence Against Women and Girls Transformation Fund (VAWG) was unsuccessful.<br><br>**<u>Resolution</u>**<br><br>It is important that the vision for establishing the Rose Centre is not thwarted, therefore partners have worked creatively to establish a much more abbreviated version of Rose with the small amount of funds that were available.<br><br>The venue, Oxford Road Community Centre (ORCC), was being renovated by Reading Borough Council and this work is now complete. This means that Reading Rose Centre now has a venue that is fit for purpose and allows partners to open a once-a-month drop in session for women to come to learn about FGM in practising communities, challenge the practise and access advice, support and where necessary, onward referral to therapeutic services (via the GP).<br><br>The remaining monies secured from the NHS England Innovation Fund (2016), which were due to be used to equip the centre, is now funding the rent for the room at ORCC and will fund attendance of the clinician at the monthly drop-in session. The clinician, a Specialist Registrar from Royal Berkshire Hospital, has a special interest in FGM and related issues. Contracts have been agreed with RBH.<br><br>Appeals for donations for equipment and furniture has proved successful, as well as colleagues and friends giving time and effort in personalising the rooms, to make the centre a welcoming place for women to come and talk about this exceptionally sensitive subject.<br><br>The centre's motto is "No Woman Turned Away". |

| | |
|---|---|
| | The centre had a soft launch on 1st September 2017 but the full service, with the clinician present will be from 6th October. A publicity effort will take place prior to this, but as there is no budget for this, we are reliant on partners using their own links and resources to really push the Rose Centre and raise awareness. |
| **Discussion** | Monies available for this very abbreviated service will allow it to run for 1 year from September 2017. Thereafter, there will need to be a collaborative approach to funding the Centre's continuation. In the meantime, as more funding options become available, partners involved in Rose will continue to make bids to any and all appropriate sources. |
| **Recommendations** | • That the report is noted by the HWB<br>• HWB members commit to promotion and awareness raising of the Drop In service across statutory agencies, e.g Social Services and Local Authorities, MASH's etc and safeguarding leads in all organisations<br>• A 'mid-way' report is provided to HWB in March 2018 to report on the activity of Rose Centre.<br>• The report is further shared with the Community Safety Partnerships in the West of Berkshire |

**READING BOROUGH COUNCIL**

**REPORT BY DIRECTOR OF ADULT CARE AND HEALTH SERVICES**

| | | | |
|---|---|---|---|
| **TO:** | **HEALTH AND WELLBEING BOARD** | | |
| **DATE:** | **06 OCTOBER 2017** | **AGENDA ITEM:** | **13** |
| **TITLE:** | **BETTER CARE FUND SUBMISSION & PERFORMANCE UPDATE** | | |
| **LEAD COUNCILLOR:** | **CLLR HOSKIN / CLLR EDEN** | **PORTFOLIO:** | **HEALTH / ADULT SOCIAL CARE** |
| **SERVICE:** | **ADULT SOCIAL CARE & HEALTH** | **WARDS:** | **ALL** |
| **LEAD OFFICER:** | **SEONA DOUGLAS** | **TEL:** | **0118 937 2094** |
| **JOB TITLE:** | **Director Adult Care and Health Services** | **E-MAIL:** | **seona.douglas@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 Better Care Fund (BCF) submission.

## 2. RECOMMENDED ACTION

**2.1 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. These National conditions have been revised and streamlined for the 2017-19 period and are now as follows:

- Plans to be jointly agreed (Local areas must ensure that their Better Care Fund (BCF) Plan covers the minimum of the pooled fund specified, and the Plan should be signed off by the Health and Wellbeing Board or by delegated authority, and by the constituent councils and Clinical Commissioning Groups.

- NHS contribution to adult social care is maintained in line with inflation (The NHS contribution to adult social care at a local level must be increased by 1.79% and 1.9% (in line with the increases applied to the money CCGs must pool) in 2017-18 and in 2018-19 respectively).

- Agreement to invest in NHS commissioned out of hospital services, which may include 7 day services and adult social care

- Managing Transfers of Care through the adoption of the National best practice "High Impact Change Model for Managing Transfer of Care"

## 4. PROGRESS UPDATE

4.1 The BCF Submission documents were assembled under the oversight of the outgoing Integration Programme Manager, Tony Marvell.

4.2 *A* draft of the document was submitted to Reading's NHS England Senior Relationship Manager, Kevin Johnson, on Thursday 31st August. During a feedback conversation on Friday 1st September, positive feedback was delivered praising the document's content, together with some suggested areas that could be expanded.

4.3 This additional content was developed and inserted during the w/c 4th September 2017. A final draft was subsequently circulated amongst the CCG and LA Directors for comment / amendments, which were duly made.

4.4 A final draft was signed-off by Cllr Hoskin and Dr Winfield (Chief Officer of the North, West and South CCGs) and submitted to NHS England on Monday 11th September 2017.

4.5 Kevin Johnson has confirmed receipt of the submission, and has noted that the submission evidences a high level of joint effort from both the CCGs and the LA.

## 5. NEXT STEPS

5.1 The BCF Submission documents will be considered by Kevin Johnson. In October, we will be informed as to whether the submission is:

- Approved.
- Approved with conditions – in which case the LA and CCGs will be given 3 months to improve the submission with active support from NHSE.
- Rejected.

5.2 Members of the Health & Wellbeing Board who have been actively involved in the submission process (primarily the CCG Directors for South, North and West and the LA Director for Adults Social Care & Health) will be kept abreast of the outcome and any associated actions. Updates will provided at future Reading Integration Board & Health and Wellbeing Board meetings.

## 6. BCF PERFORMANCE

6.1 A dashboard report summarising performance against key targets for the Better Care Fund (such as delayed transfer of care rates) is attached, covering the period April – June 2017.

6.2 A dashboard report summarising performance against key targets for the Better Care Fund across Quarter 2 (July-September) will presented at December's Health & Wellbeing Board.

## 7. COMMUNITY ENGAGEMENT AND INFORMATION

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

## 8. EQUALITY IMPACT ASSESSMENT

8.1 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.

## 9. LEGAL IMPLICATIONS

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

## 10. FINANCIAL IMPLICATIONS

10.1 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.

10.2 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.

## 11. BACKGROUND PAPERS

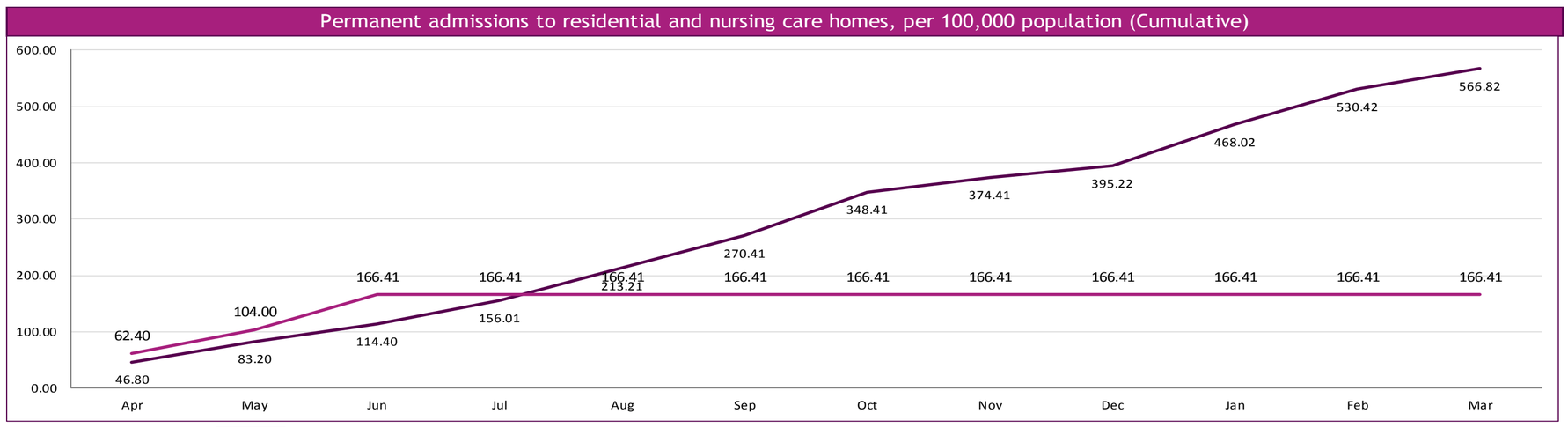
11.1 BCF Dashboard.

# Permanent Admissions to Residential and Nursing Care Homes

Report

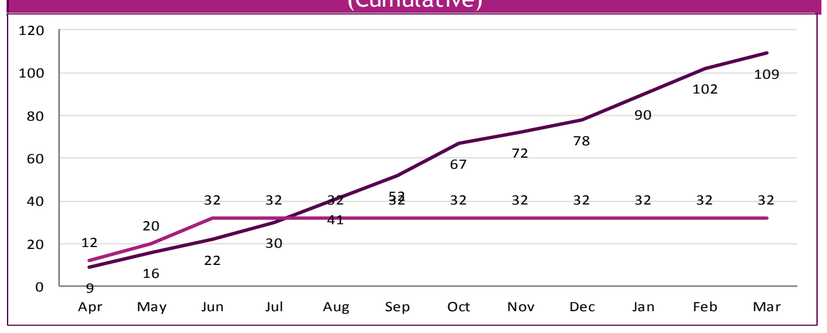
## Older Adults

### Permanent admissions to residential and nursing care homes, per 100,000 population (Cumulative)

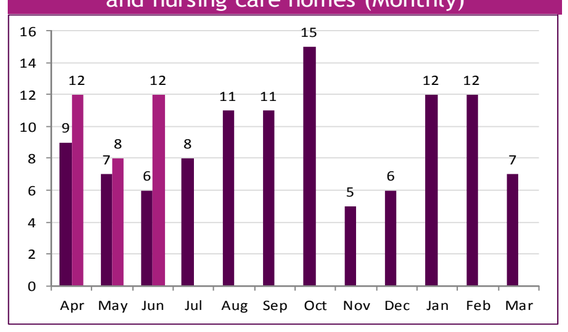



Key: 2016 to 2017 / 2017 to 2018

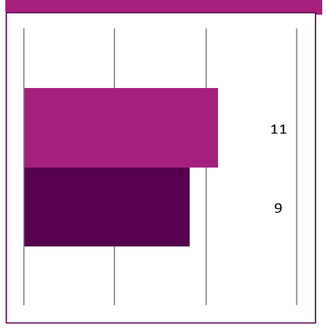
### Number of permanent admissions to residential and nursing care homes (Cumulative)




### Number of permanent admissions to residential and nursing care homes (Monthly)

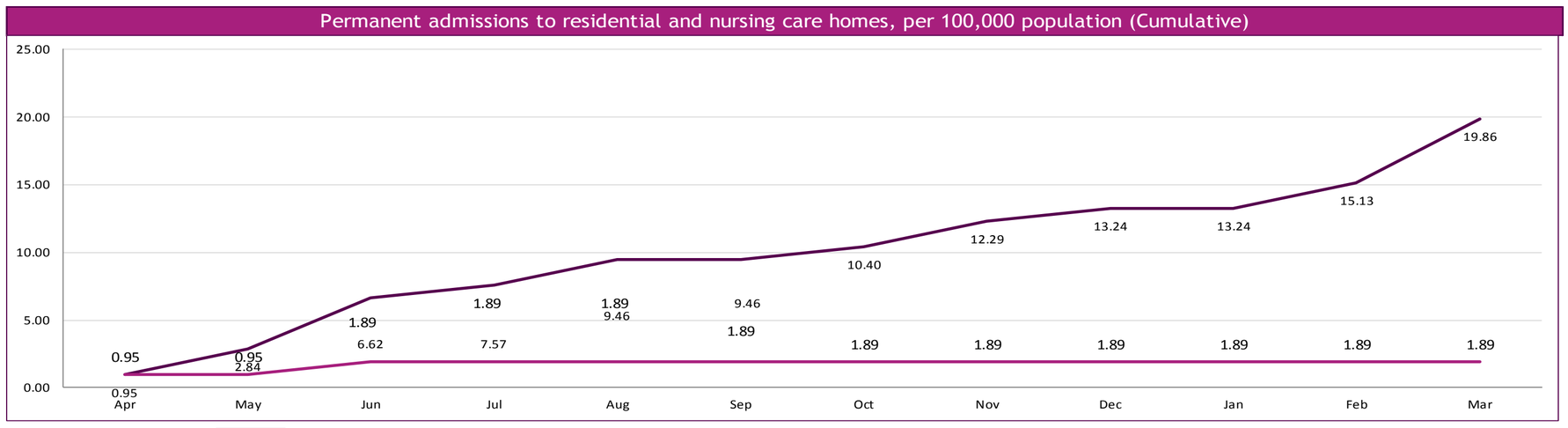



### Average



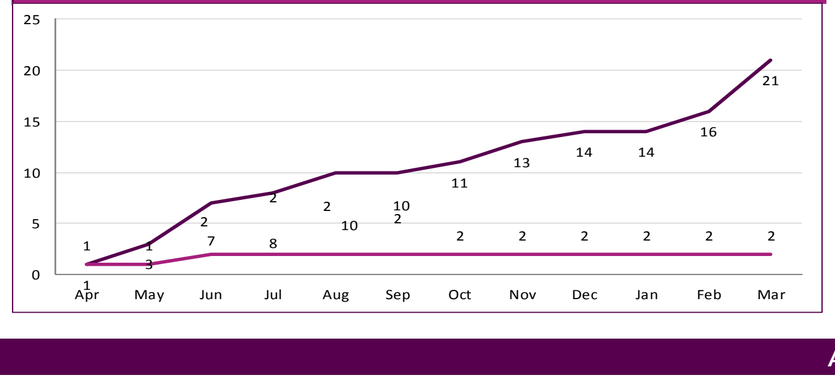

## Younger Adults

### Permanent admissions to residential and nursing care homes, per 100,000 population (Cumulative)

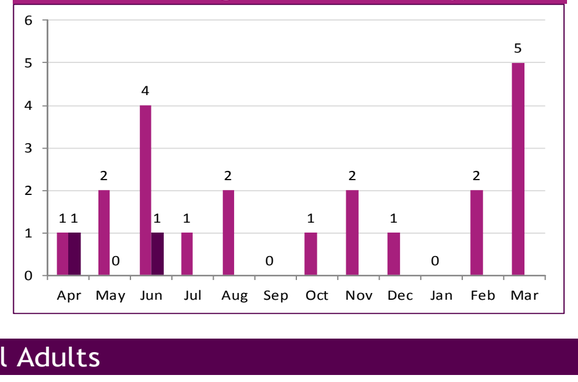



Key: 2016 to 2017 / 2017 to 2018

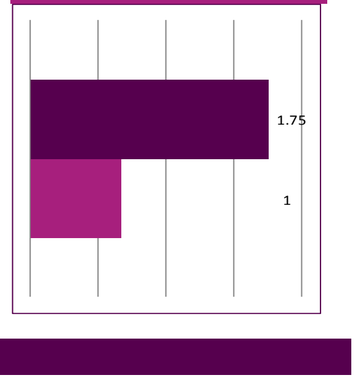
### Number of permanent admissions to residential and nursing care homes (Cumulative)




### Number of permanent admissions to residential and nursing care homes (Monthly)

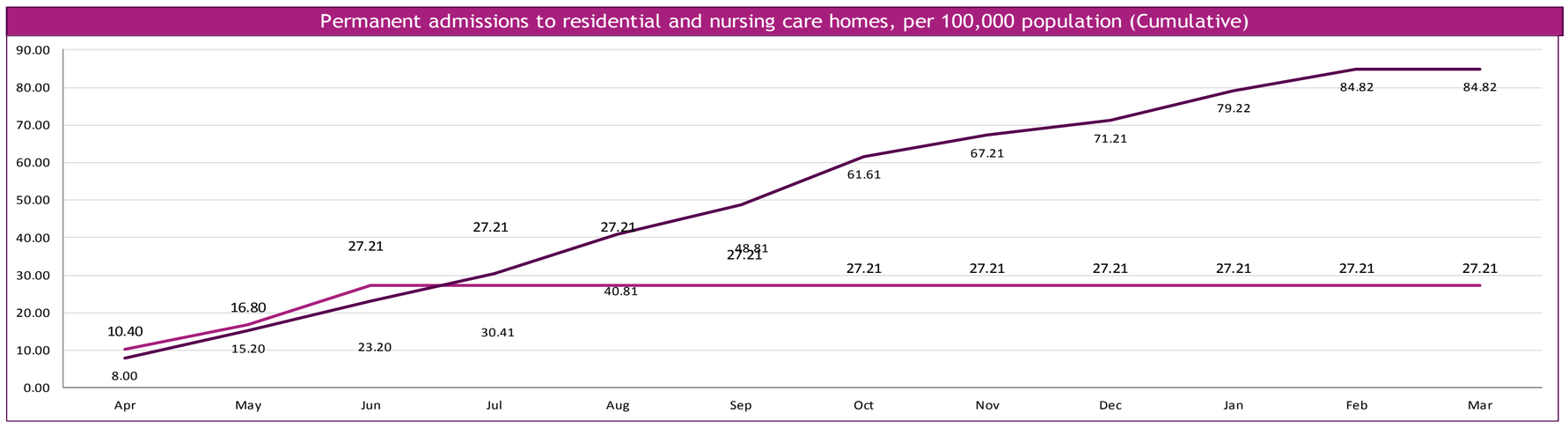



### Average



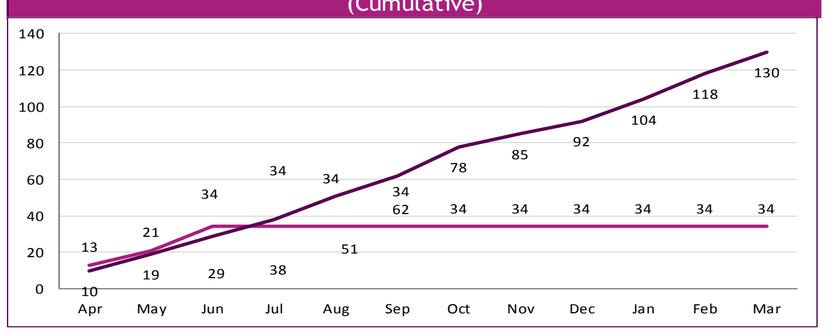

## All Adults

### Permanent admissions to residential and nursing care homes, per 100,000 population (Cumulative)

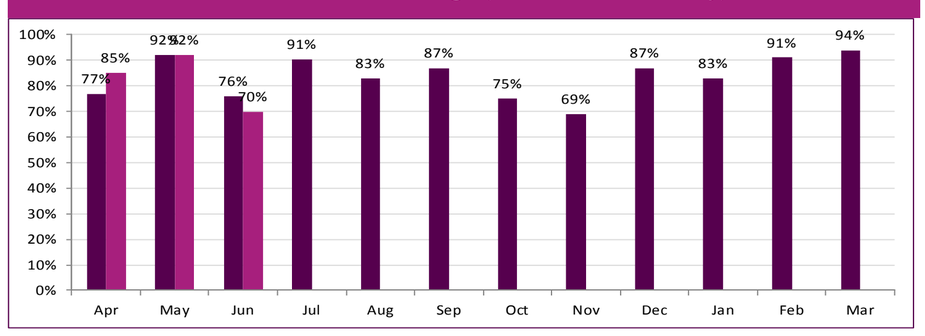



Key: 2016 to 2017 / 2017 to 2018

### Number of permanent admissions to residential and nursing care homes (Cumulative)



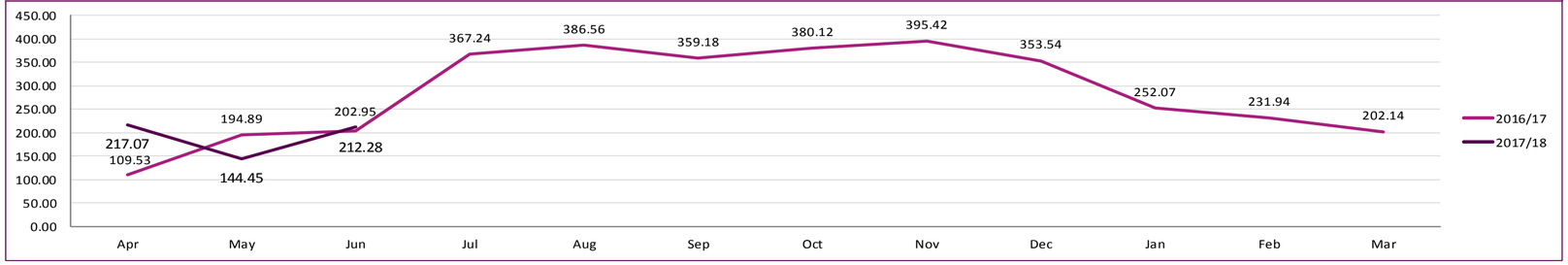

### Willows - DTA beds usage (link to BCF-DMT Only)



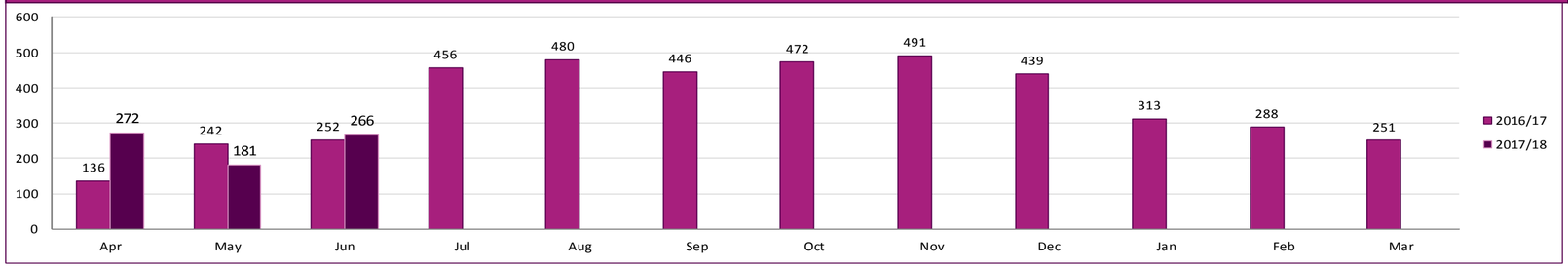
# Delayed Transfers of Care (DToC) from Hospital

Report

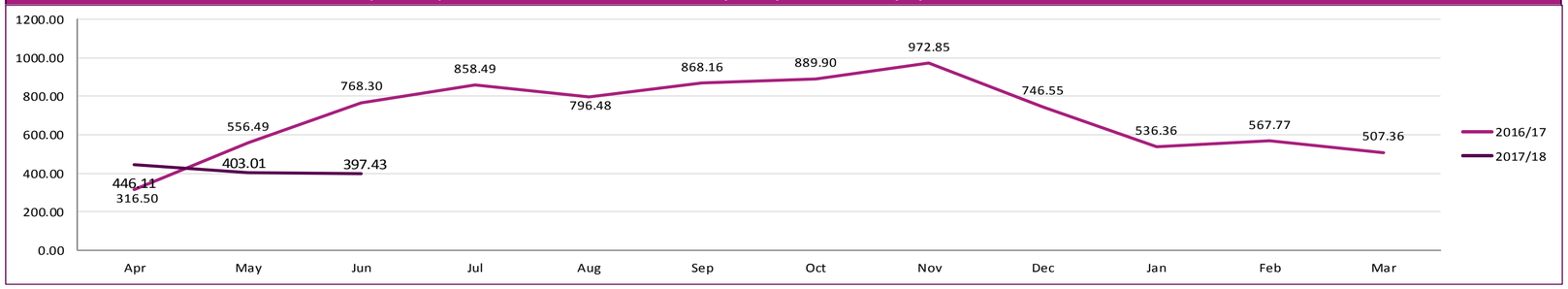
## Days Delayed transfers of care from hospital ASC (per 100,000 population)



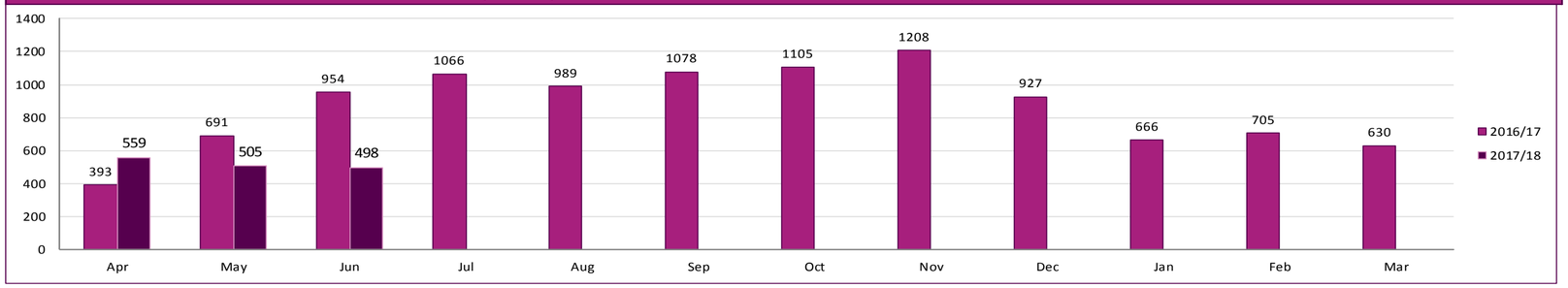

## Days delayed transfers of care from hospital - ASC




## Days Delayed transfers of care from hospital per 100,000 population - Health, ASC and Both




## Days delayed transfers of care from hospital - Health, ASC and Both



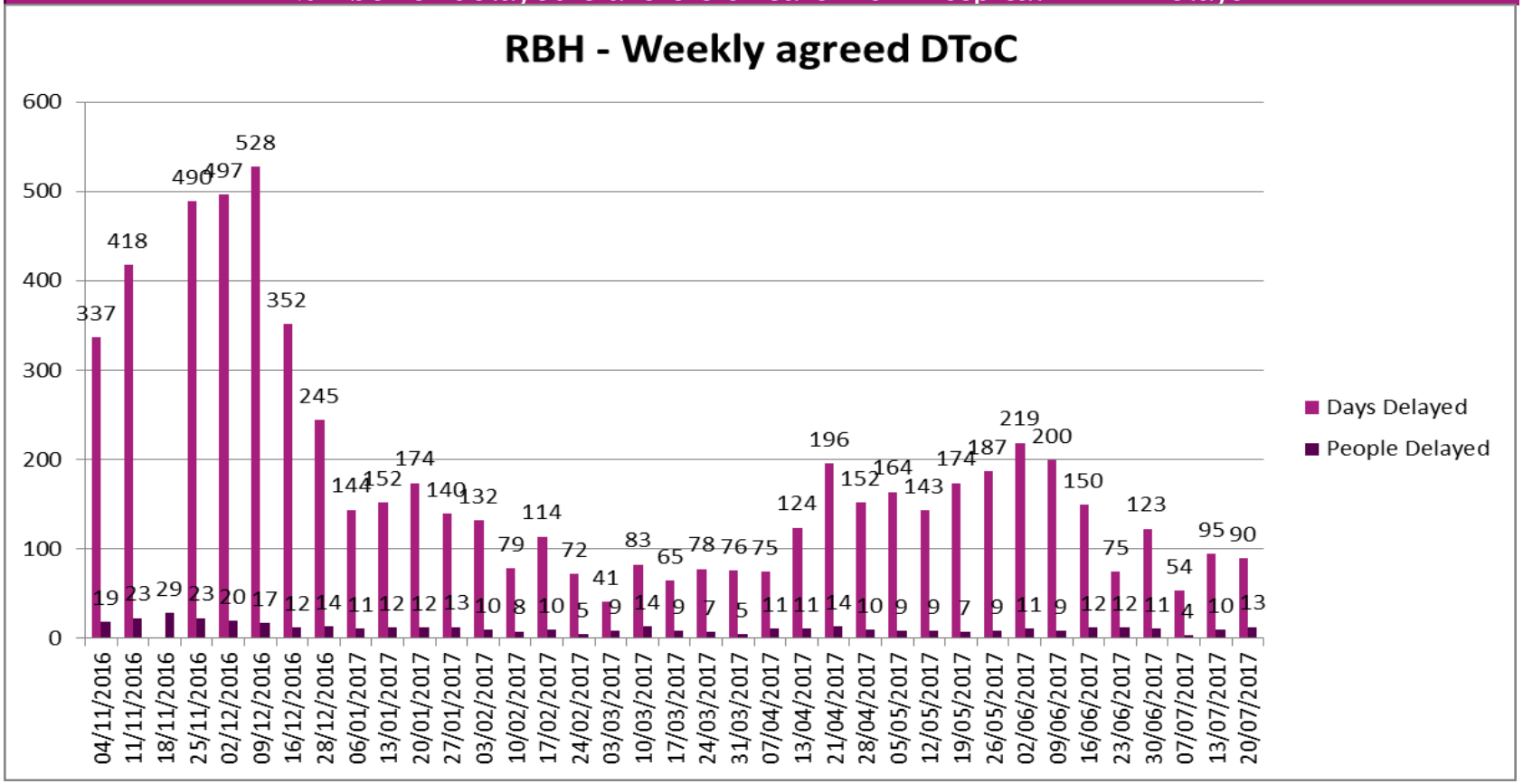

**Performance Analysis Team**
**August - 2017**

Reading Borough Council
Working better with you

# Delayed Transfers of Care (DToC) from Hospital - RBH Data

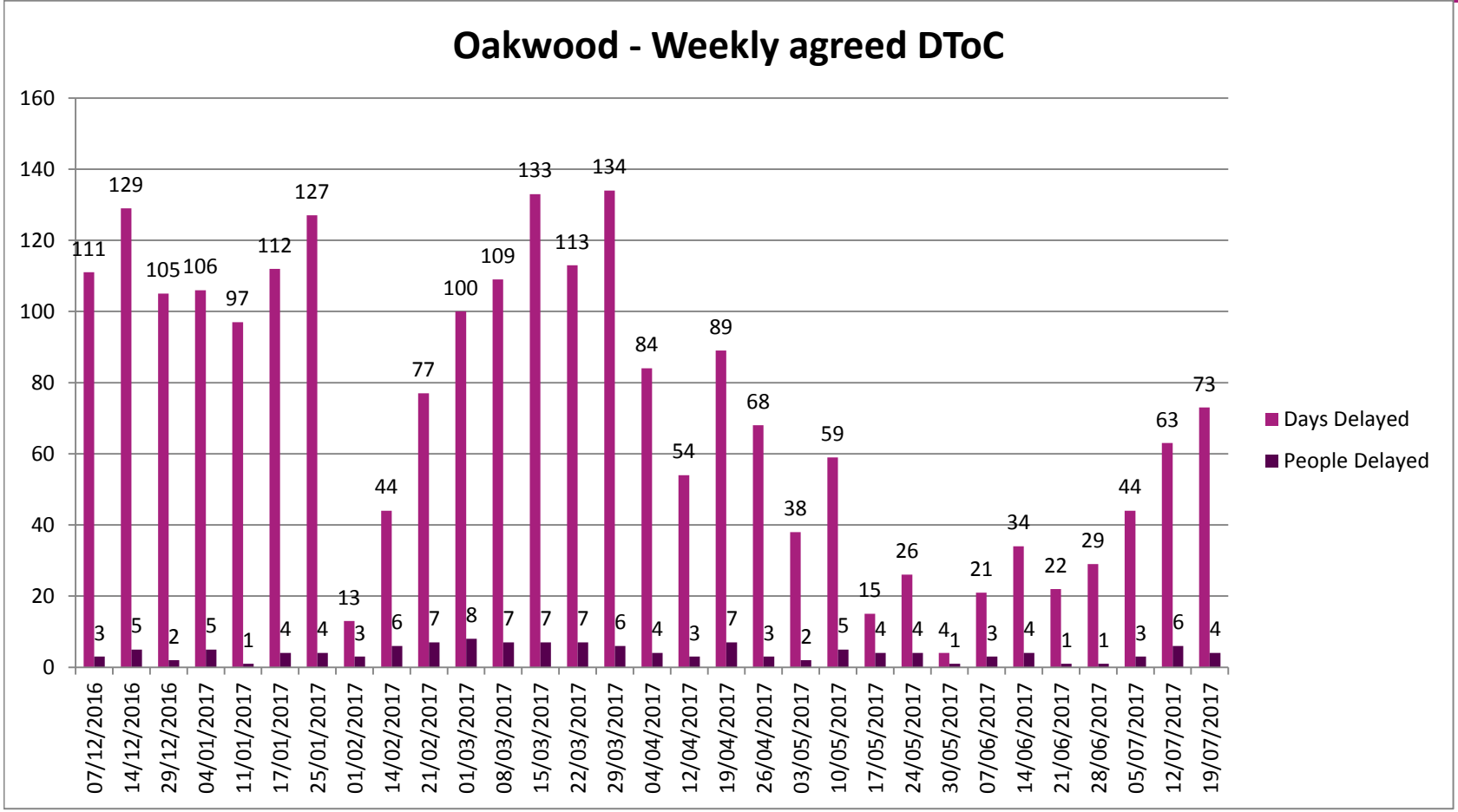
The number of people and days delayed at RBH Hospital is generally showing great improvement. An OT and other discharge staff are having a really positive impact on getting people out of hospital promptly.

## Number of delayed transfers of care from hospital - RBH Delays



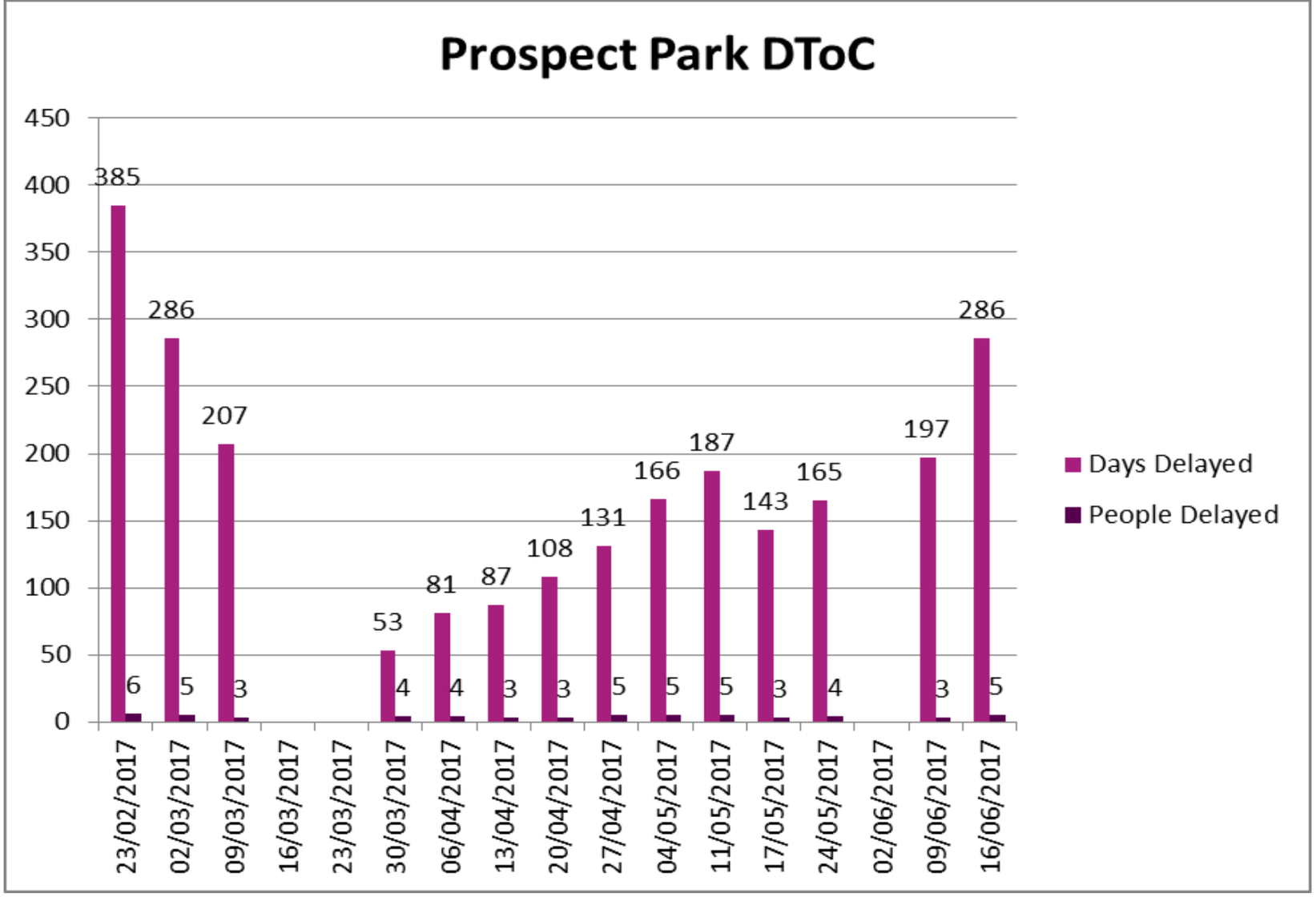
# Delayed Transfers of Care (DToC) from Hospital - Oakwood Data

## Number of delayed transfers of care from hospital - Oakwood Delays



# Delayed Transfers of Care (DToC) - Prospect Park Hospital

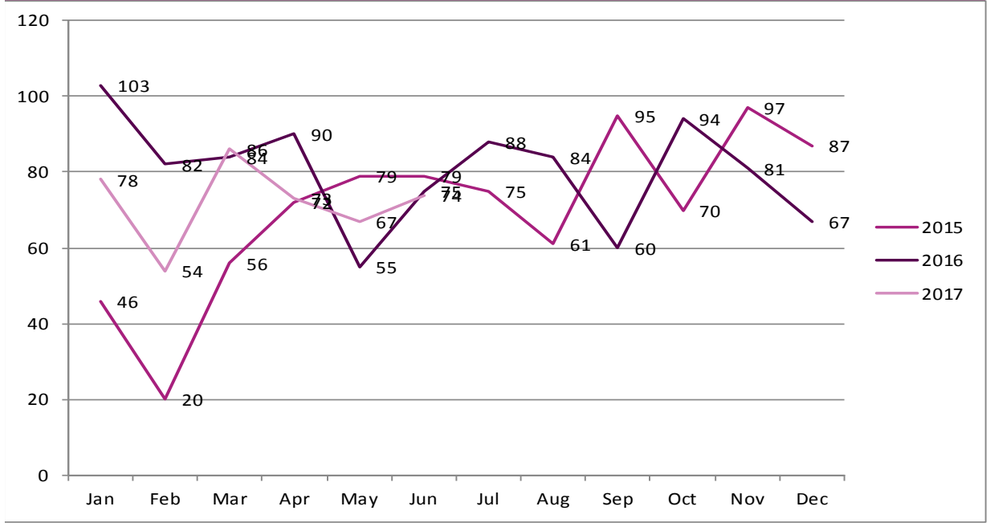
Number of delayed transfers of care from hospital - Prospect Park Delays



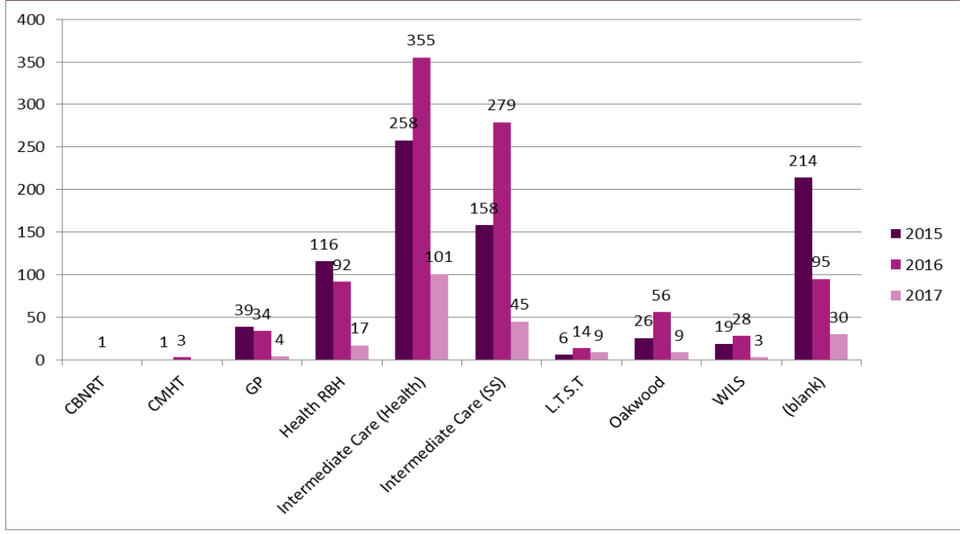
# Community Reablement Team

The admissions and discharges should balance out to maintain flow through the service.

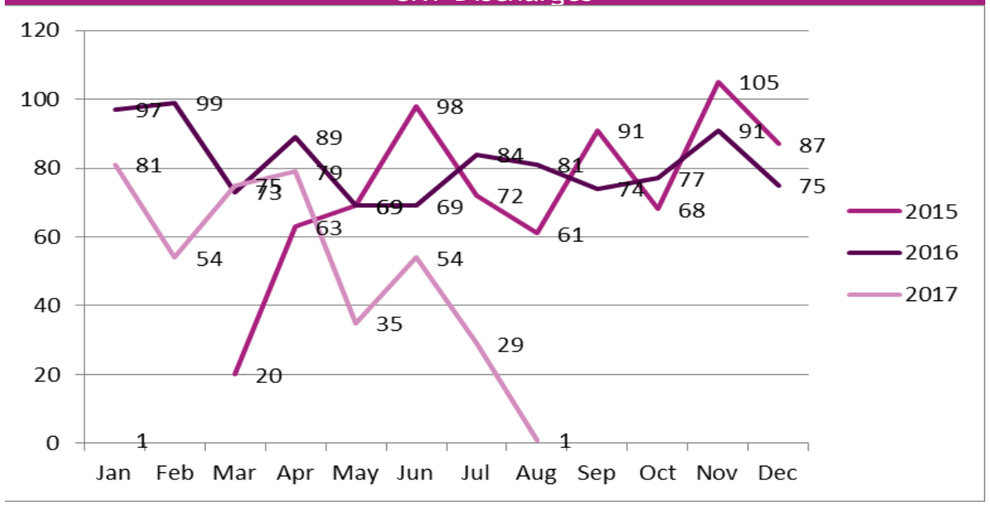
## CRT Admissions



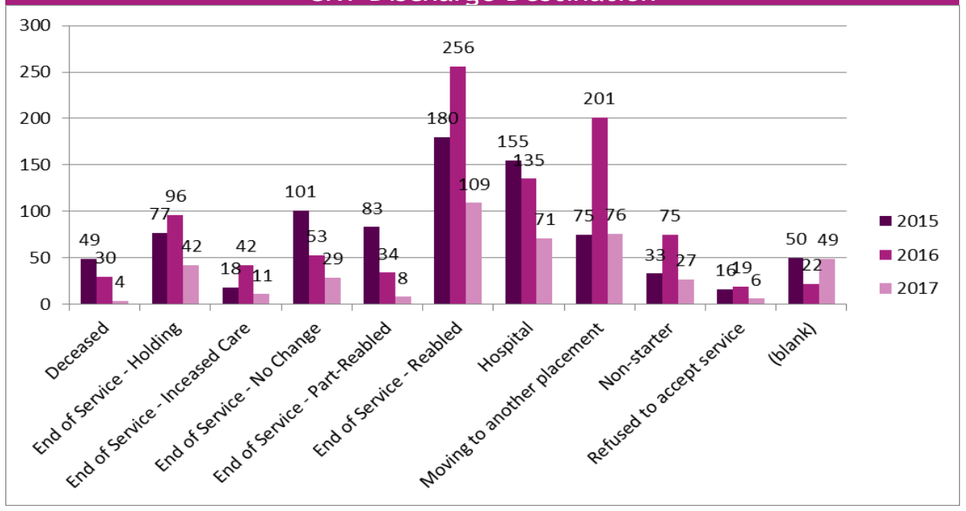

## CRT Referral Source




## CRT Discharges

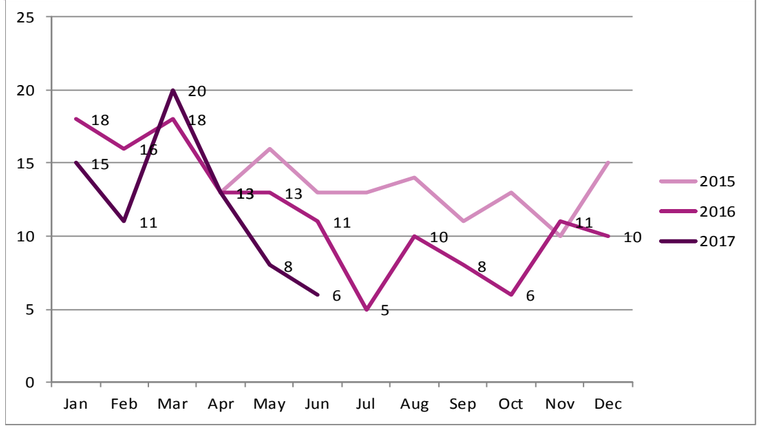



## CRT Discharge Destination

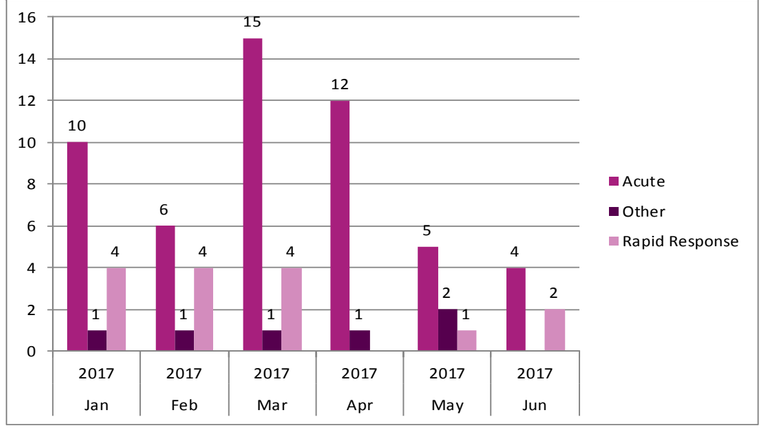


# Discharge to Assess (DTA)

## DTA Admissions



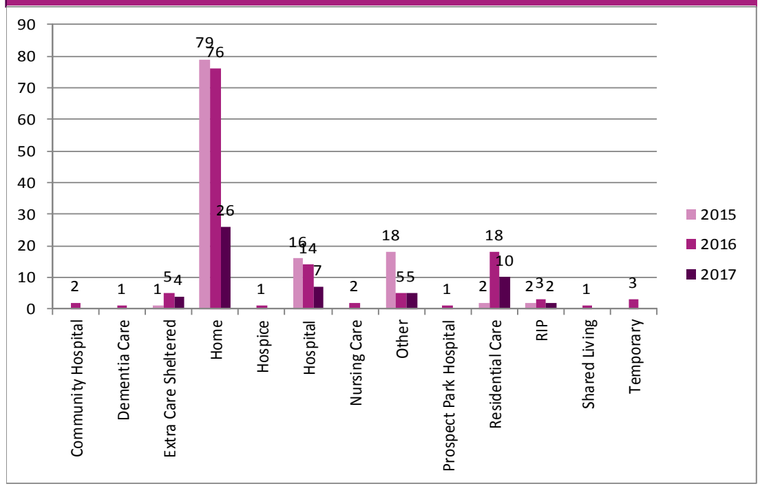

## DTA referral Source



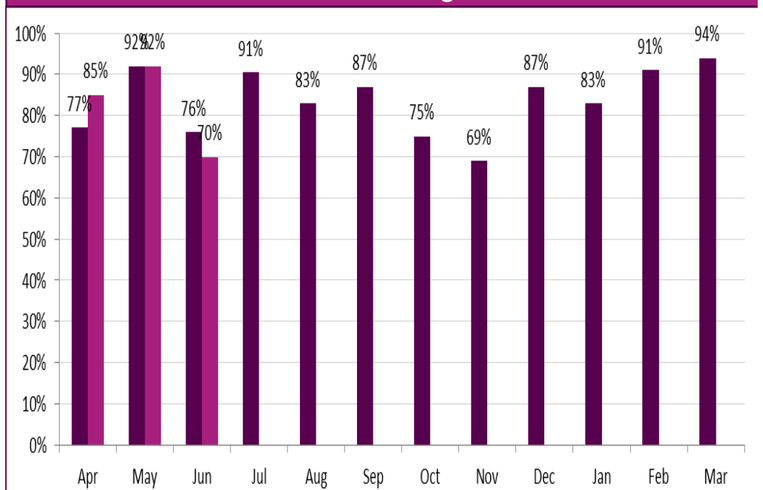

## Comments

## Comments

## DTA Destination




## DTA Bed Usage




## Comments

## Comments

# Reading BCF Performance - M12 - March 2017

<---------- ACTIVITY & BENEFITS ---------->

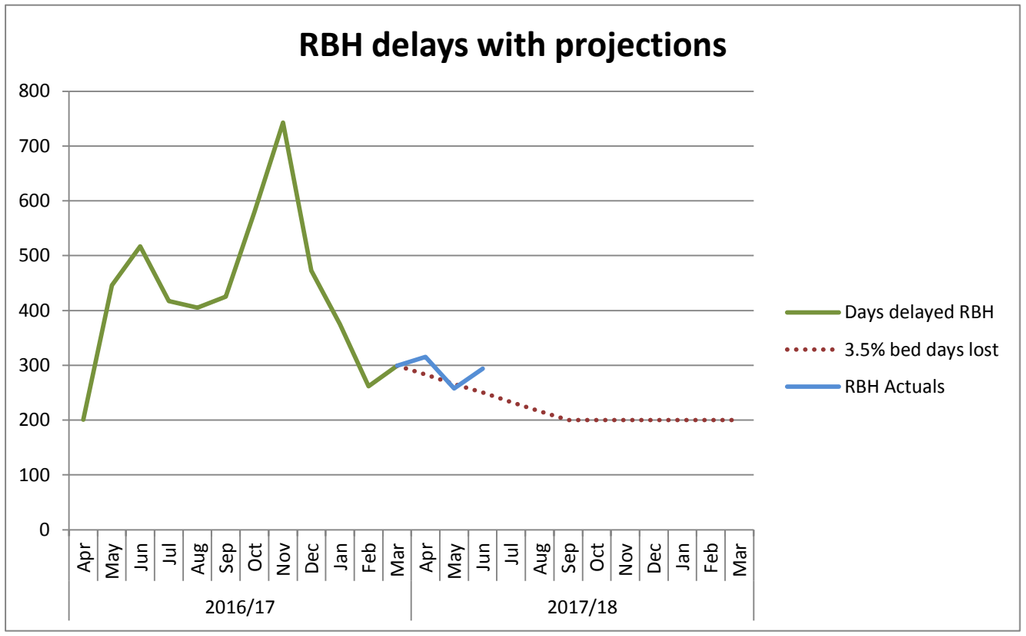
## Discharge to Assess

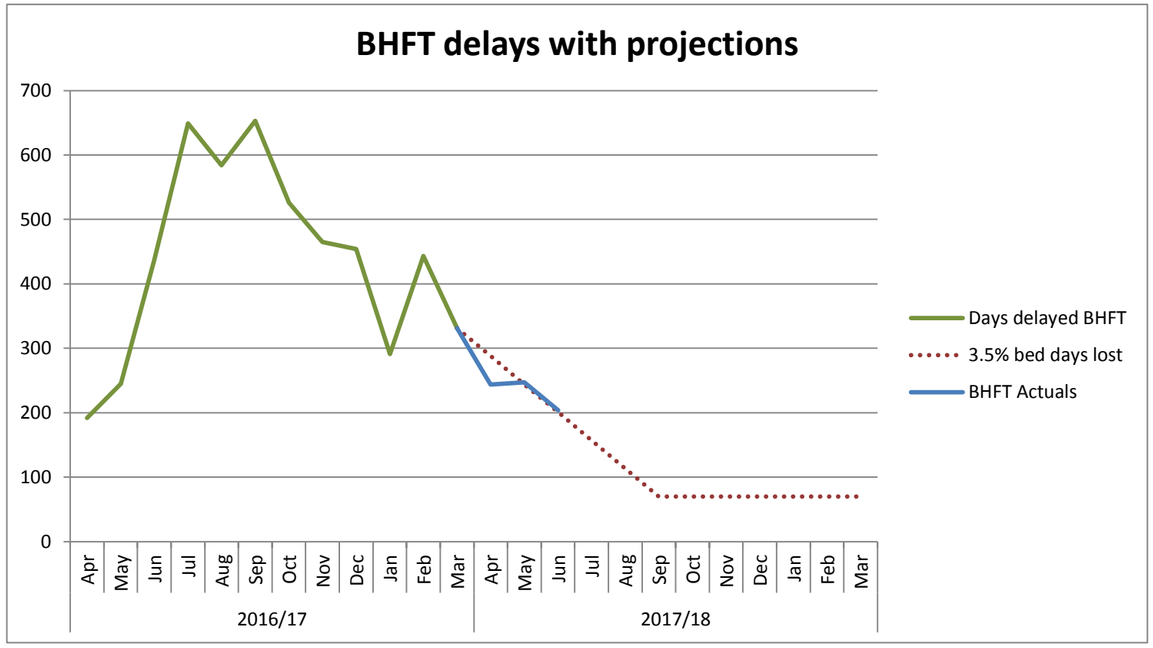
| | Y-T-D 12 months to March 2017 | | | | | Full Year | | | | |
|---|---|---|---|---|---|---|---|---|---|---|
| | Target Reduction | Actual Reduction | Target savings (£2225/NEL) (£26,000/ Care Home admission) | Actual savings (£2225/NEL) (£26,000/ Care Home admission) | Variance to target | Target Reduction | FOT Reduction | Target savings (£2225/NEL) (£26,000/ Care Home admission) | FOT savings (£2225/NEL) (£26,000/ Care Home admission) | Variance to target |
| | | | £ | £ | £ | | | £ | £ | £ |
| NEL | 12 | 28 | 26,700 | 62,300 | 35,600 | 12 | 30 | 26,700 | 66,750 | 40,050 |
| Permanent admissions of older people to residential/nursing care | 6 | 1 | 156,000 | 26,000 | -130,000 | 6 | 1 | 156,000 | 26,000 | -130,000 |

## CRT/Full Intake Model

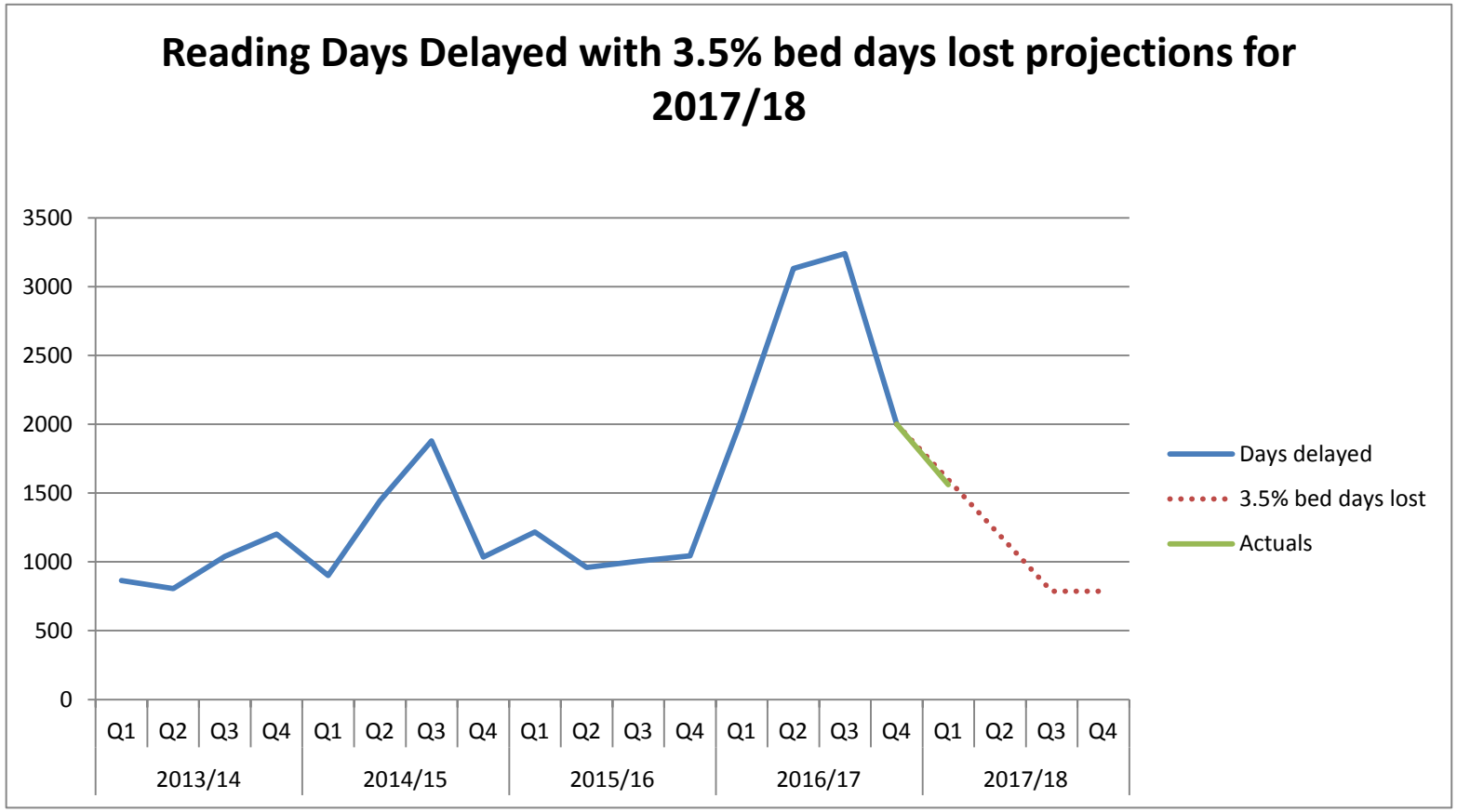
| | Y-T-D 12 months to March 2017 | | | | | Full Year | | | | |
|---|---|---|---|---|---|---|---|---|---|---|
| | Target Reduction | Actual Reduction | Target savings (£2225/NEL) (£26,000/ Care Home admission) | Actual savings (£2225/NEL) (£26,000/ Care Home admission) | Variance to target | Target Reduction | FOT Reduction | Target savings (£2225/NEL) (£26,000/ Care Home admission) | FOT savings (£2225/NEL) (£26,000/ Care Home admission) | Variance to target |
| | | | £ | £ | £ | | | £ | £ | £ |
| NEL | 36 | 112 | 80,100 | 249,200 | 169,100 | 48 | 122 | 106,800 | 271,855 | 165,055 |
| Permanent admissions of older people to residential/nursing care | 6 | 1 | 156,000 | 26,000 | -130,000 | 6 | 1 | 156,000 | 26,000 | -130,000 |

| Years | 2016/17 | | | | | | | | | | | | 2017/18 | | | | | | | | | | | |
|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|
| Months | Apr | May | Jun | Jul | Aug | Sep | Oct | Nov | Dec | Jan | Feb | Mar | Apr | May | Jun | Jul | Aug | Sep | Oct | Nov | Dec | Jan | Feb | Mar |
| Days delayed | 393 | 691 | 954 | 1066 | 989 | 1078 | 1105 | 1208 | 927 | 666 | 705 | 630 | 559 | 500 | 441 | 381 | 322 | 262 | 262 | 262 | 262 | 262 | 262 | 262 |
| | | | | | | | | | | | | | | | | | | | | | | | | |
| Days delayed RBH | 201 | 446 | 517 | 417 | 405 | 425 | 579 | 743 | 473 | 375 | 262 | 299 | | | | | | | | | | | | |
| 3.5% bed days lost | | | | | | | | | | | | 299 | 283 | 266 | 250 | 233 | 216 | 200 | 200 | 200 | 200 | 200 | 200 | 200 |
| RBH Actuals | | | | | | | | | | | | 299 | 315 | 258 | 294 | | | | | | | | | |
| Days delayed BHFT | 192 | 245 | 437 | 649 | 584 | 653 | 526 | 465 | 454 | 291 | 443 | 331 | | | | | | | | | | | | |
| 3.5% bed days lost | | | | | | | | | | | | 331 | 288 | 244 | 201 | 157 | 113 | 70 | 70 | 70 | 70 | 70 | 70 | 70 |
| BHFT Actuals | | | | | | | | | | | | 331 | 244 | 247 | 204 | | | | | | | | | |



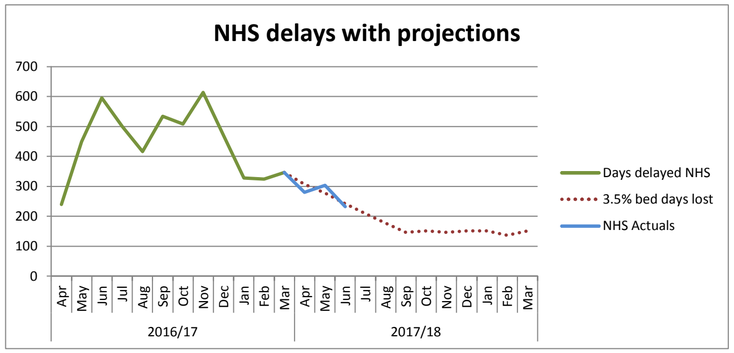



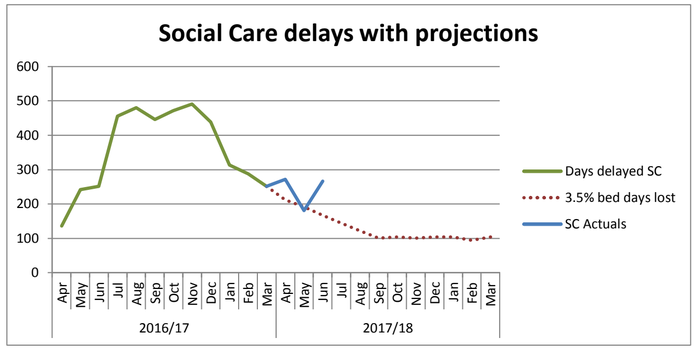
| | 2013/14 | | | | 2014/15 | | | | 2015/16 | | | | 2016/17 | | | | 2017/18 | | | |
|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|
| | Q1 | Q2 | Q3 | Q4 | Q1 | Q2 | Q3 | Q4 | Q1 | Q2 | Q3 | Q4 | Q1 | Q2 | Q3 | Q4 | Q1 | Q2 | Q3 | Q4 |
| Days delayed | 865 | 806 | 1040 | 1202 | 901 | 1444 | 1879 | 1035 | 1217 | 959 | 1005 | 1045 | 2038 | 3133 | 3240 | 2001 | | | | |
| 3.5% bed days lost | | | | | | | | | | | | | | | | 2001 | 1597 | 1192 | 787 | 787 |
| Actuals | | | | | | | | | | | | | | | | 2001 | 1562 | | | |

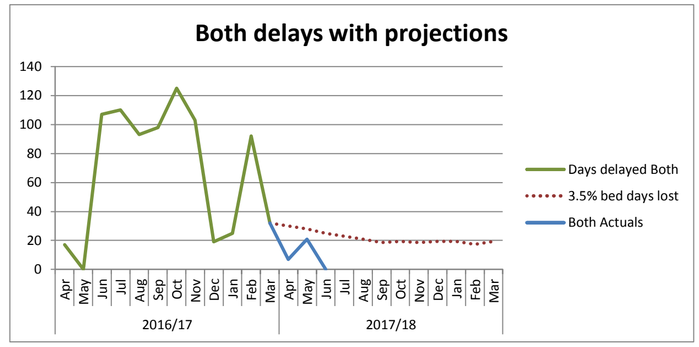


| Years | 2016/17 | | | | | | | | | | | | 2017/18 | | | | | | | | | | | |
|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|
| Months | Apr | May | Jun | Jul | Aug | Sep | Oct | Nov | Dec | Jan | Feb | Mar | Apr | May | Jun | Jul | Aug | Sep | Oct | Nov | Dec | Jan | Feb | Mar |
| Days delayed | 393 | 691 | 954 | 1066 | 989 | 1078 | 1105 | 1208 | 927 | 666 | 705 | 630 | 559 | 505 | 441 | 381 | 322 | 266 | 275 | 266 | 275 | 275 | 248 | 275 |
| Days delayed NHS | 240 | 449 | 595 | 500 | 416 | 534 | 508 | 614 | 469 | 328 | 325 | 347 | | | | | | | | | | | | |
| 3.5% bed days lost | | | | | | | | | | | | 347 | 307.45 | 277.75 | 242.55 | 209.55 | 177.1 | 146.3 | 151.25 | 146.3 | 151.25 | 151.25 | 136.4 | 151.25 |
| NHS Actuals | | | | | | | | | | | | 347 | 280 | 303 | 232 | | | | | | | | | |
| Days delayed SC | 136 | 242 | 252 | 456 | 480 | 446 | 472 | 491 | 439 | 313 | 288 | 251 | | | | | | | | | | | | |
| 3.5% bed days lost | | | | | | | | | | | | 251 | 212.42 | 191.9 | 167.58 | 144.78 | 122.36 | 101.08 | 104.5 | 101.08 | 104.5 | 104.5 | 94.24 | 104.5 |
| SC Actuals | | | | | | | | | | | | 251 | 272 | 181 | 266 | | | | | | | | | |
| Days delayed Both | 17 | 0 | 107 | 110 | 93 | 98 | 125 | 103 | 19 | 25 | 92 | 32 | | | | | | | | | | | | |
| 3.5% bed days lost | | | | | | | | | | | | 32 | 30 | 28 | 25 | 23 | 21 | 19 | 19 | 19 | 19 | 19 | 17 | 19 |
| Both Actuals | | | | | | | | | | | | 32 | 7 | 21 | 0 | | | | | | | | | |

| | | | | | | | | | | | |
|---|---|---|---|---|---|---|---|---|---|---|---|
| 55 | NHS | For HWB DToC Metric Plan Collection | | | | | | | | | |
| 38 | SC | 209.55 | 177.1 | 146.3 | 151.25 | 146.3 | 151.25 | 151.25 | 136.4 | 151.25 | |
| 7 | Both | 75.8571 | 64.1102 | 52.9606 | 54.7525 | 52.9606 | 54.7525 | 54.7525 | 49.3768 | 54.7525 | N&West C |
| | | 1.2573 | 1.0626 | 0.8778 | 0.9075 | 0.8778 | 0.9075 | 0.9075 | 0.8184 | 0.9075 | Oxf CCG |
| | | 126.9873 | 107.3226 | 88.6578 | 91.6575 | 88.6578 | 91.6575 | 91.6575 | 82.6584 | 91.6575 | SR CCG |
| | | 5.65785 | 4.7817 | 3.9501 | 4.08375 | 3.9501 | 4.08375 | 4.08375 | 3.6828 | 4.08375 | Wok CCG |



**BRIEFING NOTE FOR READING HEALTH AND WELLBEING BOARD**

**Work being done with GP Practices re registering Veterans**

1. A Veteran is anyone who has been a member of the serving Armed Forces for a day or more (includes Army, Navy, Royal Airforce and Merchant Navy).

2. Veterans have a greater likelihood of some illnesses than their civilian counterparts, such as hearing, loss, limb and joint problems, and mental health issues.

3. Veterans have priority access to NHS secondary care for conditions related to their service, subject to the clinical needs of all patients. This means they should be given priority over patients with similar medical problems - not that they should be seen in preference to other patients whose medical condition is more urgent.

4. There are specialist NHS services available for Veterans, such as mental health and trauma.

5. Most veterans are not identified within the health system and this is a problem across the country. There are many causes of this, including the definition and use of the term "Veteran", and in some cases a reluctance of the Veteran to identify themselves.

6. Accurately identifying the number of armed forces veterans that reside in Reading Borough is not straight forward, given the range and quality of data that is available. Military pension and compensation scheme data can be used as a proxy for the number of veterans in an area (however, not all veterans are in receipt of pension or compensation payments). Using this measure, as of March 2017 there were 378 veterans in receipt of a pension/compensation living in Reading borough.

7. In April 2016 we found that 40 patients in Reading surgeries were identified as Veterans. Following this, the CCGs developed guidance for practices on registering patients from the armed forces community. Also a new armed forces page on the CCG's web site set out why veterans should register themselves as such with their GP. A survey undertaken in August 2017 found that 133 patients in Reading surgeries were now identified as Veterans.

8. This Autumn practices will ask patients attending flu clinics whether they had served in the Armed Forces. This idea was piloted last year at Parkside practice, Green Road, and the practice coded 32 new patients as Veterans (previously only 1 patient was coded). The CCGs will survey the number of patients identified in January 2018 to assess the impact of this initiative.

9. Veteran identification facilitates continuity of care on medical discharge from the armed forces. All people leaving the armed forces are given a summary of their medical records, which they are advised to give to their new GP when they register. The practice will also be advised of prior registration with Defence Medical Services and with a summary of their in-service care. From 2 October 2017, all practices will need to complete new patient registrations using a new family doctor services registration form, which asks if the patient is an armed forces leaver.

Andrew Price, on behalf of South Reading and North and West CCGs, 8th September 2017

# READING BOROUGH COUNCIL

| | | | |
|---|---|---|---|
| **TO:** | **HEALTH & WELLBEING BOARD** | | |
| **DATE:** | **6th OCTOBER 2017** | **AGENDA ITEM:** | **15** |
| **TITLE:** | **SEASONAL INFLUENZA CAMPAIGN PERFORMANCE 2016-17** | | |
| **LEAD OFFICER:** | **JO JEFFERIES/ SUZIE WATT** | **TEL:** | **0134 435 2745 0118 937 4806** |
| **JOB TITLE:** | **CONSULTANT IN PUBLIC HEALTH / PROGRAMME OFFICER** | **E-MAIL:** | **Jo.Jefferies@bracknell-forest.gov.uk / suzie.watt@reading.gov.uk** |

## 1.0 PURPOSE OF REPORT

This paper is to update the Health and Wellbeing Board on the performance of the influenza (flu) vaccine campaign in winter 2016-17 to summarise lessons learned and to inform the board of changes to the national flu programme for the coming flu season and how these will be implemented in the Berkshire Local Authorities Winter Flu Plan 2017-18 (Appendix A).

**APPENDICES:**

- Appendix A - Berkshire Local Authorities Winter Flu Plan 2017-18
- Appendix B - National Flu Plan Winter 2017-18
- Appendix C - Berkshire Seasonal Influenza Vaccine Campaign 2016-17 Report
- Appendix D - Presentation from Berkshire Flu Workshop June 2017

## 2.0 RECOMMENDATIONS

**The Board is asked to:**

**2.1 Agree and endorse the multi-agency approach planned for Reading as set out in the Berkshire Local Authorities Winter Flu Plan 2017-18 (Appendix A)**

**2.2 Support respective organisations to fulfil their responsibilities as set out in the National Flu Plan Winter 2017-18 (Appendix B)**

**2.3 Note the local performance of flu vaccination uptake as set out in summary in this report and Appendix C (full detail)**

**2.4 Be flu champions – take every opportunity to promote the vaccine uptake and debunk myths, accept the offer of a flu vaccination where eligible**

## 3.0 BACKGROUND

Seasonal influenza (flu) is a key factor in NHS winter pressures. The National Flu Plan (Appendix B) aims to reduce the impact of flu in the population through a series of complementary measures. Flu vaccination is commissioned by NHS England for groups at increased risk of severe disease or death should they contract flu.

Key aims of the immunisation programme in 2016-17 were to;

- Actively offer flu vaccine to 100% of people in eligible groups.
- Immunise 60% of children, with a minimum 40% uptake in each school
- Maintain and improve uptake in over 65s clinical risk groups with at least 75% uptake among people 65 years and over, 55% among clinical risk groups and 75% among healthcare workers

### 3.1 Multi-agency approach

Flu vaccination is commissioned by NHS England for groups at increased risk of severe disease or death should they contract flu and vaccination is provided by a mix of providers including GP practice, community pharmacy, midwifery services and school immunisation teams.

The role of local authorities is to provide advocacy and leadership through the Director of Public Health and to promote uptake of flu vaccination among eligible residents and among staff providing care for people in residential and nursing care. Local authorities are also responsible for providing flu vaccine for frontline health and social care workers that are directly employed. Local authorities may also provide vaccine to staff members as part of business continuity arrangements.

CCGs are responsible for quality assurance and improvement which extends to primary medical care services delivered by GP practices including flu vaccination and antiviral medicines. The CCG also monitors staff vaccination uptake in Providers through the CQUIN scheme.

A collaborative multi-agency approach to planning for and delivering the flu programme is taken in Berkshire, beginning with a flu workshop in June. Public Health Teams used output from the workshop to develop their local flu action plan, setting out the steps they will take to engage and communicate with local residents about flu, promote the flu vaccine to eligible groups and support partners to provide and manage the programme.

Actions taken in 2016-17 as part of this approach included;

- A joint flu plan between local authority public health and the CCGs in the East / West of Berkshire
- Participation in the twice-monthly NHSE telecom to share flu data, best practice and ability to raise concerns with representation locally
- A CCG monthly local meeting is held which has representation from across all providers and local authority public health. This meeting monitors local uptake of the flu vaccination and flu activity and sharing of good practice and any concerns. Providers also have signed up to the Health and wellbeing of staff CQUIN which includes staff flu vaccination uptake
- In the East of Berkshire the CCG Quality team supporting low performing GP practices with practice visits
- Sending a flu communication pack to care homes

- Local communication is linked to the national flu campaign as well local alignment of communications between the local public health and the CCG commination teams. There is good collaborative working
- Linking with the Thames Valley Health Protection Team around management of flu outbreaks
- The Wellbeing team supporting the BHFT schools immunisation team to engage with those schools where initial engagement was less effective and home educated children who were eligible for the vaccination
- Working with local groups and key community setting's to promote flu vaccine for example links in with target community groups such as older people, people with learning disability and the community and voluntary sector.

## 4.0 READING UPTAKE 2016-17

### GP-registered patient groups

In keeping with the national and regional picture, uptake of vaccine among GP-registered patients in Berkshire was generally higher in 2016-17 than in 2015-16. Along with Bracknell and Ascot, Windsor Ascot and Maidenhead and Wokingham CCGs, Slough CCG reported improved uptake across all GP-registered patient groups.

Uptake of vaccines among GP-registered patients in Reading was similar in 2016-17 to that in 2015-16. As shown in Figure 1 below, North & West Reading saw an increase in 2016-17 in Under 65's (at risk) and in 3 year olds. Uptake decreased in all other groups, with the most notable in children aged 2 years and pregnant women.

Figure 1 also shows that South Reading CCG saw an increase in uptake in children aged 4 year olds, with a decrease reported in all other groups. The most noticeable variation between 2015-16 to 2016-17 was in pregnant women.

In line with regional and national picture, no Berkshire CCG achieved the 75% target for patients aged 65 and above.

**Figure 1. Comparison of Flu Vaccine Uptake by Reading CCGs – 2015/16 to 2016-17**

| CCG | Summary of Flu Vaccine Uptake % | | | | | |
|---|---|---|---|---|---|---|
| | 65 and over | Under 65 (at-risk) | All Pregnant Women | 2 Years old | 3 Years old | 4 Years old |
| NHS SOUTH READING | 68.9 | 46.4 | 39.3 | 35.7 | 39.6 | 30.1 |
| 2015/16 Variation | -1.6 | -1.4 | -5.2 | -0.6 | 0.0 | 0.3 |
| NHS NORTH & WEST READING | 74.0 | 54.1 | 46.3 | 42.4 | 49.1 | 37.6 |
| 2015/16 Variation | -1.1 | 1.7 | -3.1 | -5.8 | 2.6 | -2.0 |
| **Thames Valley Total** | **72.1** | **50.7** | **47.2** | **43.3** | **47.0** | **38.1** |
| 2015/16 Variation | 0.6 | 4.1 | 1.0 | 3.1 | 4.4 | 3.2 |
| **England Total** | **70.4** | **48.7** | **44.8** | **38.9** | **41.5** | **33.9** |
| 2015/16 Variation | -0.6 | 3.6 | 2.5 | 3.9 | 3.8 | 3.9 |

Data source: Seasonal influenza vaccine uptake amongst GP Patients in England

**Figure 2. Flu Vaccine Uptake across Reading Local Authority area – 2015/16 to 2016-17**

| LA | Summary of Flu Vaccine Uptake % | | | | | |
|---|---|---|---|---|---|---|
| | 65 and over | 6mo - 65y (at-risk) | All Pregnant Women | 2 Years old | 3 Years old | 4 Years old |
| Reading LA | 71 | 48.5 | 41 | 35.8 | 41.6 | 31.9 |
| 2015/16 Variation | -1.4 | 0 | -4.9 | -2.9 | 0.6 | 0.1 |
| **England Total** | **70.5** | **48.6** | **44.9** | **38.9** | **41.5** | **33.9** |
| 2015/16 Variation | **-0.50** | **3.5** | **2.6** | **3.5** | **3.8** | **3.9** |

Data source: **Seasonal influenza vaccine uptake amongst GP Patients in England**

**Children in school years 1 to 3**
The children's nasal vaccine was delivered in primary schools by a team of school immunisation nurses from Berkshire Health Foundation Trust. The team arranged and carried out visits at nearly 300 schools across Berkshire, including special schools where all year groups were offered vaccine. The BHFT school immunisation team delivered over 23,000 doses of vaccine and as shown in Figure 3 below succeeded in reaching and exceeding the 40% overall uptake target in every Berkshire LA. In keeping with the national picture, uptake was lower in older children.

**Figure 3. % of Flu Vaccination Uptake Reading compared to England 2016-17**

| LA | Flu Vaccine Uptake % | | |
|---|---|---|---|
| | Year 1 (age 5 - 6 years) | Year 2 (age 6 - 7 years) | Year 3 (age 7- 8 years) |
| Reading LA | 66.9 | 61.2 | 60.3 |
| England | 57.6 | 55.3 | 53.3 |

Data source: Seasonal influenza vaccine uptake for children of primary school age, Provisional monthly data for 1 September 2016 to 31 January 2017 by Local Authority

**NHS Healthcare workers** - Uptake in Royal Berkshire Foundation Trust was 60.6% compared to the 48.6% previous flu season, while in Frimley Health NHS Foundation Trust uptake also fell from 49.3% to 38.7%. Uptake in South Central Ambulance Trust rose from 30.5% to 54.7%, while Berkshire Healthcare Foundation Trust achieved a 76.2% uptake rate, an increase from 64.1% and the highest in Thames Valley.

**LA Health and Social Care staff and others**
Reading Borough Council staff were able to access a vaccine through a voucher scheme redeemable at participating local pharmacies. Vaccine was made available to all staff who worked in services considered essential for business.

Eligible staffs were identified via RBCs business continuity plan. This approach was supported by all DMT's across the Council. DMT's were provided with an opportunity to provide feedback on this approach, as well as content of planned communications. Once approved, these were sent to key contacts i.e. Heads of Services to disseminate to staff in the most appropriate way for their business.

Where public health were able to be identified, key business support roles were copied into communications and received advice on ways in which they could influence uptake in teams i.e. printing and handing out vouchers, discussion in team meetings.

47 staff received a vaccine through this scheme, this is markedly lower number than in 2016/17 when vaccinations were delivered onsite at the Civic Centre using the occupational health suite.

Advance bookings for vaccinations in 2016/17 were low, it was only through business support actively seeking opportunistic discussions with staff and having the list of appointments available (either on the day or the next day) there was a positive impact on uptake, although this was time intensive.

## 5.0 LEARNING FROM 2016-17

- Local Authority public health teams actively promoted flu vaccination to eligible groups using a range of channels and worked collaboratively with commissioners and providers before and during the season to identify issues.

- Whilst uptake among school children was good, uptake in other risk groups remains below the desired level; this is in line with other areas of the country.

- There remains considerable variation in uptake between GP practices, both within and between CCGs. Sharing of best practice across practices and better communication of uptake to practices throughout the flu season and ensuring patients are invited for vaccination in a way that suits them may help to reduce variation in uptake between practices.

- Use of national materials and good multi-agency working enabled consistent flu messaging to the public however there is scope to improve the reach of these messages to eligible groups

- Myths and misconceptions regarding vaccines remain an important barrier to uptake.

- Other barriers may include variation in access to GP flu clinics, lack of health literacy and inclusion of porcine element in the children's vaccine making it inappropriate for some groups.

- Uptake among front line local authority social care workers remains difficult to measure; there is scope to improve data collection in this area.

- Providers of residential and nursing care are not consistently offering flu vaccine to employees in line with national recommendations, this remains challenging for local authorities and CCGs to influence.

## 6.0 PLANS FOR 2017-18 FLU SEASON

A successful flu planning workshop took place on 14th June at the Open Learning Centre, Bracknell. This was well attended by a range of stakeholders from across Berkshire and focussed on reducing variation in performance between GP practices and working to consider actions to help increase the offer and uptake of flu vaccine among residential and nursing home front line staff in line with national guidance.

- Following the workshop, the Shared Pubic Health Team developed a high level Berkshire Flu Plan which enabled Reading Borough Council's Wellbeing team to create a local flu action plan for the 2017-18 season. Please see supporting documents for copy of RBC's Flu Vaccination Action Plan for 2017/18.

- The CCG in the West of Berkshire is developing a communications plan and will work with the Public Health/Wellbeing Team to ensure there is a collaborative approach

- RBC's Wellbeing team is supporting the school immunisation team to engage directly with information governance leads to discuss data sharing requirements and enable the immunisation team to receive class lists ahead of school visits

- Multi-agency East and West of Berkshire Flu Action group meetings will start from September with Providers, Local Authority Public Health and NHSE

- Local NHS Providers again have a CQUIN to deliver the flu vaccine to 70% of their frontline clinical staff.

# Berkshire Local Authorities Winter Flu Plan 2017-18

## Purpose of this Flu Plan

This document summarises key points of the National Flu Plan for England for 2016-17[1] and sets out the roles and responsibilities of local authorities and their partners in implementing the National Flu Plan locally.

The Berkshire winter flu plan contains information which will enable local authority public health teams to work with partners in health, social care and other organisations to implement the plan.

Local Authority Public Health teams should work with internal and external partners to develop a local flu Action Plan which aligns with the needs of their populations. Plans will be monitored and reviewed through the local Flu Action Groups for East and West Berkshire



## Contents



[1] National Flu Immunisation Programme 2017-18

## Background

Flu is a key factor in NHS winter pressures. It impacts on both those who become ill, the NHS services that provide direct care, and on the wider health and social care system that supports people in at-risk groups. Flu occurs every winter in the UK. The National Flu Plan aims to reduce the impact of flu in the population through a series of complementary measures. These measures help to reduce illness in the community and unplanned hospital admissions, and therefore pressure on health services generally and A&E in particular. The plan is therefore a critical element of the system-wide approach for delivering robust and resilient health and care services throughout the year.

The national flu immunisation programme is a key part of the plan and it is being extended to children in a phased roll-out. In July 2012, JCVI recommended that the flu vaccination programme should be extended to healthy children aged two to their seventeenth birthday. JCVI recognised that implementation of this programme would be challenging and due to the scale of the programme it is being phased in.

Vaccinating children each year means that not only are the children protected, but also that transmission across the population is reduced, lessening the overall burden of flu. Implementing this programme is therefore an important contribution to increasing resilience across the system through the winter period. Results from the implementation of the primary school childhood flu programme are encouraging, with reduced numbers of GP attendances for influenza-like illness and reduced emergency department respiratory attendances in all age groups.

It is anticipated that the children's programme, once fully implemented, will avert many cases of severe flu and flu-related deaths in older adults and people in clinical risk groups. But there is a need to ensure that we are communicating the benefits of the vaccine among all recommended groups, making vaccination as easily accessible as possible, including for frontline health and social care workers.

In addition to immunisation, influenza antiviral medicines and a range of other measures aimed at reducing transmission of flu and other respiratory virus infections (in particular good hand and respiratory hygiene) are vital elements in reducing the impact of flu each year.

## Elements of the flu programme for 2017-18

- 100% offer for all eligible groups; adults and children
- Extension of the children's flu programme to include reception and school year 4
- Prioritise those with chronic liver and neurological disease, including people with learning disabilities

Key changes from 2016-17 are

- Morbidly obese patients are now included in clinical at risk groups; previously this was recommended in Green Book, but is now also included in the GP contract.
- GPs are now commissioned to offer flu immunisation to 2 & 3 year olds but NOT 4 year olds
- The School based programme extended to include children in Reception year and school years 1,2,3 & 4.

**Table 1: Target group and uptake ambition for 2017-18**

| Target Group | Uptake ambition for 2017/18 |
|---|---|
| Aged under 65 'at risk' | 55% |
| Pregnant women | 55% |
| Eligible children aged 2 years to school year 4 age | 40-65% |
| Aged 65 years and over | 75% |
| Healthcare workers | 75% |

Immunisation against flu should form part of an organisations' policy for the prevention of transmission of infection (influenza) to protect patients, service users, staff and visitors. In addition, frontline health and social care workers have a duty of care to protect their patients and service users from infection.

Flu immunisation should be offered by NHS organisations to all employees directly involved in delivering care. Social care providers, nursing and residential homes, and independent providers such as GPs, dental and optometry practices, and community pharmacists, should also offer vaccination to staff.

NHS England has published a two year CQUIN covering 2017/18 and 2018/19[2] which includes an indicator to improve the uptake of flu vaccinations for frontline healthcare staff within providers, providing a financial incentive for organisations to achieve 75% vaccine uptake among their frontline staff .

NHS organisations and local authorities need to ensure that appropriate measures are in place for offering flu vaccination to their health and social care workers with direct patient contact.

## Commissioning in Berkshire for 2017-18

**Table 2: 2017-18 commissioning arrangements**

| | GP practice | Pharmacy | Maternity | BHFT (Schools immunisation team) |
|---|---|---|---|---|
| Aged 65 and above | ✓ | ✓ | | |
| Clinical risk groups under 65 | ✓ | ✓ | | |
| Pregnant women | ✓ | ✓ | ✓ | |
| Carers | ✓ | ✓ | | |
| Children aged 2 and 3 | ✓ | | | |
| Children in Reception and years 1,2,3 and 4 | | | | ✓ |



[2] www.england.nhs.uk/nhs-standard-contract/cquin/cquin-17-19/

## Annual cycle of the flu programme

The cycle for preparing for and responding to flu is set out in Figure 1

**Figure 1: Annual Cycle**

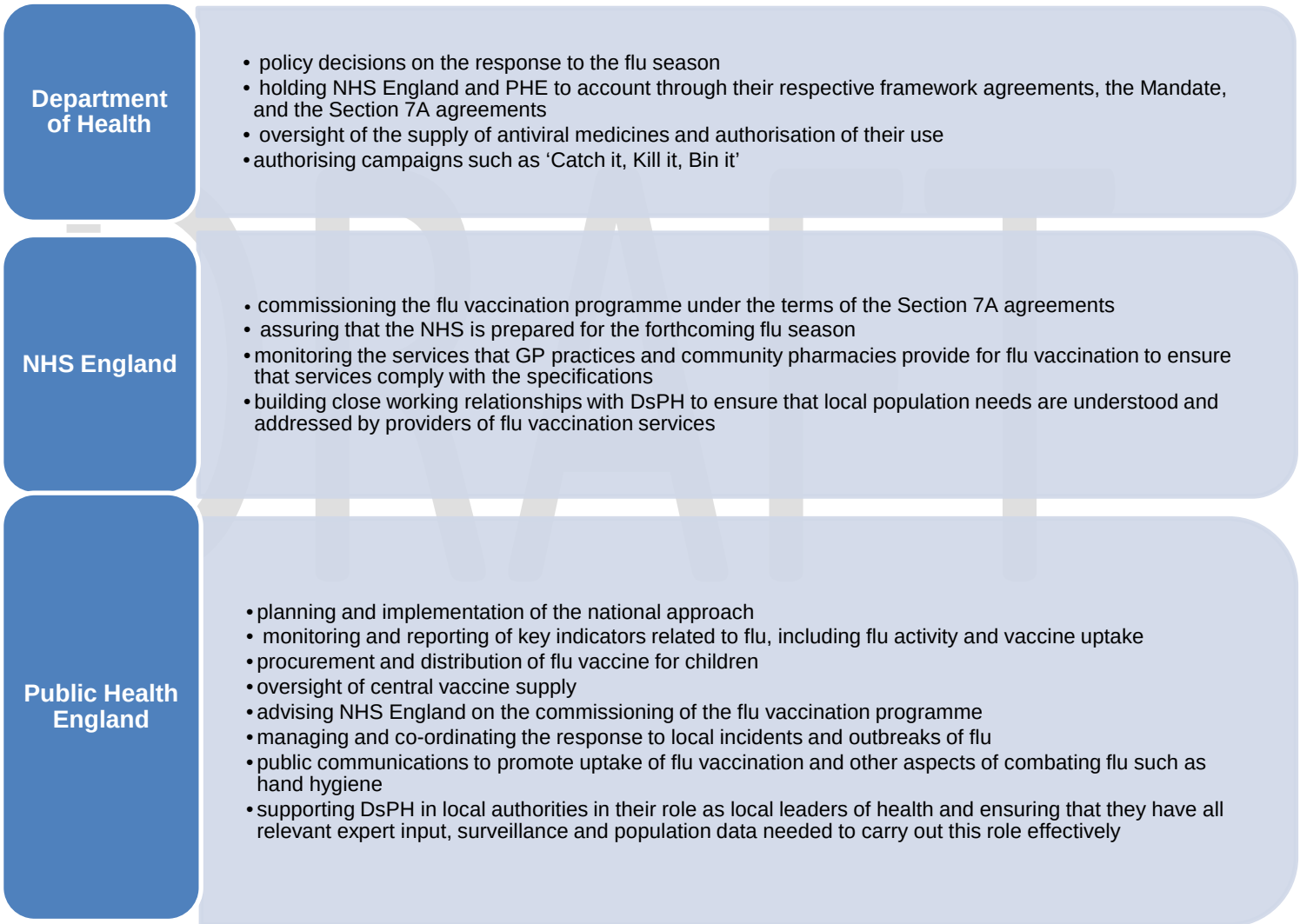
| | Vaccine manufacture | Planning | Communications | Childrens programme | Adult programme | Data collection | Data publication | Antivirals | Winter Pressures |
|---|---|---|---|---|---|---|---|---|---|
| Jan | | | | | | | | | |
| Feb | WHO announces vaccine strain selection for following winter | Enhanced service specifcations published | | | | | | | |
| Mar | | | | | | | | | |
| Apr | | Annual Flu Letter published | | | | | | CMO may issue advice to stop prescription of antivirals | |
| May | | | | | | | | | |
| Jun | Vaccine manufacture and liason with manufacturers re availability | Assurance that GPs can identify eligible patients | Information Leaflets and GP template letters available | | | | | | |
| Jul | | | | | | | | | |
| Aug | | | All stakeholders begin communications activities to promote early uptake of the vaccine among eligible groups including health and social care staff | | | | | | |
| Sep | | | | Flu vaccine for children available to order through ImmForm | Suppliers deliver vaccines to GP practices, community pharmacies, and PHE central stock. | Communications and guidance about vaccine uptake data collections issued | | | |
| Oct | | | Marketing campaign<br><br>A respiratory & hand hygiene campaign may be considered | Schools flu programme providers begin vaccination eligible children | GPs, community pharmacists and other providers begin vaccinating eligible patients and staff against flu as soon as vaccine is available | | From week 40 (early October) PHE publishes weekly reports on flu incidence, vaccine uptake, morbidity and mortality | CMO may issue advice on the use of antivirals | NHS implements winter pressures arrangements |
| Nov | | | maintain local communications to target groups with low uptake | | | Monthly GP and NHS staff flu uptake data collection period | | | |
| Dec | | | | | | | | | |
| Jan | | | | | | | | | |
| Feb | | | | | | | | | |

Adapted from National Flu Immunisation Programme 2017-18

## Roles and responsibilities

PHE have set out the roles and responsibilities of DH, NHS, PHE and Local Authorities in response to Flu. Figure 2 (next page) highlights the roles that local authorities should play in advocating and promoting uptake of flu vaccine and, providing scrutiny and challenge to local arrangements through the Director of Public Health (DPH).

**Figure 2: Roles and responsibilities of local authorities and partner organisations in response to seasonal flu**




*Continued over page*

Figure 2. *continued……*

| | |
|---|---|
| **Local Authorities** | • providing appropriate advocacy with key stakeholders and challenge to local arrangements to ensure access to flu vaccination and to improve its uptake by eligible populations - via DPH<br>• providing leadership, together with local resilience partners to respond appropriately to local incidents and outbreaks of flu infection - via DPH<br>• promoting uptake of flu vaccination among eligible groups, for example older people in residential or nursing care, either directly or through local providers<br>• promoting uptake of flu vaccination among those staff providing care for people in residential or nursing care, either directly or through local providers |
| **CCGs** | • quality assurance and improvement which extends to primary medical care services delivered by GP practices including flu vaccination and antiviral medicines<br>• Working with NHSE and Wellbeing Team (Public Health), to ensure quality assurance and improvement in flu vaccination and antiviral medicines in Primary Care services.<br>• Monitoring practice performance on a regular basis, to facilitate timely intervention should specific cohorts of patients not appear to be recieving vaccination in line with the programme.<br>• Reporting on progress of the flu programme to Berkshire West CCGs Primary Care Commissioning Committee and Urgent Care Boards.<br>• Work with local care homes to ensure that residents receive timely vaccination.<br>• Provide practices with a central resource and information point in relation to the flu programme. |
| **GP practices & Pharmacists** | • educating patients, particularly those in at-risk groups, about the appropriate response to the occurrence of flu-like illness and other illness that might be precipitated by flu<br>• ordering the correct amount and type of vaccine for their eligible patients, taking into account new groups identified for vaccination and the ambition for uptake<br>• storing vaccines in accordance with national guidance<br>• ensuring vaccination is delivered by suitably trained, competent healthcare professionals who participate in recognised on-going training and development in line with national standards<br>• maintaining regular and accurate data collection using appropriate returns<br>• encouraging and facilitating flu vaccination of their own staff<br>• ordering vaccine for children from PHE central supplies through the ImmForm website and ensuring that vaccine wastage is minimised<br>• ensuring that all those eligible for the flu vaccine are invited personally to receive their vaccine |

## Stages of implementation

The impact of the virus on the population each year is variable – it is influenced by changes that may have taken place in the virus, the number of people susceptible to infection and the severity of the illness caused by a particular strain. These factors in turn affect the pressures the NHS experiences and where they are felt most.

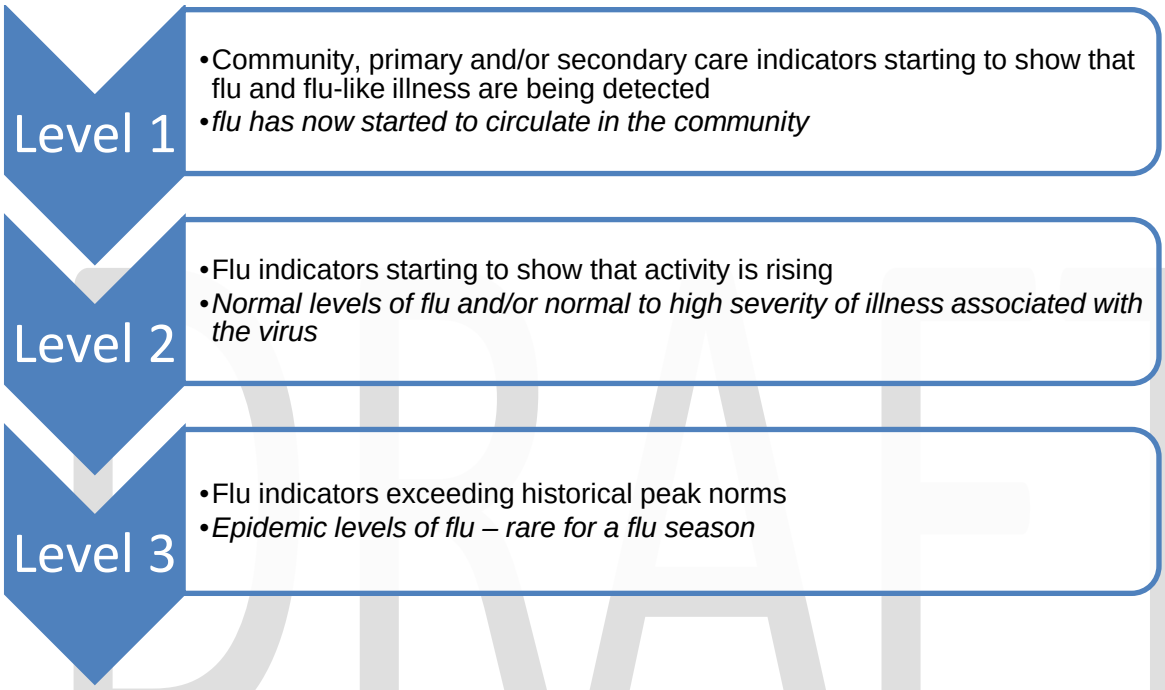
The Flu Plan operates according to a series of stages, which enable individual elements of the response to be escalated as appropriate; these are shown in Table 6.

## A flexible and proportionate response

The impact of the virus on the population each year is variable – it is influenced by changes that may have taken place in the virus, the number of people susceptible to infection and the severity of the

illness caused by a particular strain. These factors in turn affect the pressures the NHS experiences and where they are felt most. Planning for the flu season therefore needs to prepare for a range of possibilities including the need to respond quickly to modify the plans, therefore, the *Flu plan* operates according to a series of levels, which enable individual elements of the DH, NHS England, and PHE's response to be escalated as appropriate:

**Figure 3: Levels of flu response**






More detail of the required actions at each level is provided in Table 3 (next page).

**Table 3: Flu Stages with relevant actions**

| Stage and Level of flu-like illness | Actions<br>(local actions in italics, key actions for LA PH teams in bold) |
|---|---|

| Stage and Level of flu-like illness | Actions<br>(local actions in italics, key actions for LA PH teams in bold) |
|---|---|
| **Stage 1**<br><br>Community, primary and/or secondary care indicators starting to show that flu and flu-like illness are being detected<br><br>Beginning of the flu season – flu has now started to circulate in the community | • review data on flu activity and severity from the southern hemisphere<br>• GPs invite their eligible patients to be vaccinated, using call and reminder systems<br>• GPs make arrangements to vaccinate patients who cannot attend the surgery because of frailty, severe chronic illness or disability<br>• GPs encourage and facilitate their own frontline staff to be vaccinated<br>• **other NHS, local authority and care home employers arrange for their frontline staff to be vaccinated**<br>• data on flu incidence and vaccine uptake rates in England issued at a national and, if available, regional/local levels<br>• data on influenza-like illnesses, virological surveillance, vaccine uptake and NHS operational data published<br>• PHE publishes weekly reports on flu incidence, vaccine uptake, morbidity and mortality<br>• NHS England writes to the NHS if vaccine uptake is low<br>• PHE in contact with vaccine manufacturers on production and delivery schedules<br>• DH in contact with antiviral medicine manufacturers on their preparedness plans<br>• the respiratory and hand hygiene campaign may be launched<br>• ***Commence Bi-weekly teleconference led by NHS England, Berkshire Consultant in Health Protection for Berkshire shared team to attend on behalf of all Berkshire LA public health teams***<br>• ***Commence multi-agency East and West of Berkshire Flu Action Groups (frequency TBC). LA flu leads to attend*** |

| Stage and Level of flu-like illness | Actions<br>(local actions in italics, key actions for LA PH teams in bold) |
|---|---|
| **Stage 2**<br><br>Flu indicators starting to show that activity is rising<br><br>Normal levels of flu and/or normal to high severity of illness associated with the virus | • GPs and other non-medical prescribers will be alerted through a CMO/CPhO letter, to start prescribing antiviral medicines in line with the NICE guidance and Schedule 2 to the National Health Service (General Medical Services Contracts) (Prescription of drugs etc) Regulations 2004), commonly known as the Grey List or Selected List Scheme (SLS) and following expert advice that the flu virus is circulating<br>• if evidence emerges that a particular age group or people with certain clinical conditions are being disproportionately affected by the flu virus, a joint letter on behalf of DH, NHS England, and PHE may issue specific advice to both the public and health professionals to increase efforts to vaccinate that particular group, if practicable and seeking expert advice from JCVI if necessary<br>• **local NHS responds to local circumstances according to local plans and needs**<br>• review daily NHS operational data, eg critical care<br>• CMO or representatives of PHE or NHS England may provide a media briefing to provide clear, factual information on flu. This may include information for the public about what to do if they become unwell and advice on accessing services<br>• if countrywide vaccine shortages are considered likely, PHE will alert GPs to the availability of the central strategic reserve and set out how they should access it. It is likely this will be through the on-line ImmForm system. Depending on the level of shortages, restrictions may be placed on the number of doses a GP can order<br>• vaccine manufacturers contacted by PHE regarding the availability of additional supplies if needed<br>• in the event of shortages of antiviral medicines, and an evident public health need, PHE would take steps to support arrangements for supplies by using its pandemic flu stocks as buffers in the supply chain. In this system, government stocks of antiviral medicines would be supplied to the manufacturers who would distribute to community and hospital pharmacies using their normal supply chain mechanisms<br>• DH will work closely with antiviral medicines manufacturers, wholesalers and pharmacies to minimise disruptions of supply to patients<br>• DH will work closely with antibiotic manufacturers, wholesalers and pharmacies to minimise disruptions of supply to patients |

| Stage and Level of flu-like illness | Actions<br>(local actions in italics, key actions for LA PH teams in bold) |
|---|---|
| **Stage 3**<br><br>Flu indicators exceeding historical peak norms<br>Epidemic levels of flu – rare for a flu | • a national flu epidemic is declared<br>• GPs alerted that a late surge in demand for the vaccine may occur and that there may be greater use of antiviral medicines<br>• vaccine manufacturers contacted by PHE regarding availability of additional supplies<br>• antiviral medicines manufacturers contacted regarding availability of additional supplies<br>• JCVI will review the available data and amend guidance on vaccination if necessary and if sufficient supplies of vaccine are available and can be delivered and administered in time<br>• PHE may extend the vaccine uptake collections for additional weeks/months if vaccine uptake rates are still rising<br>• weekly press briefings will be considered. These will be led by CMO or representatives of PHE or NHS England<br>• maintain or boost the respiratory and hand hygiene campaign<br>• proactive work with media to allay any public concerns<br>• reiterate advice on signs and symptoms, and treatment at home<br>• **communicate regularly with clinical and professional networks and stakeholder groups for patients at risk of severe illness**<br>• regular liaison with pharmacy organisations to keep abreast of any supply problems associated with antiviral medicines<br>• continue to review daily NHS operational data, for example, critical care<br>• alert the NHS when the flu season has peaked, to aid local planning<br>• ***implement Berkshire Pandemic Flu plans*** |

## Local Flu Action Plan 2017-18

A local action plan built around the key responsibilities of local authorities to;

- **promote uptake of flu vaccination among eligible groups, for example older people in residential or nursing care, either directly or through local providers**
- **promote uptake of flu vaccination among those staff providing care for people in residential or nursing care, either directly or through local providers**

is provided in the Local Authority Flu Action Plan - see Table 4

**Table 4: Reading Borough Council Action Plan 2017/18**

| Target Audiences | Key messages | Distribution | Actions | When | Who |
|---|---|---|---|---|---|
| Pre-school services | Request to share advice/encourage service users to get child vaccinated (+ posters/newsletters)<br>▪ Flu vaccination programme – arrangements for 3 & new arrangements for 4 year olds<br>▪ Benefits/risks<br>▪ availability<br>▪ Key messages for parents (see below)<br>▪ Link to resources | FIS (MM) will send email to contacts for pre-school services/activities including:<br>▪ registered nurseries<br>▪ child-minders<br>▪ playgroups<br>▪ mother and toddler | CCG to confirm comms message and access information; LA to prep comms briefing to go out through network | 30.09.2017 | CCG Comm with support from LA |
| Parents of 3 & 4 Year olds | ▪ Benefits of immunisation/risks of flu<br>▪ Administered by nasal spray<br>▪ Available from GP only (3 year olds) – 4 years old through school<br>▪ Links to resources | | | | |

| Target Audiences | Key messages | Distribution | Actions | When | Who |
|---|---|---|---|---|---|
| Infant/Primary School Heads | ▪ Service available from IMS<br>▪ How to contact/arrange<br>▪ Flu Messages for parents (see below) to encourage uptake<br>▪ Link to resources | Email letter to head teachers; Send letter to home-educated parents;<br><br>Publish information on RSG. | BHFT to confirm school programme and LA to support to identify comms networks to help raise awareness to parents/schools. | 30.09.2017 | BHFT and LA |
| Parents of Year 1, 2, 3 and 4 year school students | ▪ Benefits of immunisation<br>▪ Administered by nasal spray<br>▪ Available via school<br>▪ Dates of birth for those turning 4 (starting school)<br>▪ Link to resources | | | | |

| Target Audiences | Key messages | Distribution | Actions | When | Who |
|---|---|---|---|---|---|
| DMT | ▪ Flu vaccination programme inc RBC Staff Offer<br>▪ Benefits and risks (to vulnerable groups and org)<br>▪ Lists of eligible teams/staff (working with vulnerable people/critical for business continuity)<br>▪ Arrangements/costs<br>▪ Approval process<br>▪ Request for managers to cascade | DMT | LA to prepare a briefing note for staff flu vaccinations – to go via DMT's and Emergency Planning team. | 30.09.2017 | LA |
| Eligible RBC staff | ▪ Benefits/risks for vulnerable groups & RBC<br>▪ eligibility<br>▪ Free jabs<br>▪ Where/when/how | ▪ Email Cascade via manager<br>▪ Team meetings<br>▪ Supervision's | LA to prepare a briefing note for staff flu vaccinations. | 30.09.2017 | LA |

| Target Audiences | Key messages | Distribution | Actions | When | Who |
|---|---|---|---|---|---|
| All RBC staff | ▪ Risks and benefits<br>▪ Who is eligible (those working with at risk groups and BC critical + anyone caring for eligible person)<br>▪ Free from GP if eligible<br>▪ When available<br>▪ Spread the word/remind family & friends | Possible resources<br>▪ IRIS feature<br>▪ "All staff" email (not able to utilise)<br>▪ Yammer<br>▪ Inside Reading<br>▪ Posters on noticeboards (all Council facilities) | LA to prepare promotional information for staff flu vaccinations. | 30.09.2017 | LA |
| Care Home Managers | ▪ Flu vaccinations for staff<br>▪ Benefits/risks to residents and day-to-day ops<br>▪ IMS services available – how to arrange<br>▪ Link to resources<br>▪ Encourage residents take-up | Email – commissioning to provide lists; | LA to prepare and cascade information to commissioned services providers for both residents and staff. | 30.09.2017 | LA |

| Target Audiences | Key messages | Distribution | Actions | When | Who |
|---|---|---|---|---|---|
| Sheltered/Extra Care Housing managers/Wardens | ▪ Awareness of programme<br>▪ Encourage residents to take up<br>▪ Links to resources | Email – housing to provide lists | LA to prepare and cascade information to commissioned services providers for both residents of sheltered housing units, staff and housing associations. | 30.10.2017 | LA |
| Care agency managers | ▪ Flu jabs<br>▪ Who should be immunised (care staff)<br>▪ Benefits/risks to service users/operations<br>▪ Support available<br>▪ Links to resources<br>▪ Request for care staff to spread the word | Email – commissioning to provide lists. To include the 'Stay Well This Winter' messages for community based staff to support with other prevention work. | LA to prepare and cascade information to commissioned community services providers for both managers and remote working staff. | 30.10.2017 | LA |

| Target Audiences | Key messages | Distribution | Actions | When | Who |
|---|---|---|---|---|---|
| Reading Residents | ▪ Generic flu fighter message<br>▪ Request to help spread the word via newsletters/website<br>▪ Link to posters/resources | Via AAI services:<br>▪ Communicare<br>▪ Age UKs (Reading & Berkshire)<br>▪ Mencap<br>▪ Libraries | CCG to confirm local programme information and details on access so local messages can be tailored for targeted groups.<br><br>LA to also access national marketing information and cascade to key stakeholders and use comms links to raise awareness. | Phase 1<br>09.10.2017<br><br>Phase 2<br><br>06.11.2017 | LA/CCGs |
| | | ▪ Joint Press Release RBC & CCG<br>▪ social Media – Facebook/Twitter<br>▪ CCG – video You Tube?<br>▪ Photo-call at Surgery | | | CCGs/LA linked in with NHS England South Central |

| Target Audiences | Key messages | Distribution | Actions | When | Who |
|---|---|---|---|---|---|
| Ante-natal services | ▪ Flu Jabs<br>▪ Benefits/Risks for pregnant women<br>▪ Request to spread the word<br>▪ Link to resources | Maternity unit (probably covered by health/hospital)<br><br>Ante natal groups (NCT,<br><br>Community midwives - | NHS England /Midwifery Leads to confirm local programme information and details on access so local messages can be tailored for targeted groups.<br><br>LA to cascade information via networks i.e. FIS, Smoking Cessation Service | 30.10.2017 | NHS England South Central commissioned provider/ Midwifery Leads with support from CCGs & LAs |

LA – Local Authority CCG – Clinical Commissioning Group BHFT – Berkshire Health Foundation Trust

## Local Contacts

**Table 5: Local Contacts**

| Group | Role | Name | Contact details |
|---|---|---|---|
| General | Wellbeing/Public Health Team LA Lead | Suzie Watt (Influenza)<br><br>Melissa Montague (Cold Weather) | Suzie.Watt@reading.gov.uk<br><br>0118 937 4806<br><br>Melissa.Montague@reading.gov.uk<br><br>0118 937 4805 |
| | Consultant in Communicable Disease (Berkshire) | Jo Jefferies | Jo.jefferies@bracknell-forest.gov.uk<br><br>07920535840 |
| | PHE Immunisations Regional Contact | Harpal Aujla | Harpal.aujia@nhs.net |
| | Senior Communications & Engagement Manager, NHS England South | Graham Groves | graham.groves@nhs.net |

| | | | |
|---|---|---|---|
| | PHE Regional Comms Lead for Influenza | Mike Burrell | Mike.Burrell@phe.gov.uk |
| | Local Authority Comms Lead | Rachel Dennis | Rachel.Dennis@reading.gov.uk<br><br>0118 937 3957 |
| | CCG Seasonal Flu Lead | Victoria Farley | Victoria.farley1@nhs.net |
| Children | Children's Centre Managers | Corinne Dishington | Corinne.Dishington@reading.gov.uk<br><br>0118 937 6012 |
| | School Nurse Lead (BHFT) | Beverley Wheeler | Beverley.wheeler@berkshire.nhs.uk<br><br>0118 9382145 |
| | Children's Social Care | Ann-Marie Dodds (Director)<br><br>Hayley Broadhurst – PA to Director of Children, | AnnMarie.Dodds@reading.gov.uk<br><br>0118 937 2421<br><br>Hayley.Broadhurst@reading.gov.uk |

| | | | |
|---|---|---|---|
| | | Education & Early Help Services | 0118 937 4665 |
| | Education lead (primary years R to 4)<br><br>Home Educated | Gill Dunlop<br><br>Sally Ollerenshaw | Gill.Dunlop@reading.gov.uk<br><br>Sally.Ollerenshaw@reading.gov.uk |
| Families | Family Information Services<br><br>Reading Borough Council | Pauline Lennox – Customer Contact Operations Manager<br><br>Maryam Makki – Family Information Service Manager | Pauline.Lennox@reading.gov.uk<br><br>Maryam.Makki@reading.gov.uk |
| Pregnant women | Midwife RBH / BHFT (Berkshire) | tbc | |
| | Local Community Midwife | tbc | |

| | | | |
|---|---|---|---|
| | Local NCT Lead | tbc | |
| People aged 65 and over<br><br>Carers Groups<br><br>Residential/Nursing Homes - Reading | Wellbeing Team (Community)<br><br>Reading Borough Council | Nina Crispin | Wellbeing.Services@reading.gov.uk |
| | Wellbeing Team (Commissioning)<br><br>Reading Borough Council | Senior Commissioning Support Officer | Contracts.Team@reading.gov.uk<br><br>0118 937 2273 |
| | *Voluntary Services* | Reading Voluntary Action | info@rva.org.uk<br><br>0118 937 2273 |
| Clinical risk groups | Respiratory | tbc | |
| | CKD | tbc | |

| | | | |
|---|---|---|---|
| | Chronic liver disease | tbc | |
| | Neurology | tbc | |
| | HIV (immunosuppressed) | tbc | |
| | Oncology (immunosuppressed through therapy) | tbc | |
| Staff Communication | Reading Borough Council | Debi Daniels – Communications & Promotion Manager<br><br>Claudine Schooling – Marketing Manager | Debi.Daniels@reading.gov.uk<br><br>Claudine.Schooling@reading.gov.uk |
| | CCG | Victoria Farley | Victoria.farley1@nhs.net |

## Supporting documentation

- National Flu Immunisation Programme 2017-18
- Annual Flu Letter 2017-18
- Influenza chapter in 'Immunisation against infectious disease' (the Green Book, chapter 19) which is updated regularly, sometimes during a flu season
- Enhanced service specifications for seasonal flu and the childhood flu vaccination programmes

  Additional guidance and resources can be found on the Annual Flu Programme web pages

Public Health England

Department of Health

NHS England

# Flu Plan

## Winter 2017/18

# About Public Health England

Public Health England exists to protect and improve the nation's health and wellbeing, and reduce health inequalities. It does this through world-class science, knowledge and intelligence, advocacy, partnerships and the delivery of specialist public health services. PHE is an operationally autonomous executive agency of the Department of Health.

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# Contents

# Foreword

Flu occurs every winter in the UK and is a key factor in NHS winter pressures. It impacts on those who become ill, the NHS services that provide direct care, and on the wider health and social care system that supports people in at-risk groups. This *Flu plan* aims to reduce the impact of flu in the population through a series of complementary measures.

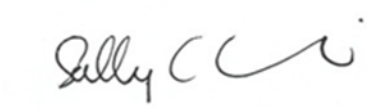
The national flu immunisation programme is a key part of the plan and it is being extended to children in a phased roll-out. Vaccinating children each year means that not only are the children protected, but also that transmission across the population is reduced, lessening the overall burden of flu. Implementing this programme is therefore an important contribution to increasing resilience across the system through the winter period. Results from the implementation of the primary school childhood flu programme are encouraging, with reduced numbers of GP attendances for influenza-like illness and reduced emergency department respiratory attendances in all age groups.

We anticipate that the children's programme, once fully implemented, will avert many cases of severe flu and flu-related deaths in older adults and people in clinical risk groups. But we should continue to work hard to ensure that we are communicating the benefits of the vaccine among all recommended groups, making vaccination as easily accessible as possible, including for frontline health and social care workers.

In addition to immunisation, influenza antiviral medicines and a range of other measures aimed at reducing transmission of flu and other respiratory virus infections (in particular good hand and respiratory hygiene) are vital elements in reducing the impact of flu each year.

This is the seventh *Flu plan* to be published. It supports a co-ordinated and evidence-based approach to planning for the demands of flu across England. It has the support of the Chief Pharmaceutical Officer (CPhO), the Chief Nursing Officer and the PHE Chief Nurse.

We commend the *Flu plan* to you, and hope that you find it useful in preparing for this coming winter.



**Professor Dame Sally C Davies**
Department of Health, Chief Medical Officer

**Professor Paul Cosford**
Public Health England, Medical Director and Director of Health Protection

**Professor Sir Bruce Keogh**
NHS England, National Medical Director

# Introduction

This *Flu plan* sets out a co-ordinated and evidence-based approach to planning for and responding to the demands of flu across England, taking account of lessons learnt during previous flu seasons. It will aid the development of robust and flexible operational plans by local organisations and emergency planners within the NHS and local government. It provides the public and healthcare professionals with an overview of the co-ordination and the preparation for the flu season, and signposting to further guidance and information.

The *Flu plan* includes details about the extension of the flu vaccination programme to children, which is being implemented gradually due to the scale of the programme. The *Flu plan* is supported by the following:

- the Annual Flu Letter[1]
- the influenza chapter in 'Immunisation against infectious disease' (the 'Green Book', chapter 19)[2] which is updated regularly, sometimes during a flu season
- the enhanced service specifications for seasonal flu and the childhood flu vaccination programmes[3]
- the public health Section 7A national service specifications for the seasonal flu programme and the seasonal flu programme for children[4]
- Immform survey user guide for GP practices and local NHS England teams[5]
- the service specification for the Community Pharmacy Seasonal Influenza Vaccination Advanced Service[6]
- the CMO/CPhO letter on antivirals issued to GPs and other prescribers working in primary care following advice from PHE that the influenza virus is circulating in the community

[1] www.gov.uk/government/collections/annual-flu-programme

[2] www.gov.uk/government/publications/influenza-the-green-book-chapter-19

[3] www.england.nhs.uk/commissioning/gp-contract/

[4] www.england.nhs.uk/commissioning/pub-hlth-res/

[5] See under 'Seasonal flu vaccine uptake: data collection guidance' at www.gov.uk/government/collections/vaccine-uptake

[6] www.PSNC.org.uk

# Roles and responsibilities in the NHS and public health system

The Health and Social Care Act 2012 created a new set of responsibilities for the delivery of public health services. In England, although the local leadership for improving and protecting the public's health sits with local government, the reforms provided specific roles across the system. Each of the partners has its own responsibilities for which it is accountable.

In outline these are:

The **Department of Health** (DH) is responsible for:

- policy decisions on the response to the flu season
- holding NHS England and PHE to account through their respective framework agreements, the Mandate, and the Section 7A agreements
- oversight of the supply of antiviral medicines and authorisation of their use
- authorising campaigns such as 'Catch it, Kill it, Bin it'

**NHS England** is responsible for:

- commissioning the flu vaccination programme under the terms of the Section 7A agreements
- assuring that the NHS is prepared for the forthcoming flu season
- monitoring the services that GP practices and community pharmacies provide for flu vaccination to ensure that services comply with the specifications
- building close working relationships with Directors of Public Health (DsPH) to ensure that local population needs are understood and addressed by providers of flu vaccination services

**Public Health England** is responsible for:

- planning and implementation of the national approach
- monitoring and reporting of key indicators related to flu, including flu activity and vaccine uptake
- procurement and distribution of flu vaccine for children
- oversight of central vaccine supply
- advising NHS England on the commissioning of the flu vaccination programme
- managing and co-ordinating the response to local incidents and outbreaks of flu
- public communications to promote uptake of flu vaccination and other aspects of combating flu such as hand hygiene



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NHS Gateway:06560

- supporting DsPH in local authorities in their role as local leaders of health and ensuring that they have all relevant expert input, surveillance and population data needed to carry out this role effectively

**Local authorities**, through their DsPH, have responsibility for:

- providing appropriate advocacy with key stakeholders and challenge to local arrangements to ensure access to flu vaccination and to improve its uptake by eligible populations
- providing leadership, together with local resilience partners to respond appropriately to local incidents and outbreaks of flu infection

**Local authorities** can also assist by:

- promoting uptake of flu vaccination among eligible groups, for example older people in residential or nursing care, either directly or through local providers
- promoting uptake of flu vaccination among those staff providing care for people in residential or nursing care, either directly or through local providers

**Clinical commissioning groups** (CCGs) are responsible for:

- quality assurance and improvement which extends to primary medical care services delivered by GP practices including flu vaccination and antiviral medicines

**GP practices and community pharmacists** are responsible for:

- educating patients, particularly those in at-risk groups, about the appropriate response to the occurrence of flu-like illness and other illness that might be precipitated by flu
- ordering the correct amount and type of vaccine for their eligible patients, taking into account new groups identified for vaccination and the ambition for uptake
- storing vaccines in accordance with national guidance
- ensuring vaccination is delivered by suitably trained, competent healthcare professionals who participate in recognised on-going training and development in line with national standards
- maintaining regular and accurate data collection using appropriate returns
- encouraging and facilitating flu vaccination of their own staff

In addition, GP practices are responsible for:

- ordering vaccine for children from PHE central supplies through the ImmForm website and ensuring that vaccine wastage is minimised
- ensuring that all those eligible for the flu vaccine are invited personally to receive their vaccine



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- ensuring that antiviral medicines are prescribed for appropriate patients, once the CMO/CPhO letter has been distributed alerting them that antiviral medicines can be prescribed

**All employers of individuals working as providers of NHS and social care services are responsible for:**

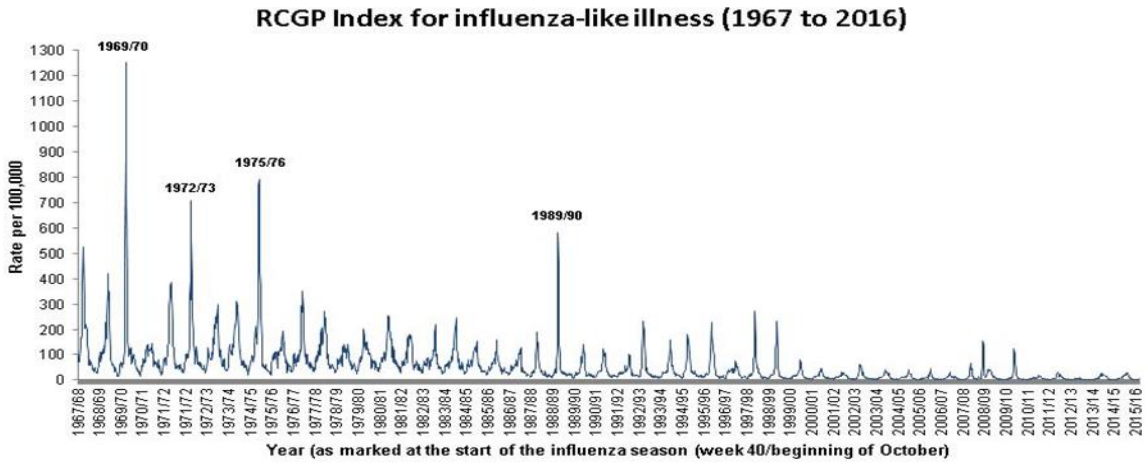
- management and oversight of the flu vaccination campaign or alternative infection control measures for their frontline staff
- support to providers to ensure access to flu vaccination and to maximise uptake among those eligible to receive it

# Influenza and the flu virus

Influenza (often referred to as flu) is an acute viral infection of the respiratory tract (nose, mouth, throat, bronchial tubes and lungs) characterised by a fever, chills, headache, muscle and joint pain, and fatigue. For otherwise healthy individuals, flu is an unpleasant but usually self-limiting disease with recovery within two to seven days. Flu is easily transmitted and even people with mild or no symptoms can still infect others. The risk of serious illness from influenza is higher among children under six months of age, older people and those with underlying health conditions such as respiratory disease, cardiac disease or immunosuppression, as well as pregnant women. These groups are at greater risk of complications from flu such as bronchitis or pneumonia or in some rare cases, cardiac problems, meningitis and/or encephalitis. The influenza chapter in the Green Book contains more details of the clinical and epidemiological features of flu.

## Impact of flu each winter on the population

The impact of flu on the population varies from year to year and is influenced by changes in the virus that, in turn, influence the proportion of the population that may be susceptible to infection and the severity of the illness. The graph below shows the rate of influenza-like illness (ILI) per 100,000 consultations in primary care in the population of England and Wales from 1967 to 2016. The data show that flu viruses circulate each winter season, but the degree of activity varies substantially.[7]




[7] Data courtesy of the Centre for Infectious Disease Surveillance and Control (CIDSC) at PHE and the Royal College of General Practitioners and Surveillance Centre. See: www.gov.uk/government/collections/seasonal-influenza-guidance-data-and-analysis



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# Strategic objectives

The aim of the national flu immunisation programme is to offer protection against the effects of flu to as many eligible people as possible, particularly those most at risk. All eligible groups should be given flu vaccination as soon as the vaccine is available to ensure that people are protected before the flu virus circulates.

Protection can be achieved directly through individual immunisation, or indirectly through herd immunity, which is one of the major benefits of the childhood flu immunisation programme. Improving and extending the children's programme is a key focus in protecting the population from flu.

The strategic intentions are:

- to increase immunisation uptake rates, in accordance with the vaccine uptake ambitions set out in the annual flu letter, for all children aged 2 to 8 years, aiming to maximise uptake, raise the performance in the lowest performing areas, and ensure an even spread across these age cohorts
- that the programme will run either in general practice for pre-school children, or usually in schools for school-aged children. Immunisation of children in these cohorts will improve protection for them and the wider community
- to continue to offer flu immunisation to all who are eligible, and to seek to increase vaccine uptake among clinical risk groups, pregnant women and healthcare workers
- to maximise protection by immunising the eligible population as early in the season as possible
- to improve patient access (eg through the continued provision of flu immunisation via GP practices, schools, pharmacies, and other settings such as maternity settings)
- to promote recording of all activity data by all providers in a format such that accuracy of uptake data is improved

The objective of the national flu plan to minimise the health impact of flu through effective monitoring, prevention and treatment, including:

- actively offering flu vaccination to 100% of all those in eligible groups
- vaccination of at least 75% of those aged 65 years and over, in line with the World Health Organization (WHO) target
- vaccination of at least 75% of healthcare workers with direct patient contact. The trust-level ambition is to reach a minimum of 75% uptake and an improvement in every trust. It is supported by a two year CQUIN covering 2017/18 – 2018/19 (see Appendix D for details). It is expected that primary care providers aim to achieve this ambition as well.



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- improving uptake for those in clinical risk groups, particularly for those who are at the highest risk of mortality from flu but have the lowest rates of vaccine uptake. The ambition for 2017/18 is to achieve at least a 55% uptake overall in these groups recognising that this figure is already exceeded in some groups, such as those with diabetes. Ultimately the aim is to achieve at least a 75% uptake in these groups
- for children, a minimum uptake of 40% has been shown to be achievable in both primary care and school based programmes and some have achieved much higher rates. As a minimum we would expect uptake levels between 40-65% to be attained by every provider
- providing direct protection to children by extending the annual flu immunisation programme and also cutting the transmission of flu across the population
- monitoring flu activity, severity of the disease, vaccine uptake and impact on the NHS
- prescribing of antiviral medicines in primary care for patients in at-risk groups and other eligible patients is governed by NHS regulations and in line with National Institute for Health and Care Excellence (NICE) guidance[8]. For details please see page 20 in the section on antiviral medicines. Antiviral medicines may be prescribed and supplied in primary care, once the CMO/CPhO letter has been sent to prescribers and community pharmacies informing them that they are now able to prescribe and supply antiviral medicines at NHS expense
- providing public health information to prevent and protect against flu
- managing and implementing the public health response to incidents and outbreaks of flu
- ensuring the NHS is well prepared and has appropriate surge and resilience arrangements in place during the flu season.

[8] NICE guidance: www.nice.org.uk/TA168

# Elements of the flu programme

## National flu vaccination programme

The flu vaccination programme is based on an assessment of the cost effectiveness of the use of vaccine for people in specific risk groups. The Joint Committee on Vaccination and Immunisation (JCVI) keeps the available evidence under review and modifies their advice should evidence suggest that the programme could be more effective.

Those aged 65 and over, pregnant women and those in a clinical risk group have been offered vaccination annually for a number of years. Those living in long-stay residential care homes, people who are the main carer of someone whose welfare may be at risk if the carer falls ill, and all frontline health and social care workers should also be offered flu vaccination (see Appendix C).

## Flu vaccination of frontline health and social care workers

Flu immunisation should be offered by NHS organisations to all employees directly involved in delivering care. Social care providers, nursing and residential homes, and independent providers such as GPs, dental and optometry practices, and community pharmacists, should also offer vaccination to staff.

Immunisation against flu should form part of an organisations' policy for the prevention of transmission of infection (influenza) to protect patients, service users, staff and visitors. In addition, frontline health and social care workers have a duty of care to protect their patients and service users from infection.

This is not an NHS service, but an occupational health responsibility provided by the staff's employers.

Vaccine uptake in healthcare workers has increased markedly in recent years. However, there continues to be considerable variation around the country and there remains scope for improvement.

NHS England has published a two year CQUIN covering 2017/18 and 2018/19 which includes an indicator to improve the uptake of flu vaccinations for frontline healthcare staff within providers[9]. See Appendix D for more information.

[9] www.england.nhs.uk/nhs-standard-contract/cquin/cquin-17-19/

## Extension of the programme to children

In July 2012, JCVI recommended that the flu vaccination programme should be extended to healthy children aged two to their seventeenth birthday. JCVI recognised that implementation of this programme would be challenging and due to the scale of the programme it is being phased in. Vaccinating children each year means that not only are the children protected, but the expectation is that transmission across the population will be cut, reducing levels of flu overall and reducing the burden of flu across the population. Implementing this programme is therefore an important contribution to increasing resilience across the system through the winter period.

Research into the first two years of the programme compared the differences between pilot areas, where the entire primary school age cohort was offered vaccination, to non-pilot areas. The results have shown a positive impact on flu transmission across a range of surveillance indicators from vaccinating children of primary school age. These include reductions in: GP consultations for influenza-like illness, swab positivity in primary care, laboratory confirmed hospitalisations and percentage of respiratory emergency department attendances. [10] [11].

The Green Book states that a live attenuated influenza vaccine (LAIV), administered as a nasal spray, is the vaccine of choice for children. The vaccine is licensed for those aged from 24 months to less than 18 years of age. JCVI recommended LAIV as it has:

- good efficacy in children, particularly after only a single dose
- the potential to provide protection against circulating strains that have drifted from those contained in the vaccine
- higher acceptability with children, their parents and carers due to intranasal administration
- it may offer important longer-term immunological advantages to children by replicating natural exposure/infection to induce potentially better immune memory to influenza that may not arise from the annual use of inactivated flu vaccines

[10] Pebody, R *et al*. 5 June 2014. Uptake and impact of a new live attenuated influenza vaccine programme in England: early results of a pilot in primary school age children, 2013/14 influenza season. *Eurosurveillance*, **19**, Issue 22. www.eurosurveillance.org/ViewArticle.aspx?ArticleId=20823

[11] Pebody, R *et al*. October 2015. Uptake and impact of vaccinating school age children against influenza during a season with circulation of drifted influenza A and B strains, England, 2014/15. *Eurosurveillance,* 20 (39). www.eurosurveillance.org/images/dynamic/EE/V20N39/art21256.pdf

LAIV is unsuitable for children with contraindications such as severe immunodeficiency, severe asthma or active wheeze. Following more evidence on the safety of LAIV in egg allergic children, JCVI have amended their advice on offering it to children with egg allergy. For the full list of contraindications please see the Green Book. Those children in clinical risk groups who are medically contraindicated to LAIV should be offered a suitable inactivated flu vaccine. Flu vaccines for children are purchased centrally by PHE – the Annual Flu Letter contains details about how to order these vaccines.

LAIV contains a highly processed form of gelatine (derived from pigs). Some faith groups do not accept the use of porcine gelatine in medical products. Current policy is that **only** those who are in clinical risk groups and have clinical contra-indications to LAIV are able to receive an inactivated injectable vaccine as an alternative. The implications of this for the programme will continue to be monitored.

## Community Pharmacy Seasonal Influenza Vaccination Advanced Service

Since 2015 all community pharmacies may provide flu vaccination, if they satisfy the requirements of the Advanced Service, to eligible adult patients (that is those aged 18 years and over and within the identified risk groups). As this service is commissioned by NHS England as an Advanced Service, contractors have the choice as to whether they provide it. The service can be provided by any community pharmacist in any community pharmacy in England that satisfies the requirements of the Advanced Service within the Community Pharmacy Contractual Framework. This includes having a consultation room, being able to procure the vaccine and meet the data recording requirements, and have appropriately trained staff. Further details are available from the Pharmaceutical Services Negotiating Committee website: http://psnc.org.uk/

## Flu vaccine effectiveness

Vaccines are produced each year, by a number of manufacturers, which provide protection against the three strains of influenza that the WHO considers may be most prevalent in the following winter. Since 2013, a quadrivalent vaccine has also been available.

PHE undertakes estimations of the protective effect of the flu vaccines in use during the flu season. The following should be noted:

- epidemiological estimation is carried out using data from consultations in general practice and standardised methodology. In order to obtain sufficiently robust estimates, only mid-season and end of season estimates are made

- In order to provide an indication of how well the vaccines are protecting against the currently circulating strains of flu, these data are combined with virological characterization data of circulating flu viruses
- Significant mismatch between circulating strains and the vaccine strains occur infrequently. Detailed virological characterization of the circulating viruses which is carried out throughout the season might give an early indication of the existence of a significant mismatch so that clinicians can be made aware.

In recent years, we have typically seen around 50% (ranging from 25 to 70%) effectiveness for the flu vaccine in the UK, with generally a good match between the strains of flu in the vaccine and those that subsequently circulate. While it is not possible to fully predict the strains that will circulate in any given season, flu vaccination remains the best protection we have against an unpredictable virus which can cause severe illness and deaths each year, particularly among at-risk groups.

In August 2016 JCVI reviewed all the UK and other international evidence after data from the US found their LAIV childhood flu vaccination programme to be ineffective in 2015/16[12].
The 58% vaccine efficacy found in the UK in 2015/16 is within the normal range for this vaccine[13]. Other countries which have introduced LAIV, such as Finland, have also found similar results to the UK. The reasons for the poor efficacy of the vaccine in the US are not fully understood and remain under investigation, but the clear recommendation of JCVI was to continue with the LAIV vaccination programme, together with on-going intensive monitoring of the programme performance.

Since 2014/15 the child flu programme has offered a quadrivalent live attenuated influenza vaccine (LAIV) rather than a trivalent vaccine. This should provide better protection against circulating influenza B strains because it contains two influenza B viruses (compared to one in trivalent vaccines). Vaccine effectiveness data for LAIV in 2016/17 are not yet available.

## Vaccine supply

The flu virus is constantly mutating and so it is necessary to formulate each season's flu vaccine for the flu vaccination programme to match the strains likely to be circulating the

[12] The JCVI statement can be found at:
www.gov.uk/government/uploads/system/uploads/attachment_data/file/548515/JCVI_statement.pdf
[13] Pebody, R et al. 15 July 2016. Effectiveness of seasonal influenza vaccine for adults and children in preventing laboratory-confirmed influenza in primary care on the United Kingdom: 2015/16 end-of-season results. *Eurosurveillance*, **21,** Issue 38.
www.eurosurveillance.org/ViewArticle.aspx?ArticleId=22592

following winter. The WHO therefore monitors the epidemiology of flu viruses throughout the world in order to make recommendations about the strains to be included in flu vaccines for the coming winter[14].

It is recommended that trivalent vaccines for use in the 2017/18 influenza season (northern hemisphere winter) contain the following:

- an A/Michigan/45/2015 (H1N1)pdm09-like virus;
- an A/Hong Kong/4801/2014 (H3N2)-like virus; and
- a B/Brisbane/60/2008-like virus.

It is recommended that quadrivalent vaccines containing two influenza B viruses contain the above three viruses and a B/Phuket/3073/2013-like virus.

Manufacturers begin vaccine production once the WHO issues recommendations in February as to which strains to include. As manufacture of flu vaccine is complex and constrained by the length of time available between the WHO recommendations and the opportunity to vaccinate before the flu season, manufacturers may not be able to respond to unexpected demands for vaccine at short notice, or to allow for changes/mutations to the strains that may be identified later in the year. More detail on the vaccine manufacturing process is in Appendix B.

For all eligible populations apart from children, providers remain responsible for ordering vaccines directly from manufacturers. It is recommended that immunisers ensure they:

- order vaccine from more than one supplier
- order sufficient vaccine before the start of the season at least to cover the uptake aspirations for all their registered eligible patients
- pay attention to ordering the most appropriate type of vaccine such as enough low ovalbumin content vaccine for those patients who may require it

PHE liaises closely with manufacturers and the vaccines group within the Association of the British Pharmaceutical Industry (ABPI). This helps promote optimal communication between GP practices, community pharmacies, and manufacturers.

PHE provides some oversight to help facilitate a constant supply of vaccine, liaising with vaccine manufacturers to ascertain whether there are any manufacturing problems that might affect either the number of doses available across the UK or the dates of delivery.

[14]www.who.int/influenza/vaccines/virus/recommendations/2017_18_north/en/



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If there are factors that are sufficiently serious to significantly affect the vaccination programme, PHE will issue guidance to the NHS suggesting arrangements to minimise the impact, for example advising GPs and pharmacists to prioritise particular clinical risk groups over other eligible groups.

**All** flu vaccines for children are purchased centrally by PHE. This includes vaccine for the national offer to all children aged 2 to 8 years old and for children in risk groups aged six months to under 18 years.

For children in risk groups under 18 years of age where LAIV is contraindicated, suitable inactivated influenza vaccines will be provided centrally and should be offered. LAIV and inactivated injectable vaccines can be ordered through the ImmForm website: www.immform.dh.gov.uk.

In 2016/17 ordering controls were introduced on centrally purchased flu vaccines. These were put in place to reduce the amount of excess vaccine, in particular LAIV, ordered by General Practice but not administered to children. It is envisaged that controls will also be in place in 2017/18. The latest information on these controls will be available in Vaccine Update both prior to, and during the flu vaccination period.

## Flu surveillance

PHE has responsibility for flu surveillance and publishes a report weekly during the flu season which includes a range of indicators on flu that is in circulation including:

- the amount of influenza-like illness (ILI) in the community
- the prevalent strain(s) of flu circulating
- the proportions of clinical samples that are positive for flu or other specified viruses
- the number of flu-related hospital and ICU admissions
- the relative impact of flu on different groups of people, by age (including data on deaths where flu is the confirmed cause) based on data from intensive care units
- excess mortality monitoring
- the international situation

## Flu vaccine uptake data

Vaccine uptake information in 2017/18 will be reported by PHE for the following groups:

- people aged 65 and over
- people aged under 65 with specific clinical conditions
- all pregnant women
- all two and three year-olds
- healthcare workers with direct patient contact
- carers
- children in reception class and school years 1, 2, 3 and 4

Flu vaccine uptake will be collected via the web-based ImmForm system for vaccinations given from the 1 September 2017 until the 31 January 2018. The GP patient weekly and monthly vaccine uptake data will be extracted automatically onto ImmForm from over 90% of GP practices[15].

The weekly GP patient vaccine uptake collection will start the first week of September and will continue until early February. Weekly data provide representative estimates of national uptake by GP patient groups.

The monthly GP patient vaccine uptake collection will start in November and continue until early February. The monthly collections provide national and local level estimates of vaccine uptake by GPs' patients for each CCG and NHS England teams. The final end of flu season data on GP patients will also be presented by local authority (aggregated by practices located in each local authority) to inform Public Health Outcomes Framework indicators 3.03xiv and 3.03xv[16].

Uptake data for healthcare workers will collect information on immunisations given from September 2017 to the end of February 2018 (final data collected in March 2018).
An ImmForm survey user guide will be made available to access from the 'Immunisation and Vaccine Uptake Guidance' web pages of the GOV.UK website closer to the start of survey[17].

[15] Vaccine uptake data is based on registered GP practice population. Data source: ImmForm reporting website www.immform.dh.gov.uk
[16] For more information on the Public Health Outcomes Framework see: www.phoutcomes.info
[17] 'Immunisation and Vaccine Uptake Guidance' web pages of the GOV.UK website can be found at: www.gov.uk/government/collections/vaccine-uptake

## Assurance of general practice and community pharmacists

NHS England teams will monitor the services that GP practices and community pharmacists provide for flu vaccination to ensure that services comply with the specifications[18]. NHS England teams will need assurance that providers have robust implementation plans in place to meet or exceed the vaccine uptake aspirations for 2017/18 and that they have the ability to identify eligible 'at-risk' patients and two-, and three- year-olds.

To support this process, a checklist is attached at Appendix F of the steps that GP practices can reasonably be expected to take to improve uptake of flu vaccine among their eligible patients.

## Local authority scrutiny

Local authorities have a responsibility to provide information and advice to relevant bodies within their areas to protect the population's health. Local authorities will provide independent challenge of the arrangements of NHS England, PHE and providers. This function may be carried out through agreed local mechanisms such as local programme boards for screening and immunisation programmes or using established health protection sub-groups of the health and wellbeing boards. They can also assist by promoting flu vaccination among frontline social care workers, offering flu vaccination through occupational health services for those staff who are directly employed and encouraging external providers to also offer flu vaccination for staff. They may also wish to offer an extended provision of flu vaccination to frontline staff working in institutions with vulnerable populations, such as special schools.

The DPH in the local authority is expected to provide appropriate challenge to arrangements and also to advocate within the local authority and with key stakeholders to improve access and uptake of flu vaccination. The DPH also needs to work with NHS England teams to ensure strategic commissioning.

## Antiviral medicines

Influenza antiviral medicines form part of the programme for protection of people who are at increased risk of severe illness due to flu. NICE has reviewed its guidance on the use of flu antivirals in seasonal influenza and it remains unchanged[19]. Influenza antivirals may only be prescribed in primary care when influenza is circulating in the community and the

[18] www.england.nhs.uk/commissioning/gp-contract/
[19] NICE guidance: www.nice.org.uk/TA168

Chief Medical Officer (CMO) and Chief Pharmaceutical Officer (CPhO) letter has been sent out. Prescribing in secondary care and in the event of outbreaks of flu is described separately.

Prescribing of antiviral medicines on the NHS is restricted through statutory prescribing restrictions set out in Schedule 2 to the National Health Service (General Medical Services Contracts) (Prescription of drugs etc.) Regulations 2004), commonly known as the Grey List or Selected List Scheme (SLS), published monthly in Part XVIIIB of the Drug Tariff.

Details of eligible and at risk patients and the circumstances when antiviral medicines can be prescribed are contained in the Drug Tariff. Antiviral medicines can only be prescribed in primary care at NHS expense when DH sends out an annual letter from CMO/CPhO, notifying prescribers and community pharmacies that the surveillance indicators are at a level that indicate that influenza is circulating in the community and that prescribers may now prescribe and community pharmacies may supply antiviral medicines for eligible patients.

The exceptions to this are outbreaks of suspected influenza in settings such as care/nursing homes which may occur out of season. Arrangements are being put in place to enable the supply of antiviral medicine for care home outbreaks out of the flu season.

Once the CMO/CPhO letter has been sent to primary care, antiviral medicines can be prescribed for patients in the at-risk groups and for patients who are not in one of the identified clinical risk groups but who are at risk of developing medical complications from flu, if not treated. The early use of antiviral medicines to treat and help prevent serious cases of flu in vulnerable patients is particularly important if the flu vaccine effectiveness is low, and remains so every flu season.

In order to minimise the development of antiviral resistance, it is important that prescribers use antiviral medicines prudently, taking into account national guidance and prescribe in accordance with the Marketing Authorisations of the antiviral medicines. GPs should continue to monitor their use, especially in immunosuppressed individuals where resistance is more likely to be seen.

## Prescribing in secondary care

The statutory prescribing that apply to primary care do not apply in secondary care. This means that if hospital clinicians believe that a person's symptoms are indicative that the person has influenza and would suffer complications if not treated, they are able to prescribe antiviral medicines. Hospital pharmacies should ensure that in such situations they are able to access antiviral medicines in a timely manner. A letter from the

CMO/CPhO is not required to provide the trigger for prescribing antiviral medicines in the hospital setting.

## Prescribing in outbreaks

PHE has published recommendations for the antiviral treatment and prophylaxis of influenza drawing on guidance already issued by NICE, the DH and WHO[20]. This guidance should be used in secondary care for any patient where influenza is suspected or confirmed at any time, in primary care it should only be used once the DH issues notice that influenza is circulating in the community and that antiviral medicines can be prescribed and supplied. However, antiviral medicines may be used in primary care outside the periods where national surveillance indicates that influenza virus is circulating in the community, in certain situations, for example, for the treatment of laboratory confirmed influenza outbreaks in 'at-risk' people who live in long-term care homes. Arrangements are being put in place to enable the supply of antiviral medicine for care home outbreaks out of the flu season.

## Liaison with manufacturers and pharmacy organisations

DH will notify the manufacturers of antiviral medicines and wholesalers when the notification has been issued to prescribers and community pharmacies that antiviral medicines can be prescribed and supplied for those eligible for antiviral medicines, to ensure that they are prepared for an increase in demand. Manufacturers will in turn need to ensure that there are enough antiviral medicines in the supply chain so that pharmacists are able to supply them when patients present to pharmacies with prescriptions and wholesalers are able to replenish supplies in a timely manner. Prior to this and during the flu season, DH will be in regular contact with manufacturers and wholesalers to ensure that there are enough antiviral medicines in the supply chain to meet demand. DH will also communicate with pharmacy organisations immediately before the letter is issued, so community pharmacies can be pre-warned that they may receive prescriptions for antiviral medicines in the near future, and regularly thereafter. This will ensure that community pharmacies are able to access and supply antiviral medicines when they are presented with prescriptions, in a timely manner.

The government holds large stocks of antiviral medicines in case of a flu pandemic. In the event of the commercial sector supply chain for antiviral medicines running low, antiviral medicines from the national pandemic flu stockpile may be made available to suppliers as a contingency, subject to arrangements about replenishment.

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[20]www.gov.uk/government/uploads/system/uploads/attachment_data/file/400392/PHE_guidance_antivirals_influenza_2014-15_5_1.pdf

## Winter planning

Flu is one of the factors that the health and social care system considers as part of winter preparedness. Each year the system plans for and responds to surges in demand, called winter pressures. Pressures associated with winter include:

- the impact of adverse weather, including cold temperatures which increase emergency hospital admissions for diseases such as cardiovascular and respiratory disease, and snow and ice which result in increased numbers of accidents and can significantly disrupt services
- flu, which has a variable impact, depending on the severity of the season
- the impact of norovirus on the acute sector, including the closure of beds in accordance with infection control processes

Local planning allows the NHS to manage winter pressures effectively by implementing local escalation plans where necessary, in response to local circumstances and needs. An example of local management of pressure could include, for instance, the cancellation of routine surgery to create additional capacity in critical care for those suffering from flu. Daily monitoring arrangements allow the NHS to monitor key indicators of pressure across the acute sector.

The Cold Weather Plan recommends a series of steps to reduce the risks to health from cold weather for the NHS, local authorities, and professionals working with people at risk, individuals, local communities and voluntary groups[21]. The cold weather alert service comprises five levels (levels 0-4), from long-term planning for cold weather, through winter and severe cold weather action, to a major national emergency. Each alert level aims to trigger a series of appropriate actions for different organisations such as flu vaccination, public health communications, and health and social care demand management. Local areas should tailor the suggested actions to their situation and ensure that they have the best fit with wider local arrangements.

[21] The Cold Weather Plan: www.gov.uk/government/publications/cold-weather-plan-cwp-for-england

# Communications

Clear and timely communication is vital to ensure that all parties involved in managing flu understand their roles and are equipped with the necessary information. Flu awareness and communications are an important element of the government's overarching Stay Well This Winter campaign.

A communications strategy will be developed to support this *Flu plan* and to provide communications colleagues in partner organisations with information and resources ahead of the 2017/18 winter flu season for use at national and local level.

While communications will take place within an overarching flu communications strategy, some elements of the communications campaign will be dictated by the severity of the flu season and subsequent impact on at-risk groups. Therefore, it will be important to maintain a flexible approach so that appropriate channels are used to maximise impact and ensure that messages are clear, consistent and relevant to the target audiences.

Communications will also aim to raise awareness of the new elements and recently introduced elements of the flu programme, including the continued rollout to new child cohorts of primary school age. This will mean effective communications at national and local level with education partners and schools (eg local authorities and academy chains) and schools (eg head teachers and governors).

The following communication mechanisms and resources are likely to play an important role in the coming flu season.

## Green Book

The Green Book, *Immunisation against infectious disease*, provides guidance for health professionals on administering the flu vaccine. The influenza chapter (chapter 19) is updated regularly, sometimes during a flu season. It is important that all those involved in the flu programme are familiar with this chapter. Alongside the Annual Flu Letter and this *Flu plan*, this comprises all the essential information needed by healthcare professionals in the implementation of the flu programme.



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## Annual Flu Letter

Every year an Annual Flu Letter[22] sets out information about the forthcoming annual seasonal flu vaccination programme. The information in the letter includes:

- groups to be immunised (including which children should be offered the vaccine)
- available vaccines and ordering vaccines for children
- data collection arrangements
- advice on increasing vaccine uptake
- the enhanced service specification and assurance arrangements
- a GP practice checklist
- information about prescribing and supply of antiviral medicines
- a table of links to key source information

## PHE weekly national influenza reports

These reports represent the most comprehensive and detailed assessment of the current situation. They will be of relevance to health and social care professionals, health planners, journalists and interested members of the public. The contents of the reports are listed in the flu surveillance section. The reports can be found at: www.gov.uk/government/publications/weekly-national-flu-reports

## NICE guidance on influenza antivirals

The NICE guidelines “Amantadine, oseltamivir and zanamivir for the treatment of influenza” published in 2009 set out the circumstances under which Oseltamivir and zanamivir are recommended for the treatment and prophylaxis of flu in adults and children. Amantadine is not recommended for the treatment of flu.

## PHE guidance on the use of influenza antiviral medicines for outbreaks

PHE has published recommendations for the antiviral treatment and prophylaxis of influenza drawing on guidance already issued by NICE, DH and WHO[23].

[22] www.gov.uk/government/collections/annual-flu-programme

[23] www.gov.uk/government/uploads/system/uploads/attachment_data/file/400392/PHE_guidance_antivirals_influenza_2014-15_5_1.pdf

## Press briefings

The CMO and representatives from DH, NHS England and PHE as appropriate will lead press conferences, as and when it is necessary. If media coverage is particularly intense and/or misinformed, press briefings may be held to provide the facts and get appropriate messages to the public, including how they can protect themselves and their families. If held, they will occur on Thursday afternoons to coincide with the release of the weekly influenza reports from PHE.

The briefings are an opportunity for:

- the CMO, and/or PHE and NHS England representatives to issue a specific public health message
- the media to have access to those dealing with the programme and for the media to obtain more detailed information to inform their reporting

## Invitations and information for patients

Proactive and personalised invitations from GPs and other health professionals to patients have a key role to play. GP practices therefore need to plan carefully to ensure that they are making every effort to identify and contact eligible patients before the flu season starts, and use any available 'free' communications channels to promote the vaccination message (such as the electronic booking system or patient newsletters). Template letters will be available for GP practices to use to invite at risk patients and those aged two to three years for flu vaccination.

Ahead of the flu season, NHS branded patient information leaflets will be reviewed and developed, tailored for different eligible groups. These materials, along with the template letters, will be available at: www.gov.uk/government/collections/annual-flu-programme and free copies of the leaflets will be available to order through the DH health and social care order line: www.orderline.dh.gov.uk/ecom_dh/public/home.jsf.

Any centrally produced communications materials such as leaflets will also be made available on NHS Choices and PHE websites. Any additional resources for NHS communicators will be made available via NHS Comms Link for regional and local use[24]. We will also be working very closely with partners including NHS Employers, the Local Government Association, the Department for Education, professional health bodies and the network of health charities to ensure that key messages are transmitted effectively through their networks.

[24] Information about any centrally-driven approach and resources will be available via the NHS Comms Link website, available to NHS communicators. See: http://nhscommslink.ning.com

## The ‘flu fighters’ campaign

NHS Employers runs a ‘flu fighters’ campaign to support flu vaccination of healthcare workers and their resources are available to order from their website at: www.nhsemployers.org/campaigns/flu-fighter There are a range of printable and adaptable resources for use in the NHS and care sector.

## National marketing campaign

The 2016/17 marketing campaign, which formed part of the wider Stay Well This Winter campaign, is being evaluated and the lessons will inform any campaign plans for 2017/18. Further information will be issued in due course.

# The annual cycle of the flu programme

The cycle for preparing for and responding to flu is set out below.

## Preparations

- **November – March:** Vaccine orders placed with suppliers for eligible patients aged 18 and over
- **December:** Section 7A service specifications for delivery of the flu immunisation programme published
- **February – September**: Manufacture of vaccine
- **February:** Enhanced service specifications for flu immunisation programme published
- **February:** WHO announces the virus strains selected for the next season's flu vaccine for the northern hemisphere
- **March/April:** Annual flu letter is sent to the NHS and local government setting out key information for the autumn's immunisation programme
- **April – June:** Liaison with manufacturers to assure the availability of vaccine
- **April – June:** Assurance that primary care providers have the ability to identify all eligible patients
- **June:** Revised flu information leaflets and GP template letters made available
- **August/September:** Communications and guidance about vaccine uptake data collections issued
- **August/September:** NHS England teams, NHS Employers, local government health and wellbeing teams, trusts, GP practices, pharmacies and local authorities begin communications activities to promote early uptake of the vaccine among eligible groups including health and social care staff
- **August – March:** DH in regular contact with manufacturers of antiviral medicines and wholesalers to ensure enough antiviral medicines in the supply chain. Weekly updates of stock levels at manufacturers and wholesalers are supplied by the manufacturers

## Flu vaccination campaign

- **September/October**: Flu vaccine for children available to order through ImmForm. Note: It is not possible to give a precise date for the availability as vaccine production involves complex biological and regulatory processes
- **September/October:** Children in eligible school age cohorts start to be offered flu vaccination
- **October**: PHE flu marketing campaign launched (if applicable)



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- **September – February:** Suppliers deliver vaccines to GP practices, community pharmacies, and PHE central stock. GPs, community pharmacists and other providers begin vaccinating eligible patients and staff against flu as soon as vaccine is available
- **September – February:** Weekly GP patients and monthly vaccination uptake data collections from primary care, and monthly data collections from secondary care begin
- **October:** From week 40 (early October) PHE publishes weekly reports on flu incidence, vaccine uptake, morbidity and mortality
- **October – February:** The CPhO and CMO may issue advice on the use of antiviral medicines, based on advice from PHE in light of flu surveillance data. Antiviral medicines from the national pandemic flu stockpile may be made available
- **October – February:** The NHS implements winter pressures co-ordination arrangements
- **October – February:** A respiratory and hand hygiene campaign may be considered
- **November – February:** Monthly GP patient flu uptake and the healthcare worker flu uptake collection commence for data submissions and closes early February.
- **March – May:** The CPhO and CMO may issue letter asking prescribers to stop prescribing antiviral medicines and community pharnacies to stop supplying antiviral medicines, once PHE informs DH that surveillance data are indicating very little flu circulating in the community and other indicators such as the number of flu-related hospital admissions

# Flexibility: a proportionate flu response

The impact of the virus on the population each year is variable – it is influenced by changes that may have taken place in the virus, the number of people susceptible to infection and the severity of the illness caused by a particular strain. These factors in turn affect the pressures the NHS experiences and where they are felt most.
Planning for the flu season therefore needs to prepare for a range of possibilities including the need to respond quickly to modify the plans (Appendix H identifies some potential scenarios). For this reason, the *Flu plan* operates according to a series of levels, which enable individual elements of the DH, NHS England, and PHE's response to be escalated as appropriate:

| Level | Level of flu-like illness | Description of flu season |
|---|---|---|
| 1 | Community, primary and/or secondary care indicators starting to show that flu and flu-like illness are being detected | Beginning of the flu season – flu has now started to circulate in the community |
| 2 | Flu indicators starting to show that activity is rising | Normal levels of flu and/or normal to high severity of illness associated with the virus |
| 3 | Flu indicators exceeding historical peak norms | Epidemic levels of flu – rare for a flu season |

Appendix G lays out in greater detail the levels of activity that would take place depending on various factors, including the levels of flu that are circulating, pressure on NHS services, and epidemiological evidence on the nature and severity of illness the virus is causing, and among which population.

Levels of circulating flu may vary between regions and local areas, requiring different approaches in different places. Local plans, therefore, need to be flexible to adapt as the flu season progresses. While the DH, NHS England, and PHE lead the strategic response to flu each winter, the system needs to be sufficiently flexible to allow local adaptation of responses to take account of local variations in the spread and type of infection and impacts on local health services.



Gateway: 2016697
NHS Gateway:06560

# Plans to improve vaccine uptake

## Children

Vaccine uptake rates for 2-4 year olds in 2016/17 was higher than previous years. Reaching these pre-school cohorts continues to be extremely important, not only for their own protection and to help to prevent the spread of flu, but also to introduce flu vaccination as part of routine care for children every autumn. Uptake was higher in the school based programmes, providing a firm foundation for future growth.

As with all parts of the flu programme there should be a 100% active offer of immunisation to eligible children. Providers and commissioners will be required, if asked, to demonstrate that such an offer has been made. A minimum uptake of 40% has been shown to be achievable in both primary care and school based programmes and some have achieved much higher rates. As a minimum, we would expect vaccine uptake rates of between 40-65% to be attained by every provider. A limited number of sessions for children who missed out on vaccination during the first routine planned session should be considered towards the end of the season. Precise arrangements for achieving this are for local determination.

## Children in at-risk groups

Vaccine uptake is particularly low in children under 16 years of age with clinical conditions that put them at most risk of complications or hospitalisation from flu. It is therefore important that children and parents of children in clinical risk groups understand the importance of these children being vaccinated against flu and the protection it offers them, particularly children with neurological disease including learning disabilities, where uptake is especially low. There is a role for paediatricians and specialist nurses in secondary care, school nurses, health visitors, pharmacists and other caregivers to raise awareness of flu vaccine as part of the care pathway for children in at-risk groups (it may be useful to consider reminder systems in hospital notes and child health records).

Some children in clinical risk groups may be offered LAIV alongside their peers as part of local provision for children in eligible school age cohorts or in the primary school-aged geographic pilots. If a child in an at-risk group does not receive flu vaccination through this route, then they should be offered it in general practice. For instance, a child may miss out due to being absent from school on the day the vaccination was offered, or because the child is contraindicated to LAIV and the local service provider does not offer inactivated flu vaccines. At-risk children may be offered immunisation at school, however

if school visits are late in the season parents should be reminded that they can have their children immunised by their GP.

Where a child is vaccinated but not by their GP, it is important that the vaccination information is provided to the practice for the timely update of clinical records and that the data is entered on the system.

## Pregnant women

Pregnant women are particularly vulnerable to severe complications of flu. During the period 2009 to 2012, one in eleven maternal deaths was due to influenza infection[25]. All pregnant women are recommended to receive the inactivated flu vaccine irrespective of their stage of pregnancy. If a woman becomes pregnant after the ideal vaccinating period of September to December, it is still worth considering offering the vaccine. Clinicians should apply clinical judgement to assess the needs of an individual patient, taking into account the level of if flu-like illness circulating in the community. Women should be offered the vaccine every time they are pregnant as the flu virus constantly mutates and therefore the strains included in the vaccine are reviewed annually.

Flu vaccination for pregnant women may be offered in general practice, through maternity services, or through community pharmacies. Maternity services are encouraged to provide the vaccine as part of routine care for all pregnant women. It is recognised that offering immunisation at the health venue women attend most when pregnant, and it being offered by their midwife, is the ideal route to improve access to, and uptake of, this vital protection for pregnant women. See Appendix E for more information.

## People aged under 65 in clinical risk groups

People in clinical risk  groups are at particular risk of becoming very unwell from flu and flu related illness. The table below shows flu mortality by clinical risk group and demonstrates the increased risk of death.

[25] Knight M et al (2014) MBRRACE Saving Lives, Improving Mothers' Care: National Perinatal Epidemiology. www.npeu.ox.ac.uk/mbrrace-uk/reports

**Table 3[26]: Influenza related mortality ratios and population rates among those aged six months to 64 years of age by risk group in England, September 2010-May 2011**

| | Number of fatal flu cases (%) | Mortality rate per 100,000 population | Age-adjusted relative risk* | Lower RR 95% CI | Upper RR 95% CI |
|---|---|---|---|---|---|
| **In a risk group** | 213 (59.8) | 4.0 | 11.3 | 9.1 | 14.0 |
| **Not in any risk group** | 143 (40.2) | 0.4 | Baseline | Baseline | Baseline |
| **Chronic renal disease** | 19 (5.3) | 4.8 | 18.5 | 11.5 | 29.7 |
| **Chronic heart disease** | 32 (9.0) | 3.7 | 10.7 | 7.3 | 15.7 |
| **Chronic respiratory disease** | 59 (16.6) | 2.4 | 7.4 | 5.5 | 10.0 |
| **Chronic liver disease** | 32 (9.0) | 15.8 | 48.2 | 32.8 | 70.6 |
| **Diabetes** | 26 (7.3) | 2.2 | 5.8 | 3.8 | 8.9 |
| **Immunosuppression** | 71 19.9) | 20.0 | 47.3 | 35.5 | 63.1 |
| **Chronic neurological disease (exc. stroke/TIA)** | 42 (11.8) | 14.7 | 40.4 | 28.7 | 56.8 |
| **Total*** | 378 | 0.8 | | | |

* Including 22 cases with no information on risk factors.

Mantel-Haenszel age-adjusted rate ratio (RR), with corresponding exact 95% CI calculated for each risk group using the two available age groups (from six months up to 15 years and from 16 to 64 years)

Despite continued efforts, for a number of years around only half of patients in clinical risk groups have been vaccinated. For 2017/18, the ambition for this cohort is to achieve at least a 55% uptake overall in these groups recognising that this figure is already exceeded in some of the groups, such as those with diabetes. Ultimately the aim is to achieve at least a 75% uptake in these groups.

The Community Pharmacy Seasonal Influenza Vaccination Advanced Service provides an excellent opportunity to inform and vaccinate people in these groups as the majority of these people visit their community pharmacies regularly to collect repeat prescriptions. There is also a role for doctors and specialist nurses in secondary care, health visitors, pharmacists and other caregivers to raise awareness of flu vaccine as part of the care pathway for people in clinical risk groups.

[26] Table reproduced from *Surveillance of influenza and other respiratory viruses in the UK 2011-12 report* by kind permission of PHE.

## People aged 65 and over

For a number of years the vaccine uptake rates for those aged 65 and over have been close to the WHO target of 75%. This represents a tremendous achievement especially given that the numbers in this group are growing due to an ageing population. Therefore, GP practices and other providers have vaccinated larger absolute numbers even though the uptake rate has remained similar or slightly fallen. Given the increased risk for older people of severe complications from flu, they remain an important target group.

## Healthcare workers with direct patient contact and social care workers

Frontline health and social care workers have a duty of care to protect their patients and service users from infection. This includes getting vaccinated against flu. The impact of flu on frail and vulnerable people in communities, care homes, and in hospitals can be fatal. In addition, immunisation against influenza should form part of the organisations' policy for the prevention of transmission of influenza to protect patients, residents, service users, staff and visitors.[27]

NHS organisations, local authorities, and independent care sector providers need to ensure that appropriate measures are in place for offering flu vaccination to their health and social care workers with direct patient/service user contact. This service is organised locally by these employers, often through the occupational health service for those organisations with one. GPs will only be involved in providing this part of the vaccination programme where this has been agreed locally. However, GP practices need to encourage and facilitate flu vaccination of their own staff through occupational health. Where staff are not vaccinated for any reason, employers should consider what alternative infection control measures should be put in place, for example wearing face masks.

NHS Employers run a national staff-facing campaign to encourage healthcare workers to get vaccinated. The campaign provides support to NHS Trusts in England running their local staff flu vaccinations campaigns, ensures consistency of message, shares good practice and harnesses clinical and professional leadership at both national and local levels. Further information and contact details can be found on the NHS Employers flu fighter website[28].
There are a range of printable and adaptable resources for use in the NHS and care sector.

[27]www.gov.uk/government/uploads/system/uploads/attachment_data/file/449049/Code_of_practice_280715_acc.pdf
[28] www.nhsemployers.org/flu

NHS England has published a two year CQUIN covering 2017/18 and 2018/19 which includes an indicator to improve the uptake of flu vaccinations for frontline healthcare staff within providers[29]. See Appendix D for more information.

## Carers

People in receipt of a carer's allowance, or who are the main carer of an older or disabled person whose welfare may be at risk if the carer falls ill, should be offered flu vaccination. This includes carers who are children. Practices should remind at-risk patients that if they have someone who cares for them, this person is also eligible for the flu vaccine. For more information including posters that can be downloaded and displayed in general practices, community pharmacies, and other locations visit the Carers Trust website for professionals[30].

## Commissioning services for those with particular needs

In addition to those patients who can attend a surgery or clinic to receive a vaccination, NHS England teams need to plan to offer vaccination to those who require home visits; those who are in long-term care; those who are not registered with a general practice; those children that do not attend the main stream private and state schools and those adults and children that do not readily engage with the health system. Commissioners may wish to consider the continuation of local innovative services, such as vaccination by pharmacists and in high risk settings such as care homes and special schools, where there is clear evidence of improved easy access and beneficial outcomes.

[29] www.england.nhs.uk/nhs-standard-contract/cquin/cquin-17-19/

[30] https://professionals.carers.org/flu-vaccinations-carers-campaign-useful-resources

# Appendix A: Treatment of flu

## Treatment at home

People with suspected flu who are not in the at-risks groups should:

- stay at home
- rest
- drink plenty of fluids while they are recovering
- seek advice from a pharmacist about the best remedy for their symptoms
- consider taking the appropriate dose of paracetamol/ibuprofen-based painkillers or cold remedies to lower their temperature and relieve their symptoms. Some cold remedies already contain paracetamol or ibuprofen, so some care needs to taken to ensure that people do not receive a double dose of either paracetamol or ibuprofen.
- avoid visiting GP surgeries and hospitals where they may infect other more vulnerable people and use community pharmacists as first port of call for early symptoms

## Antiviral medicines

Antiviral medicines can prevent the influenza virus from replicating inside the body. They can lessen symptoms by a couple of days and reduce their severity, and help to reduce the likelihood of complications.

Antiviral medicines are available on the NHS for certain groups of patients, including those in one of the identified at-risk categories as outlined in Appendix C.

It should be noted that NICE guidance states that during localised outbreaks of influenza-like illness (outside the periods when national surveillance indicates that influenza virus is circulating generally in the community), antiviral medicines may be given to at-risk people living in long-term residential or nursing homes, whether or not they are vaccinated. However, this should be done only if there is a high level of certainty that the causative agent in a localised outbreak is influenza.  The CMO/CPhO letter, when published, will provide more details.

## Treatment in secondary care

In certain groups and individuals, flu can progress from a mild flu-like illness manifesting as fever, cough, sore throat, headache, malaise, and muscle and joint pains to one in which there is shortness of breath, chest pain or confusion, indicative of pneumonia, and/or a significant exacerbation of an underlying medical condition (such as heart, liver,

lung or renal insufficiency or diabetes mellitus). Patients presenting with these symptoms will usually need assessment and treatment in hospital.

If the infection is thought to be due to a bacterial infection secondary to flu, then as well as using antiviral medicines, intravenous antibiotics will be used. The statutory Grey List restrictions for prescribing antiviral medicines in primary care do not apply to hospitals. Depending on the severity of the disease and any other co-morbidities, then some form of ventilation in a level 2 or level 3 critical care facility may be required. A pneumonia that is caused directly by the flu virus (as was the case in a number of hospitalised cases of H1N1 (2009) flu) is usually considered more serious, requiring a prolonged admission to a level 3 critical care facility where specialist ventilatory techniques may be needed.

For a few critically ill patients, a more invasive and complex intervention called Extra-Corporeal Membrane Oxygenation (ECMO) is required. ECMO involves removing blood from the patient, adding oxygen to the blood and then pumping it back into the patient in order to allow the lungs to heal. This is a complex procedure which is only carried out in certain specialist centres using highly trained specialist teams. It is high risk and is, therefore, only used as a matter of last resort in exceptional cases.

# Appendix B: Vaccine manufacture and supply

Flu vaccine manufacture and supply are undertaken on a global basis. Six international companies manufacture flu vaccines for the UK. They all also supply other European countries and some manufacture vaccine for North America as well.

Manufacturers make a decision on their overall flu vaccine production quantities based on expected demand from all the countries that they supply. Such estimates will be based on a number of factors, such as current quantities supplied; anticipated changes in vaccine recommendations in different countries; and other commercial decisions regarding market share. Based on this information, the manufacturers start their planning cycle, which includes reviewing existing production capacity and possible need for expansion; ordering sufficient pathogen-free eggs to meet production needs; and filling, packaging and labelling needs. This planning cycle starts 18 months before a flu vaccination programme.

The flu vaccine production ‘window’ is limited. WHO makes recommendations on the composition of the northern hemisphere flu vaccine in February. Its recommendations are based on the flu virus strains that they judge to be the most likely to circulate the following winter, and take into account data from the southern hemisphere flu season. Production of the vaccine usually runs from March to August/September, and packaging and labelling can continue until October. Once vaccine composition is agreed, then the manufacturers have to grow the vaccine viruses, formulate the vaccine, test, license, package and supply the vaccine within six months in order to ensure stocks are available for the beginning of the vaccination programme.

Following a thorough clean down of the production facility, most manufacturers then switch to flu vaccine production for the next southern hemisphere season. Hence, the flu vaccine production period is limited and complex, with little room for slippage in the process.

The UK arm of a vaccine manufacturer will take orders for flu vaccine from its customers from November to January for the following season, with the majority of orders being placed by December. The UK company, along with their sister companies in other countries, will then ‘bid’ for a share of vaccine supplies from their international headquarters. The process to finalise volume requirements for each country is completed at a national and European level between December and February/March. This completes a process on vaccine volumes that started with initial estimates made in the preceding May – that is 18 months prior to supply of vaccine.

Some manufacturers may plan to produce slightly greater quantities of vaccine than they have orders for. This allows for a number of eventualities such as: lower than anticipated



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vaccine yield; the potential of some vaccine batches to fail their release testing; late additional orders for vaccine. The quantity of surplus stock will vary year on year, and the manufacturers will sell what stock they have to the countries where there is demand.
It should be noted that flexibility is limited if the vaccine has already been packaged and labelled. The vaccine will only be available for use in those countries where it complies with the licence; so, for example, vaccine labelled in a foreign language would need a licence variation to be granted by the MHRA in order for the vaccine to be licensed for use in the UK. Licence conditions vary between countries and the MHRA may not necessarily agree to a licence variation.

Customers can place orders with manufacturers after March. However, it is likely that they will have a limited choice of vaccine and there is a risk that there will be no further vaccine available to order.

# Appendix C: Groups included in the national flu immunisation programme

1. In 2017/18, flu vaccinations will be offered under the NHS flu vaccination programme to the following groups:

- people aged 65 years or over
  (including those becoming age 65 years by 31 March 2018)
- people aged from 6 months to less than 65 years of age with a serious medical condition such as:
  - chronic (long-term) respiratory disease, such as severe asthma, chronic obstructive pulmonary disease (COPD) or bronchitis
  - chronic heart disease, such as heart failure
  - chronic kidney disease at stage three, four or five
  - chronic liver disease
  - chronic neurological disease, such as Parkinson's disease or motor neurone disease, or learning disability
  - diabetes
  - splenic dysfunction
  - a weakened immune system due to disease (such as HIV/AIDS) or treatment (such as cancer treatment)
  - morbidly obese (defined as BMI of 40 and above)
- all pregnant women (including those women who become pregnant during the flu season)
- all those aged two and three (but not four years or older) on 31 August 2017 (ie date of birth on or after 1 September 2013 and on or before 31 August 2015)
- all children in reception class and school years 1, 2, 3, and 4[31]
- primary school-aged children in former primary school pilots areas
- people living in long-stay residential care homes or other long-stay care facilities where rapid spread is likely to follow introduction of infection and cause high morbidity and

[31]Reception Year is defined as four rising to five year olds (ie date of birth between 1 September 2012 and on or before 31 August 2013)
Year 1 is defined as five rising to six year olds (ie date of birth between 1 September 2011 and on or before 31 August 2012)
Year 2 is defined as six rising to seven-year-olds (ie date of birth between 1 September 2010 and on or before 31 August 2011)
Year 3 is defined as seven rising to eight-year-olds (ie date of birth between 1 September 2009 and on or before 31 August 2010)
Year 4 is defined as eight rising to nine-year-olds (ie date of birth between 1 September 2008 and on or before 31 August 2009)
Some children in Reception year and years 1, 2, 3 and 4 might be outside of these date ranges (e.g. if a child has been accelerated or held back a year). It is acceptable to offer and deliver immunisations to these children with their class peers.

mortality. This does not include, for instance, prisons, young offender institutions, or university halls of residence

- people who are in receipt of a carer's allowance, or those who are the main carer of an older or disabled person whose welfare may be at risk if the carer falls ill
- consideration should also be given to the vaccination of household contacts of immunocompromised individuals, specifically individuals who expect to share living accommodation on most days over the winter and therefore for whom continuing close contact is unavoidable.

2. The list above is not exhaustive, and the healthcare practitioner should apply clinical judgement to take into account the risk of flu exacerbating any underlying disease that a patient may have, as well as the risk of serious illness from flu itself. Flu vaccine should be offered in such cases even if the individual is not in the clinical risk groups specified above.

3. It is also important that health and social care workers with direct patient/service user contact should be vaccinated as part of an employer's occupational health obligation.

| |
|---|
| Healthcare practitioners should refer to the Green Book influenza chapter for further detail about clinical risk groups included in the national flu immunisation programme. This is regularly updated, sometimes during the flu season, and can be found at: www.gov.uk/government/collections/immunisation-against-infectious-disease-the-green-book<br><br>Further information on the Section 7A service specifications for delivery of the seasonal influenza immunisation programme and the seasonal influenza programme for children can be found at: www.england.nhs.uk/commissioning/pub-hlth-res/ |



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# Appendix D: Health and social care worker vaccination programme

## Importance of vaccinating health and social care workers with direct patient/service user contact

Flu immunisation should be offered by NHS organisations to all employees directly involved in delivering care. Immunisation against influenza should form part of healthcare organisations' policy for the prevention of transmission of infection (influenza) to protect patients, staff and visitors[32]. In addition, frontline healthcare workers (ie staff involved in direct patient care) have a duty of care to protect their patients from infection. This is not an NHS service, but an occupational health responsibility provided to NHS staff by employers.

Social care providers, nursing and residential homes, and independent providers such as GPs, dental and optometry practices, and community pharmacists, should also offer vaccination to staff. Staff in the residential and care home sector and those providing care to people in their own homes are working with some of the most vulnerable people in our communities, so it is important that they help protect themselves and service users against flu.

Doctors are reminded of the General Medical Council's (GMC) guidance on Good Medical Practice (2013), which advises immunisation 'against common serious communicable diseases (unless otherwise contraindicated)' in order to protect both patients and colleagues[33].

Nurses, midwives and health visitors are reminded that the NMC Code requires registrants to "take all reasonable personal precautions necessary to avoid any potential health risks to colleagues, people receiving care and the public".[34]

Pharmacists are reminded by the General Pharmaceutical Council to consider getting vaccinated and to encourage their staff to get vaccinated as well.

The General Pharmaceutical Council advises pharmacy professionals providing key healthcare services, and often dealing with patients directly, to consider getting vaccinated and to encourage their staff to get vaccinated as well.

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[32] www.gov.uk/government/uploads/system/uploads/attachment_data/file/449049/Code_of_practice_280715_acc.pdf

[33] See paragraph 29 at: www.gmc-uk.org/guidance/good_medical_practice/your_health.asp

[34] www.nmc.org.uk/globalassets/sitedocuments/nmc-publications/nmc-code.pdf

Health professionals such as physiotherapists, radiographers and paramedics registered with the Health and Care Professionals Council, are reminded of the requirement: “You must take all reasonable steps to reduce the risk of harm to service users, carers and colleagues as far as possible.” [35]

Chapter 12 of the Green Book provides information on which groups of staff can be considered as involved in direct patient care[36].

Influenza outbreaks can arise in health and social care settings with both staff and their patients/service users being affected when flu is circulating in the community. It is important that staff get vaccinated to help protect themselves against flu as well as other staff and family members. Vaccination also reduces the risk of them passing the virus to vulnerable patients, residents, and service users, some of whom may have impaired immunity increasing their risks of flu and who may not respond well to vaccination.

Vaccination of healthcare workers with direct patient contact against influenza has been shown to significantly lower rates of influenza-like illness, hospitalisation and mortality in the elderly in long term healthcare settings[37,38,39, 40].

Vaccination of essential frontline workers helps reduce the level of sickness absenteeism that can jeopardise the NHS and care services. This is essential in the winter when pressures on these services increase.

Health and social care workers are a very influential group. Patients and service users trust their nurses, doctors, pharmacists and other health and care professionals and their opinions can affect the way they act.  A vaccinated member of staff can talk from first-hand experience and reassure them of the benefits of being vaccinated. Staff need to understand the benefits of the vaccine and dispel the myths that may have developed about the vaccine.

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[35] www.hcpc-uk.org/assets/documents/10004EDFStandardsofconduct,performanceandethics.pdf

[36] www.gov.uk/government/publications/immunisation-of-healthcare-and-laboratory-staff-the-green-book-chapter-12

[37] Potter, J, Stott, DJ, Roberts, MA *et al.* (1997). The influenza vaccination of health care workers in long-term-care hospitals reduces the mortality of elderly patients. *Journal of Infectious Diseases*; **175**:1-6.

[38]Carman, WF, Elder, AG, Wallace, LA *et al.* (2000) Effects of influenza vaccination of healthcare workers on mortality of elderly people in long term care: a randomised control trial. *The Lancet*; **355**:93-7.

[39]Hayward, AC, Harling, R, Wetten, S *et al*. (2006) Effectiveness of an influenza vaccine programme for care home staff to prevent death, morbidity, and health service use among residents: cluster randomised controlled trial. *British Medical Journal*; doi:10.1136/bmj.39010.581354.55 (published 1 December 2006).

[40]Lemaitre, M, Meret, T, Rothan-Tondeur, M *et al*. (2009) Effect of influenza vaccination of nursing home staff on mortality of residents:a cluster randomised trial. *Journal of American Geriatric Society*; **57**:1580-6.

A range of interventions can be employed to increase uptake[41]. Senior clinical staff can be influential in increasing staff awareness and understanding of the importance of staff vaccination against flu, and can lead by example to drive up rates of vaccination among frontline staff.

The Secretary of State for Health and CMO and other senior professionals take a keen interest in seeing increased flu vaccine uptake in healthcare and social care workers.

NHS Employers produce guidance and material to support trusts in delivering their own healthcare worker flu vaccination campaigns and provide advice to those running vaccination campaigns at local level. These materials can be accessed via the internet[42]. There are a range of printable and adaptable resources for use in the NHS and care sector.

Additionally, DH will continue to work with PHE, NHS England, and NHS Improvement to agree action to ensure trusts take the necessary action to increase uptake rates.

## Infection control

Immunisation against influenza should be an important part of healthcare organisations policy and strategy for the prevention of transmission of influenza and is an adjunct to other measures such as isolation of patients with respiratory infections. If a staff member is not vaccinated then consideration should be given to alternative approaches to reducing the spread of flu such as the wearing of face masks. Measures such as this are intended to provide a demonstrable commitment to infection prevention, building public confidence.

The code of practice on the prevention and control of infections and related guidance[43] reminds both NHS and social care bodies of their responsibilities. These are to ensure, so far as is reasonably practicable, that health and social care workers are free of, and are protected from exposure to, infections that can be caught at work, and that all staff are suitably educated in the prevention and control of infections.

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[41]Can we achieve high uptakes of influenza vaccination of healthcare workers in hospitals? A cross-sectional survey of acute NHS trusts in England. *Epidemiol Infect. 2013 May* **15**:1-10. http://journals.cambridge.org/abstract_S095026881300112X

[42]www.nhsemployers.org/flu

[43] https://www.gov.uk/government/publications/the-health-and-social-care-act-2008-code-of-practice-on-the-prevention-and-control-of-infections-and-related-guidance

This includes ensuring that occupational health policies and procedures in relation to the prevention and management of communicable diseases in healthcare workers, including immunisation, are in place.

The flu vaccination given to healthcare staff directly involved in patient care, and social care workers who are employed to provide personal care, acts as an adjunct to good infection prevention and control procedures. As well as reducing the risk to the patient/ service user of infection, the reduction of flu infection among staff, and reduced staff absenteeism, have also been documented.

## Commissioning for Quality and Innovation (CQUIN) guidance

NHS England has published a two year CQUIN covering 2017/18 and 2018/19 which includes an indicator to improve the uptake of flu vaccinations for frontline healthcare staff within providers[44]. As in previous years, the national ambition is that a minimum of 75% of staff in trusts are vaccinated against flu. However, in recognition of the fact that for some trusts this represents a significant amount of work, the CQUIN indictor (1c) for the first year is for providers to achieve an uptake of flu vaccinations by frontline healthcare staff of 70%, rising to 75% in the second year. Providers commissioned under the NHS Standard Contract will be eligible for CQUIN payments, e.g. acute, mental health, community and ambulance trusts.

## Who should be vaccinated?

Trusts/employers must ensure that health and social care staff directly involved in delivering care are encouraged to be immunised and that processes are in place to facilitate this.

Examples of staff who may be directly involved in delivering care include:

- clinicians, midwives and nurses, and ambulance crew
- occupational therapists, physiotherapists and radiographers
- primary care providers such as GPs, practice nurses, district nurses and health visitors
- social care staff working in care settings
- social care staff providing domiciliary care
- pharmacists, both those working in the community and in clinical settings
- staff working in direct support of clinical staff, often with direct patient care

[44] www.england.nhs.uk/nhs-standard-contract/cquin/cquin-17-19/

Students and trainees in these disciplines and volunteers who are working with patients should also be included. This is not an exhaustive list and decisions to provide immunisation should be based on local assessment of likely risk and exposure to flu.

For further information on data collection of vaccine uptake in healthcare workers see the ImmForm user guidance under ‘Seasonal flu vaccine uptake: data collection guidance’ at www.gov.uk/government/collections/vaccine-uptake



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# Appendix E: Pregnant women

## Rationale and target groups

There is good evidence that pregnant women are at increased risk from complications if they contract flu[45,46,47]. In addition, there is evidence that having flu during pregnancy may be associated with premature birth and smaller birth size and weight[48,49] and that flu vaccination may reduce the likelihood of prematurity and smaller infant size at birth associated with an influenza infection during pregnancy[50]. Furthermore, a number of studies shows that flu vaccination during pregnancy provides passive immunity against flu to infants in the first few months of life[51,52,53,54,55].

A review of studies on the safety of flu vaccine in pregnancy concluded that inactivated flu vaccine can be safely and effectively administered during any trimester of pregnancy and that no study to date has demonstrated an increased risk of either maternal complications or adverse fetal outcomes associated with inactivated influenza vaccine[56].

**All pregnant women** are recommended to receive the inactivated flu vaccine irrespective of their stage of pregnancy.

## When to offer the vaccine to pregnant women

The ideal time for flu vaccination is before flu starts circulating. However, even after flu is in circulation vaccine should continue to be offered to groups such as newly pregnant women. Clincians should apply clinical judgement to assess the needs of an individual woman,

45 Knight M et al (2014) MBRRACE Saving Lives, Improving Mothers' Care : National Perinatal Epidemiology

46 Neuzil KM, Reed GW, Mitchel EF et al. (1998) Impact of influenza on acute cardiopulmonary hospitalizations in pregnant women. Am J Epidemiol. 148:1094-102.

47 Pebody R et al. (2010) Pandemic influenza A (H1N1) 2009 and mortality in the United Kingdom: risk factors for death, April 2009 to March 2010. Eurosurveillance 15(20):19571.

48 Pierce M, Kurinczuk JJ, Spark P et al. (2011) Perinatal outcomes after maternal 2009/H1N1 infection: national cohort study. BMJ. 342:d3214.

49 McNeil SA, Dodds LA, Fell DB et al. (2011) Effect of respiratory hospitalization during pregnancy on infant outcomes. Am J Obstet Gynecol. 204:(6 Suppl 1) S54-7.

50 Omer SB, Goodman D, Steinhoff MC et al. (2011) Maternal influenza immunization and reduced likelihood of prematurity and small for gestational age births: a retrospective cohort study. PLoS Med. 8:(5) e1000441.

51 Benowitz I, Esposito DB, Gracey KD et al. (2010) Influenza vaccine given to pregnant women reduces hospitalization due to influenza in their infants. Clin Infect Dis. 51:1355-61.

52 Eick AA, Uyeki TM, Klimov A et al. (2010) Maternal influenza vaccination and effect on influenza virus infection in young infants. Arch Pediatr Adolesc Med. 165:104-11.

53 Zaman K, Roy E, Arifeen SE et al. (2008) Effectiveness of maternal influenza immunisation in mothers and infants. N Engl J Med. 359:1555-64.

54 Poehling KA, Szilagyi PG, Staat MA et al.(2011) Impact of maternal immunization on influenza hospitalizations in infants. Am J Obstet Gynecol. 204:(6 Suppl 1)S141-8.

55 Dabrera G, Zhao H, Andrews N et al. (2014) Effectiveness of seasonal influenza vaccination during pregnancy in preventing influenza infection in infants, England, 2013/14. Eurosurveill. Nov 13:19. www.eurosurveillance.org/ViewArticle.aspx?ArticleId=20959

56 Tamma PD, Ault KA, del Rio C et al. (2009) Safety of influenza vaccination during pregnancy. Am. J. Obstet. Gynecol. 201(6):547-52.

taking into account the level of flu-like illness in their community and the fact that the immune response following flu vaccination takes about two weeks to develop fully.

## Data review and data recording

Uptake of vaccine by pregnant women, along with other groups, will be monitored. GPs will need to check their patient database throughout the flu season in order to identify women who are not pregnant at the start of the immunisation programme but become pregnant during the winter. GPs should also review their records of pregnant women before the start of the vaccination programme to ensure that women who are no longer pregnant are not called for vaccination (unless they are in other clinical risk groups) and so that they can measure the uptake of flu vaccine by pregnant women accurately.

## Maternity services

Midwives need to be able to explain the benefits of flu vaccination to pregnant women and either refer them back to their GP practice or a community pharmacy for the vaccine or offer the vaccine in the maternity service itself. A number of different models exist including running flu vaccination clinics alongside the maternity service, where cold storage facilities exist. NHS England teams will explore ways of commissioning maternity services to provide flu vaccination or linking maternity services with GP practices or community pharmacies where relevant. If arrangements are put in place where midwives or community pharmacies administer the flu vaccine, it is important that the patient's GP practice is informed in a timely manner, ideally by the end of the next working day, so their records can be updated accordingly, and included in vaccine uptake data collections. Maternity providers should ensure they inform GPs when a woman is pregnant or no longer pregnant.



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# Appendix F: GP practice checklist

Practices are encouraged to implement the guidelines below which are based on evidence about factors associated with higher flu vaccine uptake[57]. For guidance on improving uptake among children in general see 'Increasing influenza immunisation uptake among children' on the GOV.UK website[58].

## Named lead

1. Identify a named lead individual within the practice who is responsible for the flu vaccination programme and liaises regularly with all staff involved in the programme.

## Registers and information

2. Hold a register that can identify all pregnant women and patients in the under 65 years at risk groups, those aged 65 years and over, and those aged two and three years.

3. Update the patient register throughout the flu season paying particular attention to the inclusion of women who become pregnant and patients who enter at risk groups during the flu season.

4. Submit accurate data on the number of its patients eligible to receive flu vaccine and the flu vaccinations given to its patients on ImmForm (www.immform.dh.gov.uk), ideally using the automated function. Submit data on uptake among healthcare workers in primary care using the ImmForm data collection tool.

## Meeting any public health ambitions in respect of such immunisations

5. Order sufficient flu vaccine taking into account past and planned improved performance, expected demographic increase, and to ensure that everyone at risk is offered the flu vaccine. It is recommended that vaccine is ordered from more than one supplier and in respect of children from PHE central supplies through the ImmForm website.

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[57] Dexter, L. *et al.* (2012) Strategies to increase influenza vaccination rates: outcomes of a nationwide cross-sectional survey of UK general practice. http://bmjopen.bmj.com/content/2/3/e000851.full

[58] www.gov.uk/government/collections/annual-flu-programme

## Robust call and recall arrangements

6. Invite patients recommended to receive the flu vaccine to a flu vaccination clinic or to make an appointment (eg by letter, e-mail, phone call, text)[59]. This is a requirement of the enhanced service specification.

7. Follow-up patients, especially those in at risk groups, who do not respond or fail to attend scheduled clinics or appointments.

## Maximising uptake in the interests of at-risk patients

8. Start flu vaccination as soon as practicable after receipt of the vaccine. This will help ensure the maximum number of patients are vaccinated as early as possible and are protected before flu starts to circulate. Aim to complete immunisation of all eligible patients before flu starts to circulate and ideally by end of December.

9. Collaborate with maternity services to offer and provide flu vaccination to pregnant women and to identify, offer and provide to newly pregnant women as the flu season progresses.

10. Offer flu vaccination in clinics and opportunistically.

11. Where the patient has indicated they wish to receive the vaccination but is physically unable to attend the practice (for example is housebound) the practice must make all reasonable effort to ensure the patient is vaccinated. The GP practice and/or CCG will collaborate with other providers such as community or health and social care trusts to identify and offer flu vaccination to residents in care homes, nursing homes and house-bound patients, and to ensure that mechanisms are in place to update the patient record when flu vaccinations are given by other providers.

[59] Template letters will be available from: www.gov.uk/government/collections/annual-flu-programme

# Appendix G: Levels of activity

| Levels | Level of flu-like illness | Description of flu season |
|---|---|---|
| **1** | Community, primary and/or secondary care indicators starting to show that flu and flu-like illness are being detected | Beginning of the flu season – flu has now started to circulate in the community |
| **2** | Flu indicators starting to show that activity is rising | Normal levels of flu and/or normal to high severity of illness associated with the virus |
| **3** | Flu indicators exceeding historical peak norms | Epidemic levels of flu – rare for a flu season |

| **Activity that would be undertaken at Level 1** | |
|---|---|
| **Level 1** | • review data on flu activity and severity from the southern hemisphere<br>• GPs invite their eligible patients to be vaccinated, using call and reminder systems<br>• Community pharmacies offering flu vaccination through the advanced service offer vaccine to those eligible<br>• GPs make arrangements to vaccinate patients who cannot attend the surgery because of frailty, severe chronic illness or disability<br>• GPs encourage and facilitate their own frontline staff to be vaccinated<br>• other NHS, local authority, care home employers and community pharmacies arrange for their frontline staff to be vaccinated<br>• data on flu incidence and vaccine uptake rates in England issued at a national and, if available, regional/local levels<br>• data on ILIs, virological surveillance, vaccine uptake and NHS operational data published<br>• PHE publishes weekly reports on flu incidence, vaccine uptake, morbidity and mortality<br>• If vaccine uptake is low NHS England Directors of Commissioning Operations and local public health teams work with providers to improve uptake in season.<br>• PHE in contact with vaccine manufacturers on production and delivery schedules<br>• DH in contact with antiviral medicine manufacturers on their preparedness plans<br>• the respiratory and hand hygiene campaign may be launched |

| Activity that would be undertaken in Level 2 | |
|---|---|
| **Level 2** | • Prescribers and community pharmacies will be alerted through a CMO/CPhO letter, to start prescribing and supplying antiviral medicines in line with the NICE guidance and Schedule 2 to the National Health Service (General Medical Services Contracts) (Prescription of drugs etc) Regulations 2004), commonly known as the Grey List or Selected List Scheme (SLS) and following expert advice that the flu virus is circulating<br>• if evidence emerges that a particular age group or people with certain clinical conditions are being disproportionately affected by the flu virus, a joint letter on behalf of DH, NHS England, and PHE may issue specific advice to both the public and health professionals to increase efforts to vaccinate that particular group, if practicable and seeking expert advice from JCVI if necessary<br>• local NHS responds to local circumstances according to local plans and needs<br>• review daily NHS operational data, eg critical care<br>• CMO or representatives of PHE or NHS England may provide a media briefing to provide clear, factual information on flu. This may include information for the public about what to do if they become unwell and advice on accessing services<br>• vaccine manufacturers contacted by PHE regarding the availability of additional supplies if needed<br>• in the event of shortages of antiviral medicines, and an evident public health need, PHE would take steps to support arrangements for supplies by using its pandemic flu stocks as buffers in the supply chain. In this system, government stocks of antiviral medicines would be supplied to the manufacturers who would distribute to community and hospital pharmacies using their normal supply chain mechanisms. Plans will be in place with the manufacturers to replenish stocks that were used from the national stockpile.<br>• DH will work closely with antiviral medicines manufacturers, wholesalers and pharmacies to minimise disruptions of supply of antiviral medicines to patients<br>• DH will work closely with antibiotic manufacturers, wholesalers and pharmacies to minimise disruptions of supply to patients<br>• DH will receive at least weekly reports of levels of antiviral medicines in the supply chain |



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| Activity that would be undertaken in Level 3 | |
|---|---|
| **Level 3** | • a national flu epidemic is declared<br>• GPs alerted that a late surge in demand for the vaccine may occur and that there may be greater use of antiviral medicines<br>• vaccine manufacturers contacted by PHE regarding availability of additional supplies<br>• antiviral medicines manufacturers contacted regarding availability of additional supplies, with more regular updates on levels of antiviral medicines in the supply chain, eg daily reporting<br>• JCVI will review the available data and amend guidance on vaccination if necessary and if sufficient supplies of vaccine are available and can be delivered and administered in time<br>• PHE may extend the vaccine uptake collections for additional weeks/months if vaccine uptake rates are still rising<br>• weekly press briefings will be considered. These will be led by CMO or representatives of PHE or NHS England<br>• maintain or boost the respiratory and hand hygiene campaign<br>• proactive work with media to allay any public concerns<br>• reiterate advice on signs and symptoms, and treatment at home<br>• communicate regularly with clinical and professional networks and stakeholder groups for patients at risk of severe illness<br>• regular liaison with pharmacy organisations to keep abreast of any supply problems associated with antiviral medicines<br>• vigilance required with manufacturers of antiviral medicines to ensure they have plans inplace to obtain additional stocks if necessary<br>• continue to review daily NHS operational data, for example, critical care<br>• alert the NHS when the flu season has peaked, to aid local planning |



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# Appendix H: Potential scenarios

The table below gives examples of factors affecting the DH, PHE, NHS England and the NHS flu response during the flu season, and describes the actions they could take in response. It should be noted that this table is indicative – it cannot cover all potential eventualities and the consequential actions.

| | Event | Action |
|---|---|---|
| **Vaccination** | Delay in vaccine released from manufacturer | PHE communicates with NHS, via NHS England, informing them of delay so GP practices, community pharmacists and other providers can reschedule vaccination clinics |
| | Production problems mean insufficient doses of vaccine are available nationally | PHE communicates with NHS, via NHS England, informing them of shortage and advising which risk groups to prioritise, following JCVI advice as appropriate |
| | Vaccine uptake remains below expected rate for the time of year. Virus adversely affects groups outside those recommended for vaccination | Joint letter issued on behalf of DH, PHE, and NHS England to NHS recommending appropriate action to increase uptake |
| | The vaccine does not protect against the predominant circulating strain | PHE, via NHS England, communicates the issue to GPs, community pharmacists and the public. The flu vaccination programme is maintained to ensure that older people and those in clinical risk groups are protected against the two or three other strains of flu covered by the vaccine<br>PHE alerts the NHS, via NHS England, that they may have higher numbers of flu cases to manage, and reminds prescribers that the regulations have been broadened to give them some discretion to prescribe antiviral medicines for patients who are not in one of the identified clinical at-risk groups, but who they consider may be at risk of developing serious complications from flu and could benefit from receiving treatment. It is expected that prescribers will be guided by |

| | Event | Action |
|---|---|---|
| | | the CMO in the use of this discretion<br>DH contacts manufacturers of antiviral medicines to check levels of antiviral medicines available from manufacturers and discusses arrangements to get additional supplies should the need arise<br>PHE considers launching the respiratory and hand hygiene campaign |
| | Issue over safety of vaccine emerges | The Medicines and Healthcare products Regulatory Agency (MHRA) considers the available evidence and recommends course of action. Depending on balance of risks and benefits, MHRA may amend prescribing advice to minimise any risks. Action may be taken by the European Medicines Agency (EMA). PHE and/or MHRA will give advice on implications of safety issue<br>PHE communicates with the NHS, via NHS England, informing it of the consequences of the safety issue if it impacts on supplies and advising which risk groups to target, following JCVI advice as appropriate |
| **Treatment** | Antiviral medicines not available from pharmacies | DH discusses stock levels with manufacturers and wholesalers to determine whether they can meet the increased demand<br>DH has regular contact with pharmacy organisations to determine any problems that community pharmacies may be encountering obtaining supplies of antiviral medicines, to inform discussions with manufacturers of antiviral medicines and wholesalers<br>PHE considers releasing the national stockpile to ease shortages, if appropriate |

| | Event | Action |
|---|---|---|
| **NHS operations** | Extra cases put increased pressure on care locally | Local action in line with local plans, under existing contractual arrangements |
| | Extra cases put excessive pressure on care regionally or nationally | NHS England teams, PHE, DH and the NHS Chief Executive keep under review the need to trigger strategic command arrangements for the NHS, as per 'The NHS England Emergency Preparedness, Resilience and Response Framework'[60] |
| **Media coverage** | Increased media interest on particular issues | CMO and/or representatives of PHE and NHS England hold press briefing to communicate the facts and latest data to the media |

[60] www.england.nhs.uk/wp-content/uploads/2015/11/eprr-framework.pdf

# Useful links

| Document | Web link |
|---|---|
| National Flu plan | www.gov.uk/government/collections/annual-flu-programme |
| Green Book Influenza Chapter | www.gov.uk/government/publications/influenza-the-green-book-chapter-19 |
| NHS England Public Health Functions Agreement 2017/18 (known as Section 7A agreement) | www.england.nhs.uk/commissioning/pub-hlth-res/ |
| NHS England enhanced service specification (For GP providers) | www.england.nhs.uk/commissioning/gp-contract/ |
| Immform Survey User guide for GP practices, local NHS England teams, and NHS Trusts<br><br>Flu vaccine uptake figures | www.gov.uk/government/collections/vaccine-uptake |
| ImmForm website for ordering child flu vaccines | www.immform.dh.gov.uk |
| Flu immunisation PGD templates (Note: These templates require authorisation before use) | www.gov.uk/government/collections/immunisation-patient-group-direction-pgd |
| National Q&As / training slide sets/ e-learning programme | www.gov.uk/government/collections/annual-flu-programme<br>www.e-lfh.org.uk/programmes/flu-immunisation/ |
| Seasonal flu/influenza GP practice vaccination programmes supporting documents | www.nhsemployers.org/vandi201718 |
| NHS England Commissioning for Quality and Innovation (CQUIN) Guidance for 2017/18 & 2018/19 | www.england.nhs.uk/nhs-standard-contract/cquin/cquin-17-19/ |
| Vaccine Update<br><br>To **register** to receive the monthly newsletter by email please go to: | www.gov.uk/government/collections/vaccine-update<br><br>https://public.govdelivery.com/accounts/UKHPA/subscribers/new?preferences=true |
| NHS Employers Flu Fighter campaign | www.nhsemployers.org/flu |

| | |
|---|---|
| PHE Immunisation home page | www.gov.uk/government/collections/immunisation |
| PHE Flu Immunisation Programme home page | www.gov.uk/government/collections/annual-flu-programme |



Gateway: 2016697
NHS Gateway:06560

# Berkshire Seasonal Influenza Vaccine Campaign 2016-17; final uptake figures and feedback from local authority public health teams

## Executive Summary

1. **Background** - Seasonal influenza (Flu) is a key factor in NHS winter pressures. The National Flu Plan aims to reduce the impact of flu in the population through a series of complementary measures. Flu vaccination is commissioned by NHS England for groups at increased risk of severe disease or death should they contract flu.

   Key aims of the immunisation programme in 2016-17 were to;

   - Actively offer flu vaccine to 100% of people in eligible groups.
   - Immunise 60% of children, with a minimum 40% uptake in each school
   - Maintain and improve uptake in over 65s clinical risk groups with at least 75% uptake among people 65 years and over and 75% among healthcare workers

2. **Role of local authorities** - the role of local authorities in the flu programme is to provide advocacy and leadership through the Director of Public Health and to promote uptake of flu vaccination among eligible residents and among staff providing care for people in residential and nursing care. Local authorities are responsible for providing flu vaccine for frontline health and social care workers that are directly employed. Local authorities may also provide vaccine to staff members as part of business continuity arrangements.

3. **Local uptake** - In keeping with the national and regional picture, uptake of vaccine among GP-registered patients in Berkshire was generally higher in 2016-17 than in 2015-16. Along with Bracknell and Ascot, Windsor Ascot and Maidenhead and Wokingham CCGs, Slough CCG reported improved uptake across all GP-registered patient groups.

   - **Patients in clinical risk groups** - uptake increased in all CCGs with the exception of South Reading
   - **Over 65s** - the 75% target was not met in any CCG, in line with regional and national uptake
   - **Pregnant Women** - Uptake was down on the previous flu season in Newbury & District, North & West Reading and South Reading. This is in contrast to uptake in Thames Valley and at the national level, where uptake increased.
   - **Children aged 2 to 4** - uptake among 2 year olds increased in all Berkshire CCGs with the exception of North & west Reading and South Reading, uptake among 3 year olds increased or was maintained in all CCG areas. For four years olds, uptake increased in all CCGs except North & West Reading
   - **Children in school years 1 to 3** - the 40% overall uptake target was reached or exceeded in every Berkshire LA
   - **Healthcare workers** - Uptake in Royal Berkshire Foundation Trust was 60.6% compared to the 48.6% previous flu season. Berkshire Healthcare Foundation Trust achieved a 76.2% uptake rate, an increase from 64.1% and the highest in Thames Valley

## 4. Summary

Local Authority public health teams actively promoted flu vaccination to eligible groups using a range of channels and worked with commissioners and providers during the season to identify issues. Whilst uptake among school children was good, uptake in other risk groups remains below the desired level; this is in line with other areas of the country. There remains considerable variation in uptake between GP practices, both within and between CCGs. There is scope to improve communicating uptake to practices throughout the flu season and to improve the way patients are invited for vaccination. Myths and misconceptions regarding vaccines remain an important barrier to uptake. Other barriers may include variation in access to GP flu clinics, lack of health literacy and inclusion of porcine element in the children's vaccine making it inappropriate for some groups. Uptake among front line local authority social care workers remains difficult to measure; there is scope to improve data collection in this area. Providers of residential care are not consistently offering flu vaccine to employees in line with national recommendations, this remains challenging for local authorities to influence.

### Key recommendations for LA Public Health Teams

- Establish a joint flu communications plan with CCG comms colleagues ahead of the flu campaign launch and ensure LAs provide regular updates on planned timing and nature of LA flu comms to the CCGs to improve the uptake of opportunities to share communications. Communications should take account of uptake in each eligible group and target appropriately
- Ensure communication between all LAs in the summer period to establish model for staff flu vaccine offer in order to secure most cost-effective and accessible
- Deliver a separate event/ specific publicity for training/planning for Care Agencies/ residential homes to advocate for provision of staff vaccines and support employers
- Work with commissioners of residential, nursing and domiciliary care to include KPIs around staff flu vaccine and record keeping
- Liaise more closely with PHE colleagues to measure and communicate the impact of suspected and confirmed flu outbreaks in care home and childcare settings
- Continue to engage with hospital specialists and local patient advocates to help promote flu vaccine to patients with clinical risk conditions
- Support the school immunisation team to communicate with schools and head-teachers on the flu programme ahead of the autumn term and throughout flu season

## 1. Seasonal influenza

Seasonal influenza (Flu) is a key factor in NHS winter pressures. It impacts on those who become ill, the NHS services that provide direct care, and on the wider health and social care system that supports people in at-risk groups. Flu occurs every winter in the UK. The National Flu Plan aims to reduce the impact of flu in the population through a series of complementary measures. These measures help to reduce illness in the community and unplanned hospital admissions, and therefore pressure on health services generally and A&E in particular. The plan is therefore a critical element of the system-wide approach for delivering robust and resilient health and care services throughout the year. Successful local implementation of the flu plan depends on partnership working between stakeholders at National and local levels. Key stakeholders include Department of Health, NHS England, Clinical Commissioning Groups, GPs, Community Pharmacy, PHE, Local Authorities and community groups.

## 2. Role of the local authority

The National Flu plan states that;

Local authorities, through their DsPH, have responsibility for:

- providing appropriate advocacy with key stakeholders and challenge to local arrangements to ensure access to flu vaccination and to improve its uptake by eligible populations
- providing leadership, together with local resilience partners to respond appropriately to local incidents and outbreaks of flu infection

Local authorities can also assist by:

- promoting uptake of flu vaccination among eligible groups, for example older people in residential or nursing care, either directly or through local providers
- promoting uptake of flu vaccination among those staff providing care for people in residential or nursing care, either directly or through local providers

## 3. 2016-17 Flu activity

Moderate levels of influenza activity were seen in the community in the UK in 2016 to 2017, with influenza A(H3N2) the dominant circulating virus for the majority of the season peaking in week 01 2017. The majority of circulating A(H3N2) strains in the UK were genetically and antigenically similar to the Northern Hemisphere 2016/17 (H3N2)vaccine strain, this is in line with many Northern Hemisphere countries.

Nationally the impact of influenza A(H3N2) was predominantly seen in older adults, with a consistent pattern of outbreaks in care homes noted, a total of 1,055 acute respiratory illness outbreaks in closed settings were reported in the UK to PHE compared to 656 in 2015 to 2016 and 687 in 2014 to 2015. 78.3% of reported outbreaks occurred in care homes in 2016-17, compared to 75% in 2014/15, the most recent A(H3N2) dominant season. Reported outbreaks peaked in week 1 of 2017 (Figure 1).

Levels of excess all-cause mortality were elevated particularly in the elderly, but were lower than the 2014/15 season in which influenza A(H3N2) also dominated.

**Figure 1: Reported Outbreaks (National)**

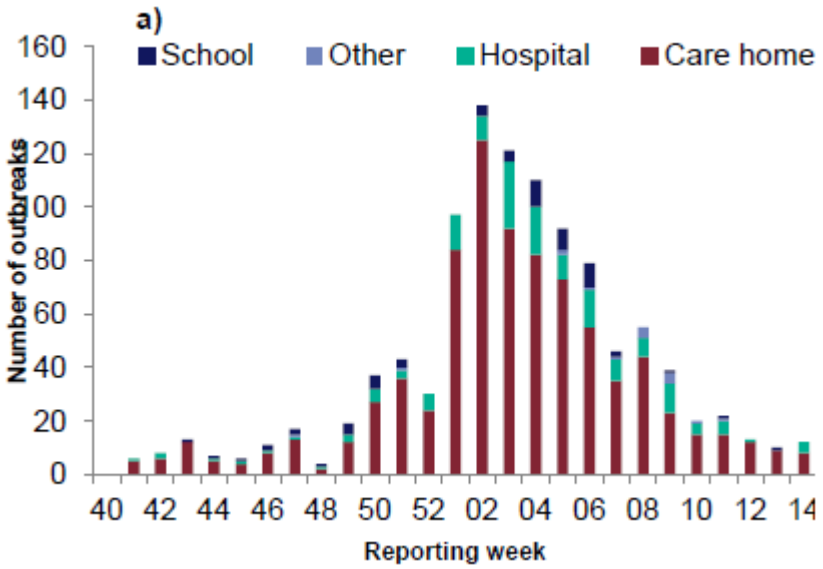



Figure taken from Surveillance of influenza and other respiratory viruses in the UK: Winter 2016 to 2017 (PHE, 2017)

## 4. Local outbreaks

There were 25 outbreaks of influenza-like illness (ILI) reported in the Thames Valley between 1st September 2016 and 31st March 2017, of these 21 were in care, residential and nursing home settings. 14 of the ILI outbreaks reported during this time period received laboratory confirmation for swabs taken. In all outbreaks where testing was undertaken, the result returned was positive for Influenza A.

There were four outbreaks in which deaths were recorded with influenza-like-illness listed as a possible contributing factor (based on self-report from the care home and not death certificates). Hospitalisation of residents was required in 13 outbreaks. The highest number of hospitalisations during an outbreak was eight residents from one establishment**.**

## 5. Flu vaccine efficacy

At time of publication this data had not been released by the national team for 2016-17

## 6. Groups eligible for vaccination

Flu vaccination remains the best way to protect people from flu. People in certain groups are at increased risk of severe symptoms and deaths if they contract flu, these groups were eligible for free flu vaccine in 2016-17.

- Adults aged 65 or above
- Children aged 2 to 4 years or in school years 1, 2 and 3
- Pregnant women
- Paid and unpaid carers
- Frontline health and social-care workers
- People living in long-stay residential care homes,
- Adults and children (6 months to 64 years) with one or more of the following conditions;
    - a heart problem
    - a chest complaint or breathing difficulties, including bronchitis, emphysema or severe asthma
    - kidney disease
    - lowered immunity due to disease or treatment (such as steroid medication or cancer treatment)
    - liver disease
    - stroke or a transient ischaemic attack (TIA)
    - diabetes
    - a neurological condition, e.g. multiple sclerosis (MS), cerebral palsy or learning disability

The only change to the programme in 2016-17 compared to 2015-16 was the extension of the offer of live attenuated influenza vaccine (LAIV) to children of appropriate age for school year 3, in addition to those children in school years 1 and 2. This is in line with the principle for future extension of the programme to extend upwards through the age cohorts.

In Berkshire, children of appropriate age for school years 1, 2 and 3 were offered flu vaccine in school, with arrangements in place to ensure home-schooled children are also offered a vaccine.

## 7. Aims of the flu immunisation programme

The aims of the immunisation programme in 2016-17 were to;

- Actively offer flu vaccine to **100%** of people in eligible groups.
- Immunise 60% of children, with a minimum **40%** uptake in each school
- Maintain and improve uptake in over 65s and 6 months to 64 years in clinical risk groups with at least **75%** uptake for those aged 65 years and over and **75%** uptake for health and social care workers
- Improve uptake over and above last season among those in clinical risk groups and prioritise those with the highest risk of mortality from flu but who have the lowest rates of vaccine uptake (i.e. immunosuppression, chronic liver and neurological disease, including people with learning disabilities); achieving at least 55% uptake in all clinical risk groups and maintain higher rates where they have previously been achieved.

## 8. Communications and resources

In 2016-17, flu vaccine was for the second year running included as a component of the jointly coordinated PHE and NHS England “Stay well this winter” campaign.

Resources were available from the online PHE Campaign Resources Centre

Local authorities used their social media accounts to enforce national messages on flu vaccine as well as other winter health messages. A Berkshire press release template was prepared for local modification by local authority public health teams. Leaflets and posters from the national resource centre were distributed to local venues including Children’s centres, childcare settings and local shops by Berkshire public health teams. Easy-read versions of the leaflet were shared with LA Learning Disabilities colleagues for use with their clients. Flu vaccine was promoted to carers during national carer’s rights day (20/11/2015) and to those with long term conditions as part of national self-care week (16-22/11/2015)

## 9. Local plans

Across Berkshire residents were able to access flu vaccine in a number of ways **Table 1**

**Table 1: Access to flu vaccine for eligible groups**

| Group | Provider |
|---|---|
| Children aged 2 to 4 | Primary Care |
| Children in School years 1, 2 and 3 | School based programme delivered by Berkshire Healthcare Trust |
| Special Schools | School based programme delivered by Berkshire Healthcare Foundation Trust |
| Adults aged 65 or above | Primary Care or Community Pharmacy |
| Adults in clinical risk groups | Primary Care or Community Pharmacy |
| Children in clinical risk groups | Primary Care (or through special school programme) |
| Paid and unpaid carers | Primary Care or Community Pharmacy |
| Pregnant Women | Maternity Unit at Royal Berkshire Hospital, Wexham Park Hospital or Primary Care |
| Health and social care workers | Via occupational health arrangements |

A stakeholder workshop was held in June 2016, this was jointly delivered by Jo Greengrass (East Berks CCGs), Dr Chris Cook and Harpal Aujla, Screening and Immunisation Team NHS England South - South Central and Berkshire local authority public health teams. Participants from a range of stakeholder organisation attended, including representatives from Berkshire CCGs, GP practices, NHS provider organisations, Public Health England, drug and alcohol commissioners and providers and public health teams across Berkshire.

The aims of the workshop were to;

- hear NHS England commissioning intentions for 2016-17
- review campaigns and uptake for the previous 2015-16 season
- draw on learning to develop local plans for promotion of vaccine to all eligible groups in 2017-18

Outputs from the workshop enabled stakeholders in each locality to identify key actions for inclusion in their local ‘Flu Action Plan’, building on work done in the previous flu season.

The plans set out key actions that LA teams would take to promote vaccine to each of the eligible groups. Actions included but were not limited to,

- promoting flu vaccine though joint communications initiatives with local CCGs
- use of corporate and public health social media channels to communicate with residents
- Internal comms to LA staff, including LA newsletters, intranet articles and internal screen-savers
- attending local events and workshops such as National Carers Day
- distributing national campaign materials to other local organisations such as children’s centres, child minders and organisations supporting older people and people with learning disabilities
- promoting through LA newsletters and websites
- providing leaflets to older people at lunch clubs and when collecting a free bus-pass
- placing promotional materials in community settings used by older people and young families

- working with clinical leads in HIV and Neurology to include messages prompting those in specific clinical risk groups to attend GP or pharmacy for a free flu vaccine
- working with care staff to advocate to those with stable neurological conditions living in the community
- in collaboration with NHS England, working with Occupational Health leads in RBH and Wexham Park Hospitals to develop and distribute flyers prompting healthcare staff to promote flu vaccine to patients in clinical risk groups who receive care in hospital, e.g. people living with COPD, chronic liver disease, chronic kidney disease or receiving care for chronic heart disease or a neurological condition
- a letter was sent to Healthwatch asking for their support in making people aware of their eligibility and right to receive a free flu vaccine
- Using links into parish councils to communicate in other community settings and village events

All communications and promotional materials were part of the suite of 'Stay Well This Winter' materials provided nationally by NHS England, no locally produced campaign materials were produced, following guidance from NHS England South Central Flu leads.

In addition to the fortnightly Thames-Valley teleconferences led by NHS England, fortnightly teleconferences or meetings were held in East and West Berkshire to monitor flu levels, vaccine uptake and progress with local actions.

## 10. Uptake Figures 2017-18

Uptake of vaccine in primary care, community pharmacy and among healthcare workers is monitored by Public Health England. During Flu season NHS England commissioners of the vaccine programmes extracted and collated uptake data from GP practices on a weekly basis and nationally on a monthly basis. Data on numbers of vaccines provided to adults through community pharmacy and to pregnant women by NHS midwives was monitored by NHSE and shared with stakeholders.

### *10.1. GP registered patients by CCG*

In keeping with the national and regional picture, uptake of vaccine among GP-registered patients in Berkshire was generally higher in 2016-17 than in 2015-16. Along with Bracknell and Ascot, Windsor Ascot and Maidenhead and Wokingham CCGs, Slough CCG reported improved uptake across all GP-registered patient groups, see Table 2.

In line with regional and national picture, no Berkshire CCG achieved the 75% target for patients aged 65 and above.

Among patients in clinical risk groups, uptake increased in all CCGs with the exception of South Reading.

Uptake among pregnant women was down on the previous flu season in Newbury & District, North & West Reading and South Reading, in contrast to uptake in this group in Thames Valley and at the national level, where uptake increased.

Uptake among 2 year olds increased in all Berkshire CCGs with the exception of North & west Reading and South Reading, uptake among 3 year olds increased or was maintained in all CCG areas. For four years olds, uptake increased in all CCGs except North & West Reading.

**Table 2: Flu vaccine uptake among GP registered patients - Sept 1 2016 to Jan 31 2017 in comparison to 2015/16 time-point.***

| CCG | Summary of Flu Vaccine Uptake % | | | | | |
|---|---|---|---|---|---|---|
| | 65 and over | Under 65 (at-risk) | All Pregnant Women | 2 Years old | 3 Years old | 4 Years old |
| NHS BRACKNELL AND ASCOT | 70.9 | 54.0 | 51.1 | 49.5 | 50.5 | 41.0 |
| 2015/16 Variation | 0.6 | 4.1 | 1.2 | 10.5 | 4.3 | 7.3 |
| NHS NEWBURY AND DISTRICT | 74.4 | 55.7 | 45.1 | 53.6 | 53.9 | 46.3 |
| 2015/16 Variation | 0.5 | 6.0 | -4.7 | 2.6 | 3.1 | 0.7 |
| NHS NORTH & WEST READING | 74.0 | 54.1 | 46.3 | 42.4 | 49.1 | 37.6 |
| 2015/16 Variation | -1.1 | 1.7 | -3.1 | -5.8 | 2.6 | -2.0 |
| NHS SLOUGH | 68.2 | 50.6 | 40.8 | 26.7 | 33.2 | 25.4 |
| 2015/16 Variation | 0.5 | 3.1 | 0.7 | 0.2 | 3.2 | 4.5 |
| NHS SOUTH READING | 68.9 | 46.4 | 39.3 | 35.7 | 39.6 | 30.1 |
| 2015/16 Variation | -1.6 | -1.4 | -5.2 | -0.6 | 0.0 | 0.3 |
| NHS WINDSOR, ASCOT & M'HEAD | 68.4 | 47.0 | 44.5 | 37.0 | 44.2 | 32.3 |
| 2015/16 Variation | 0.9 | 2.8 | 2.9 | 4.5 | 7.6 | 5.1 |
| NHS WOKINGHAM | 72.7 | 50.7 | 50.4 | 48.1 | 53.5 | 42.9 |
| 2015/16 Variation | 1.1 | 4.9 | 2.1 | 1.1 | 3.5 | 1.6 |
| **Thames Valley Total** | **72.1** | **50.7** | **47.2** | **43.3** | **47.0** | **38.1** |
| 2015/16 Variation | 0.6 | 4.1 | 1.0 | 3.1 | 4.4 | 3.2 |
| **England Total** | **70.4** | **48.7** | **44.8** | **38.9** | **41.5** | **33.9** |
| | -0.6 | 3.6 | 2.5 | 3.9 | 3.8 | 3.9 |

Data source: **Seasonal influenza vaccine uptake amongst GP Patients in England**

* includes those GP-registered patients who were vaccinated through national community pharmacy scheme or by hospital midwives

### 10.2. Schools Campaign

In Berkshire, the children's nasal vaccine was delivered in primary schools by a team of school immunisation nurses from Berkshire Health Foundation Trust. The team arranged and carried out visits at nearly 300 schools across Berkshire, including special schools where all year groups were offered vaccine The BHFT school immunisation team delivered over 23,000 doses of vaccine and succeeded in reaching and exceeding the 40% overall uptake target in every Berkshire LA

.

**Table 3: Uptake for year 1, 2 and 3 children[$], by local authority 2016-17**

| | Year 1 (age 5 - 6 years) | | | Year 2 (age 6 - 7 years) | | | Year 3 (age 7- 8 years) | | |
|---|---|---|---|---|---|---|---|---|---|
| **Local Authority** | **Estimated total number of children eligible for vaccination** | **No. of children vaccinated with at least 1 dose of influenza vaccine[1]** | **Vaccine uptake (%)** | **Estimated total number of children eligible for vaccination** | **No. of children vaccinated with at least 1 dose of influenza vaccine[1]** | **Vaccine uptake (%)** | **Estimated total number of children eligible for vaccination** | **No. of children vaccinated with at least 1 dose of influenza vaccine[1]** | **Vaccine uptake (%)** |
| Bracknell Forest | 1,575 | 1162 | 73.8 | 1618 | 1222 | 69.3 | 1601 | 1053 | 65.8 |
| Reading | 2097 | 1403 | 66.9 | 2068 | 1266 | 61.2 | 2011 | 1212 | 60.3 |
| Slough | 2432 | 1108 | 45.6 | 2445 | 1072 | 43.8 | 2469 | 987 | 40.0 |
| West Berkshire | 2129 | 1641 | 77.1 | 2063 | 1523 | 73.8 | 2026 | 1454 | 71.8 |
| Windsor And Maidenhead | 1937 | 1241 | 64.1 | 1976 | 1277 | 64.6 | 1853 | 1154 | 62.3 |
| Wokingham | 2316 | 1723 | 74.4 | 2353 | 1716 | 72.9 | 2210 | 1589 | 71.9 |
| **England** | **684,647** | **394,172** | **57.6** | **675,275** | **373,695** | **55.3** | **666,266** | **355,088** | **53.3** |

**Data source:** Seasonal influenza vaccine uptake for children of primary school age, Provisional monthly data for 1 September 2016 to 31 January 2017 by Local Authority

[$] Data is provisional and represents 100% of all Local Authorities (LAs) in England responding to the January 2017 survey. Where a total for England is quoted (e.g. sum of number of patients registered and number vaccinated) this is taken from the 100% of all LAs and is therefore NOT an extrapolated figure for all of England.

### 10.3. Pharmacy Campaign for adults

As in 2015-16, in 2016-17 pharmacies signed up to the National Advanced Service could offer flu vaccine to the following groups;

- People aged 65 and over.
- Pregnant women
- Adults in a clinical risk group

National data from the Pharmaceutical Services Negotiating Committee [1] shows that at least 817,357 doses were delivered in pharmacies as part of the National Advanced Service. As not all pharmacies used Pharmoutcomes or the alternative system to record administration this is likely to be an underestimate of the total number nationally. Nationally[1], among pharmacies using Pharmoutcomes, 67% of doses were to people aged 65 or over, 3% to carers and 1.4% to pregnant women, with the remainder given to adults in clinical risk groups, people with diabetes accounted for 8% of the total doses recorded in Pharmoutcomes.

A total of 132 pharmacies in Berkshire signed up to deliver the service , providing 13,334 doses of vaccine (Table 4).

**Table 4: Berkshire Pharmacies and Flu vaccine doses 2016-17**

| CCG | Pharmacies signed up | Vaccines claimed to March 2017 |
|---|---|---|
| BRACKNELL AND ASCOT CCG | 23 | 2023 |
| NEWBURY AND DISTRICT CCG | 15 | 1825 |
| NORTH & WEST READING CCG | 14 | 1060 |
| SLOUGH CCG | 20 | 1492 |
| SOUTH READING CCG | 21 | 1439 |
| WINDSOR, ASCOT AND MAIDENHEAD CCG | 20 | 2767 |
| WOKINGHAM CCG | 19 | 2728 |
| **Berkshire CCGs** | **132** | **13,334** |
| **Thames Valley** | **311** | **32,721** |

Across Thames Valley, over two thirds of the vaccines provided via this service were given to people over 65 years of age and just over a quarter to adults in clinical risk groups, further breakdown is given below.

- 65 years and over: 17949 (68.2%)
- 18 to 64 years at risk: 7086 (26.9%)
- Pregnant: 420 (1.6%)
- Carers: 681 (2.6%)
- Person in long-stay residential care home 63 (0.2%)
- Household contact of immunocompromised individual 113 (0.4%)

[1] Flu vaccination data from PharmOutcomes and Sonar Informatics for 2016/17

### 10.4. Healthcare workers (NHS Flu Fighters)

Nationally uptake of flu vaccine among front line healthcare workers in NHS Trusts is reported by Trusts and uptake among healthcare workers in Primary Care and ISHCP

Frontline HCWs involved in direct patient care in acute trusts, ambulance trusts, mental health trusts, foundation trusts, primary care, and independent sector health care providers are encouraged to receive seasonal influenza vaccination annually to protect themselves and their patients from influenza. In Thames Valley uptake in 2016-17 was 65.4% compared to 55.0% in 2015-16, and an increas from the 57.9% in 2014-15.

Nationally, uptake among healthcare workers with direct patient care (based on 98.9% of NHS Trusts) was 63.4%, an increase from the 2015-16 figures of 50.8%, and 54.9% in 2014-15

Uptake for frontline healthcare workers in Berkshire overall and by staff group is outlined in Table 5. Uptake in both Royal Berkshire Foundation Trust and Berkshire Healthcare Foundation trust improved compared to the previous flu season. Berkshire Healthcare Foundation Trust achieved a 76.2% uptake rate, which was the highest in Thames Valley.

**Table 5: Vaccine uptake among front line healthcare workers**

| | 2016-17 | | | | 2015-16 | | |
|---|---|---|---|---|---|---|---|
| **Organisation** | **All HCWs in direct patient care** | **Seasonal flu doses given since 1 September 2016** | **Vaccine uptake (%)** | | **All HCWs in direct patient care** | **Seasonal flu doses given since 1 September 2016** | **Vaccine uptake (%)** |
| Royal Berkshire NHS Foundation Trust | 4714 | 2855 | 60.6 | ↑ | 4669 | 2271 | 48.6 |
| Berkshire Healthcare Foundation Trust | 2971 | 2264 | 76.2 | ↑ | 3098 | 1985 | 64.1 |
| Frimley Health NHS Foundation Trust* | 9263 | 3577 | 38.7 | ↓ | 6730 | 3321 | 49.3 |
| South Central Ambulance Trust | 2484 | 1358 | 54.7 | ↑ | 1858 | 567 | 30.5 |
| **Thames Valley** | **28,294** | **18,516** | **65.4** | ↑ | **31,388** | **17,256** | **55.0** |
| **England** | **974,568** | **618,275** | **63.4** | ↑ | **966,131** | **490,881** | **50.8** |

**Source:** Seasonal influenza vaccine uptake amongst frontline healthcare workers (HCWs) in England, February Survey 2016/17

*Data for Frimley Health includes staff at all hospital sites including Wexham Park and Heatherwood Hospitals in Berkshire and Frimley Hospital in Surrey. Frimley Health figures are not included in the Thames Valley total.

### 10.5. LA Health and Social Care staff and others

Local authorities are responsible for providing flu vaccine for frontline health and social care workers that are directly employed. Local authorities may also provide vaccine to staff members as part of business continuity arrangements.

The majority of residential care provision in Berkshire is through privately run care homes and nursing homes. Employers are responsible for providing flu vaccine to their employees under occupational health arrangements, however it has proved challenging to engage care home providers around the benefits of staff immunisation.

During the 2016-17 flu season, CCGs and LA public health worked together to produce and distribute a newsletter for care home managers which aimed to provide information on the responsibility of employers to protect staff against infectious diseases including flu, benefits to staff, residents and the wider community of staff vaccination, links to national guidance and ways that organisations could access flu vaccine and implement a staff vaccine campaign.

A short survey was circulated to care homes at the end of the flu season asking whether the newsletter had been received and seeking to assess knowledge of guidance and regulation in relation to staff vaccine as well as asking if flu vaccine was provided.

Results are summarised below:

A link to a short electronic survey was cascaded to care home managers by local flu leads; the survey was live from 12 April to 17 May 2017. There were 28 responses in total, 22 provided information on the LA in which they were based, of these 11 were from RBWM, five from Slough, three from Reading, two from Wokingham and one from Bracknell Forest.

The largest number of employees the respondents had was 400+ and the smallest was 10. The average number employed (not including the organisation with 400+) was 42.

Three quarters of respondents said they had received the newsletter, however only ten respondents (37%) said they had received any training on the potential impact on staff and patients/clients within the health and social care sector if staff do not receive flu vaccination.

Awareness of regulatory requirements was high, with 100% reporting they were aware of the CQC requirement for staff to be supported, and to have their rights and wellbeing protected, 96% aware of the CQC requirement for organisations to have enough staff to keep patients safe. 96% reported being aware that the Health and Social Care Act 2008 Code of Practice for Health and Adult Social Care on the prevention and control of infections and related guidance requires organisations to keep a record of relevant staff immunisations.

Despite awareness of this last point, only 15 respondents reported keeping an up to date record of staff immunisations. 26 respondents indicated that their organisation had an up to date infection control policy, with two not completing this question. Of the 26 who reported having an infection control policy, 24 said the policy included information on provision of vaccinations to staff as per Health and Safety Executive guidance.

Twenty two respondents answered the question “Did your organisation provide staff flu vaccinations or reimburse staff for flu vaccinations as part of occupational health during the winter 2016-17 flu season?. Seven respondents said they did not provide flu vaccine for their staff, six said that staff could access at work, six said that staff were reimbursed if they had paid for a flu vaccine (e.g. at local pharmacy) and five said that staff were provided flu

vaccine in another way – this included arranging a local pharmacy to give flu vaccinations, staff receiving vaccine at Boots The Chemist, and through a local charity. One respondent said that staff were given the opportunity to get a flu vaccine in various locations supplied by the borough, and another reported that staff who agreed to have the Flu injection were supported in doing so and others who were entitled to the vaccination with their GP were encouraged to do so. One larger organisation, employing 400+ employees, provided flu vaccine via local pharmacy.

12 respondents provided residential care; 7 of which offered flu vaccine. 6 provided nursing care; 5 offered vaccine. 5 respondents provided both residential and nursing care; 4 offered flu vaccine.

Free text box at the end of the survey invited additional comments. 5 responded. 2 mentioned difficulty in accessing the vaccine; 1 suggested on-site option for shift workers. 1 requested information on where to go for staff training.

Please contact ph.information@bracknell-forest.gov.uk if you require a full copy of the survey results.

**Table 6: LA Business Continuity and Health and Social Care staff vaccine schemes**

| Local Authority | Vaccination scheme description |
|---|---|
| RBWM | Each directorate in RBWM takes responsibility for offering flu vaccine to business continuity staff. There was a mix of providers.<br><br>No data is available on numbers of doses or on the number of eligible staff in the denominator. |
| Bracknell Forest | BFBC business continuity staff were able to access vaccine through BFBC occupational health with numbers of doses broadly similar to the previous flu season.<br><br>In October and November 2016, 173 employees had a flu vaccination with Occupational Health.<br><br>The majority of these were employed in Adult Social Care Health and Housing (74), with others being staff from Children's Services (52), Children Young People and Learning (43) and Environment, Culture and Communities (4). Staff were offered flu vaccine if their role involved personal care (20), contact with residents or clients that was not considered personal care (99), or if their role was defined as business critical within the BFBC business continuity plan (54).<br><br>It is not possible to calculate uptake as no denominator information on the number of eligible staff is available.<br><br>There was no BFBC and / or CCG scheme to provide free flu vaccine to front line care home staff in 2016-17. |

| | |
|---|---|
| Slough | SBC Flu plan is directly promoted to care workers where they are in charge of vulnerable adults. Other staff are risk assessed based on need for the Flu Jab. Direct link with HR and Internal comms<br><br>18 SBC staff were vaccinated through a drop-in clinic run by Occupational Health. Internal comms was provided with emphasis on front line staff to utilise the national programme via their local pharmacy where eligible |
| Reading | Staff were able to access a vaccine through a voucher scheme redeemable at participating local pharmacies. Vaccine was made available to all staff who worked in services considered essential for business.<br><br>Eligible staff were identified via RBCs business continuity plan. This approach was supported by all DMT's across the Council. DMT's were provided with an opportunity to provide feedback on this approach, as well as content of planned communications. Once approved, these were sent to key contacts i.e. Heads of Services to disseminate to staff in the most appropriate way for their business.<br><br>Where we were able to be identified, key business support roles were copied into communications and received advice on ways in which they could influence uptake in teams i.e. printing and handing out vouchers, discussion in team meetings.<br><br>47 staff received a vaccine, this is markedly lower number than in 2016/17 when vaccinations were delivered onsite at the Civic Centre using the occupational health suite.<br><br>Advance bookings for vaccinations in 2016/17 were low, however through business support actively seeking opportunistic discussions with staff and having the list of appointments available (either on the day or the next day) there was a positive impact on uptake, although this was time intensive |
| West Berkshire | WBC operated a voucher scheme to offer flu vaccine to particular groups outside of the NHS offer; including, health and social care staff, council staff who work in any capacity with the public, business critical staff, staff in adult care settings commissioned by the council, Children's Centre staff and staff in early years settings (that get the Government grant). Vaccine was also offered to staff working in Special Schools through in-school clinics provided by a pharmacist as part of this offer.<br><br>In 2016-17, 321 doses were given with the estimated number of eligible staff being 1591, an uptake of 20%. The number of doses declined from 384 in the previous flu season, it is not clear if the numbers of staff eligible changed. |

| | |
|---|---|
| Wokingham | Wokingham Borough Council promoted the campaign through presentations to provider and carer forums and the Learning Disabilities Partnership Board. The campaign was supported by internal communications to all staff and social media messages.<br><br>Staff were offered vaccinations at an on-site drop in clinic at various times over a number of days, this was delivered by a local pharmacist. A total of 198 WBC staff took up the offer of the vaccination. Twenty care staff from Optalis were vaccinated at the Tesco pharmacy under an agreement between WBC PH and Tesco. |

## 11. Summary of local flu campaign activities

| Did you do anything new to promote flu vaccination this year? If so what and how did you measure success? |
|---|
| • Specific engagement with shopping centre in Slough and local community 'fun' events,<br>• Placing posters and promotional materials in community venues such as children's play-parks in order to "target people where they go"<br>• Promoting the children's flu vaccine campaign at events for registered child-minders and identifying benefits and addressing myths and queries with the aim of empowering child minders to ask parents if children have received their vaccine<br>• Targeted work in special schools<br>• Established processes with home-education teams and agreed a process that supported BHFT to disseminate vaccination information to parents of all eligible children<br>• Worked with Quality & Performance Monitoring Team and provided information and advice on what the national priorities and messages were for local adult social care providers (nursing, residential, supported living, extra-care sheltered housing, community care).<br>• Inclusion of flu vaccine information and advice with cold weather alerts, utilising the link to the Stay Well This Winter resources<br>• Executive member of Adult Social Care Health and Housing was the Flu Campaign Champion and ran some publicities with local practices in B&A CCG<br>• increased use of social media to promote flu vaccine<br>• Reading & West Berks had a joint contract for flu vouchers with local pharmacies for their staff (RBC) and staff plus wider eligible groups (WB) with a view to reducing the unit cost. Payment was only due once vouchers were redeemed. |
| **What worked well this year?** |
| • Establishing a link with Quality Performance & Monitoring Officers and BHFT Reading Care Home Support Team. Both teams supported us to raise awareness of staff vaccinations to local providers during their visits.<br>• The QPM/Contracts & Commissioning team's business support officers also helped us disseminate the national campaign information and Berkshire newsletter produced for care homes.<br>• Promoting flu vaccine at School admission events, staff highlighted Childrens' Flu campaign<br>• Working with the virtual school to promote flu vaccination in BFBC |

- Roll out of the pharmacy voucher scheme was simple, services were offered vouchers redeemable at pharmacies that had opted in across West Berks and Reading.

**What was the biggest challenge?**

- Evaluating the impact of social media and other engagement activities on vaccine uptake is very challenging
- Faith schools engaging with vaccination due to porcine / animal elements (Nasal spray)
- Establishing how communications would be shared across NHS and LA organisations was challenging at times, there is a need to establish a joint communications plan with CCG comms colleagues ahead of the flu campaign
- Getting local media to pick up press release on flu (it's not 'news')
- Developing and agreeing a staff vaccine offer was challenging, there was a relatively short lead in time for making arrangements for staff flu offer within a protected budget
- Enabling school immunisation teams to engage with head-teachers ahead of the school visits in order to address queries or myths – this was addressed by including information in schools bulletin rather than enabling providers to attend headteachers forums in some areas.
- Agreeing the model for staff and wider flu vaccine offer in West Berks took some time, there was also a delay in engaging a pharmacist to deliver vaccine to staff in Special Schools in West Berkshire as part of their offer (no other LAs offer vaccine to this group)
- Misconceptions and myths around the need for and the benefits of having a vaccination remain a barrier to uptake.

**Plans for 2017-18 to address challenges**

- Working more closely with our key partners and networks (Such as Children Centres, School networks) to ensure the messages are widely received.
- Review how we can better use digital platforms in the borough to expand on the readership and audience
- Targeted engagement work with faith schools, sharing best practise of other schools that have similar demographic make-up and who are well engaged.
- Begin planning a staff vaccine offer earlier, engaging with other Berkshire LAs to scope out potential for jointly commissioning staff vaccines, if using a pharmacist to deliver vaccines on site, engage early to ensure delivery within the flu season, bearing in mind that vaccine is most effective when delivered in the autumn.
- Build on growing use of social media to engage with local communities on a more personal level to promote flu vaccine
- Proactively engage and update local CCGs on LA Action Plan and with the aim of reducing duplication and supporting them with targeting messages and work. If we can provide regular updates to the CCGs this might improve the uptake of opportunities to share communications.

**Recommendations**

- Establish a joint flu communications plan with CCG comms colleagues ahead of the flu campaign launch and ensure LAs provide regular updates on planned timing and nature of LA flu comms to the CCGs to improve the uptake of opportunities to share communications. Communications should take account of uptake in each eligible group and target appropriately
- Ensure communication between all LAs in the summer period to establish model for staff flu vaccine offer in order to secure most cost-effective and accessible
- Deliver a separate event/ specific publicity for training/planning for Care Agencies/ residential homes to advocate for provision of staff vaccines and support employers
- Work with commissioners of residential, nursing and domiciliary care to include KPIs around staff flu vaccine and record keeping
- Liaise more closely with PHE colleagues to measure and communicate the impact of suspected and confirmed flu outbreaks in care home and childcare settings
- Continue to engage with hospital specialists and local patient advocates to help promote flu vaccine to patients with clinical risk conditions
- Support the school immunisation team to communicate with schools and head-teachers on the flu programme ahead of the autumn term and throughout flu season
-

Jo Jefferies
Public Health Services for Berkshire
11th July 2017

# Berkshire Flu Workshop 2017/18

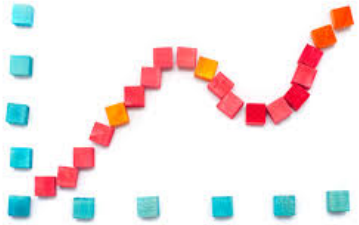
THE NHS CONSTITUTION
the NHS belongs to us all

# Welcome and Introduction

# Aims

- Review and reflect on 2017/18 flu season
  - what went well?
  - what did not go so well?
- Understand local commissioning intentions for 2017-18
  - What has changed
  - Focus on priority groups
- Consider how we can improve uptake and reduce practice variation between practices
  - What can practices do?
  - What can CCGs do?
  - What can commissioners do?

# Feedback on local uptake of flu immunisation 2016-17



# Picture in Thames Valley and Nationally

| | Thames Valley | | England | |
|---|---|---|---|---|
| | 2016-2017 (%) | 2015-2016 (%) | 2016-2017 (%) | 2015-2016 (%) |
| ≥ 65 years | 72.1 | 71.5 | 70.4 | 71.0 |
| < 65 at risk | 50.7 | 46.6 | 48.7 | 45.1 |
| Pregnant women | 47.2 | 46.2 | 44.8 | 42.3 |

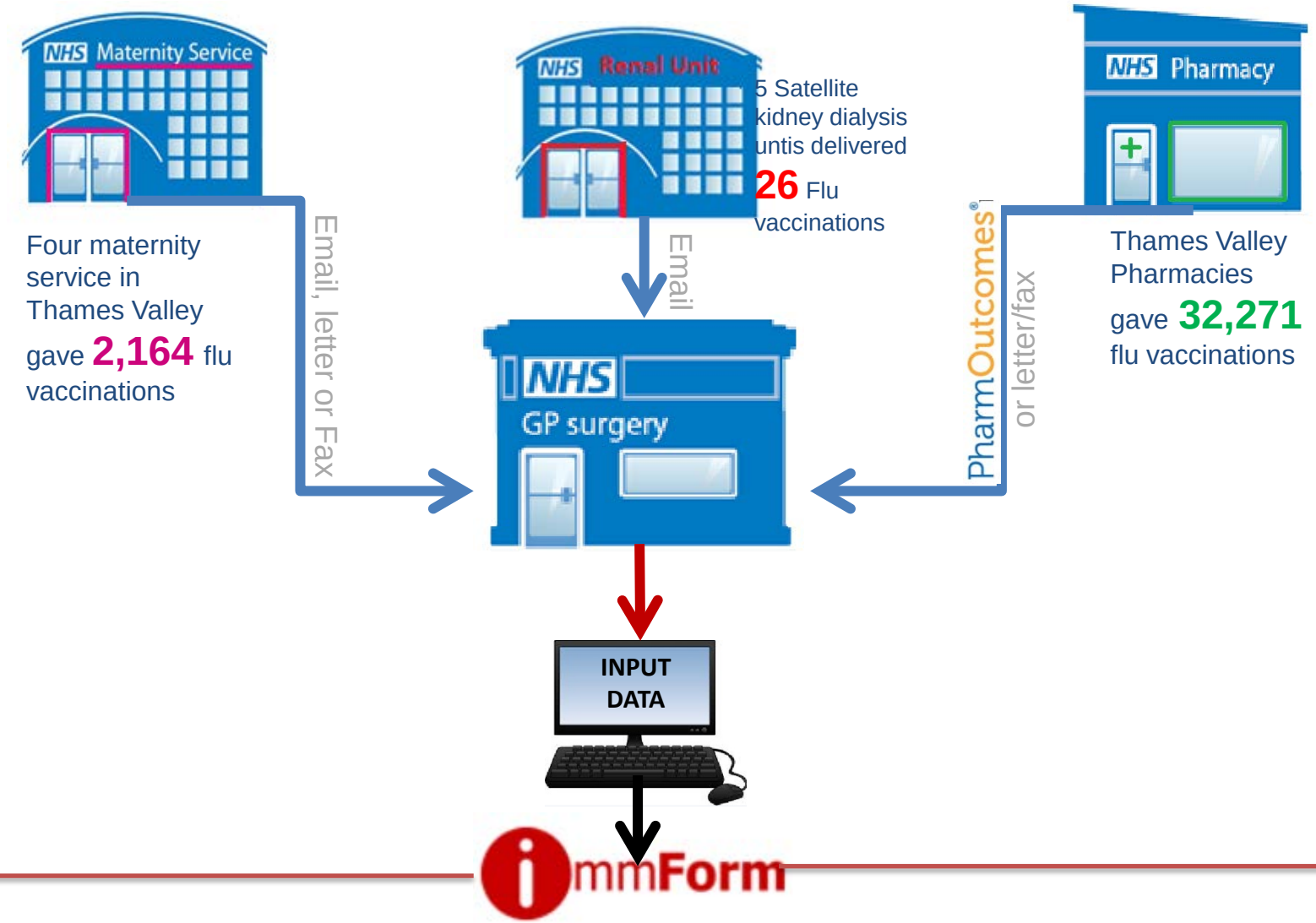
# CCG Level

## Two Year Comparison of Seasonal Influenza Vaccination Uptake Rates

NHS England

| CCG | 65 and over (%) | | Under 65 at risk (%) | | Pregnant women (%) | | All Aged 2 (%) | | All Aged 3 (%) | | All Aged 4 (%) | |
|---|---|---|---|---|---|---|---|---|---|---|---|---|
| | 2016-17 | 15/16 Variation | 2016-17 | 15/16 Variation | 2016-17 | 15/16 Variation | 2016-17 | 15/16 Variation | 2016-17 | 15/16 Variation | 2016-17 | 15/16 Variation |
| Newbury & District | **74.4** | 0.5 | **55.7** | 5.7 | **45.1** | -5.0 | **53.6** | 2.6 | **53.9** | 3.1 | **46.3** | 0.7 |
| N&W Reading | **74.0** | -1.1 | **54.1** | 1.7 | **46.3** | -3.1 | **42.4** | -5.8 | **49.1** | 2.6 | **37.6** | -2.0 |
| South Reading | **68.9** | -1.6 | **46.4** | -1.4 | **39.3** | -5.2 | **35.7** | -0.6 | **39.6** | 0.0 | **30.1** | 0.3 |
| Wokingham | **72.7** | 1.1 | **50.7** | 4.9 | **50.4** | 2.1 | **48.1** | 1.1 | **53.5** | 3.5 | **42.9** | 1.6 |
| Bracknell &Ascot | **70.9** | 0.6 | **54.0** | 4.1 | **51.1** | 1.2 | **49.5** | 10.5 | **50.5** | 4.3 | **41.0** | 7.3 |
| Slough | **68.2** | 0.5 | **50.6** | 3.1 | **40.8** | 0.7 | **26.7** | 0.2 | **33.2** | 3.2 | **25.4** | 4.5 |
| Windsor, Ascot & M'head | **68.4** | 0.9 | **47.0** | 2.8 | **44.5** | 2.9 | **37.0** | 4.5 | **44.2** | 7.6 | **32.3** | 5.1 |

# Additional Services in Thames Valley



# 2017/18 flu season (northern hemisphere)

Recommended trivalent vaccines containing

- A/Michigan/45/2015 (H1N1)pdm09-like virus;
- A/Hong Kong/4801/2014 (H3N2)-like virus; and
- B/Brisbane/60/2008-like virus.

It is recommended quadrivalent vaccines containing two influenza B viruses contain the above three viruses and a B/Phuket/3073/2013-like virus.

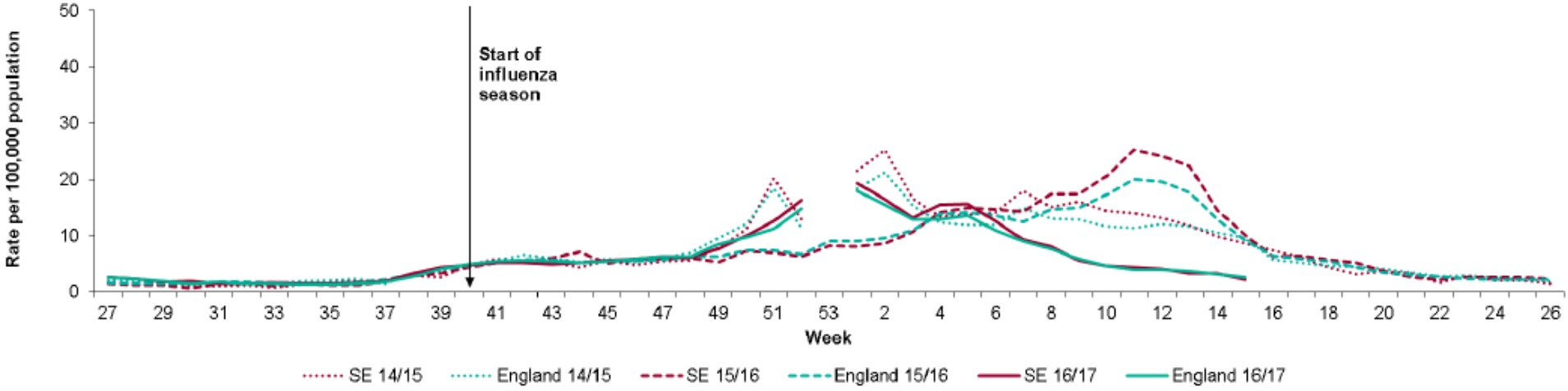
2016-17

- A/California/7/2009 (H1N1)pdm09-like virus
- A/Hong Kong/4801/2014 (H3N2)-like virus
- B/Brisbane/60/2008-like virus

Quadrivalent vaccines containing two influenza B viruses contain the above three

- B/Phuket/3073/2013-like virus

# Seasonal flu activity 2014-17
## PHE Surveillance



# Thames Valley commissioning intentions for 2017-18

-Pharmacy
-Maternity
-Special Schools

# Flu Plan; winter 2017-18

| Target Group | Uptake ambition for 2017/18 |
|---|---|
| Aged under 65 ‘at risk’ | 55% |
| Pregnant women | 55% |
| Eligible children aged 2 years to school year 3 age | 40-65% |
| Aged 65 years and over | 75% |
| Healthcare workers* | 75% |

Elements of the flu programme

- 100% offer for all eligible groups; adults and children
- Prioritise those with chronic liver and neurological disease, including people with learning disabilities

*A Trust-level ambition to reach a minimum of 75% uptake and an improvement in every Trust

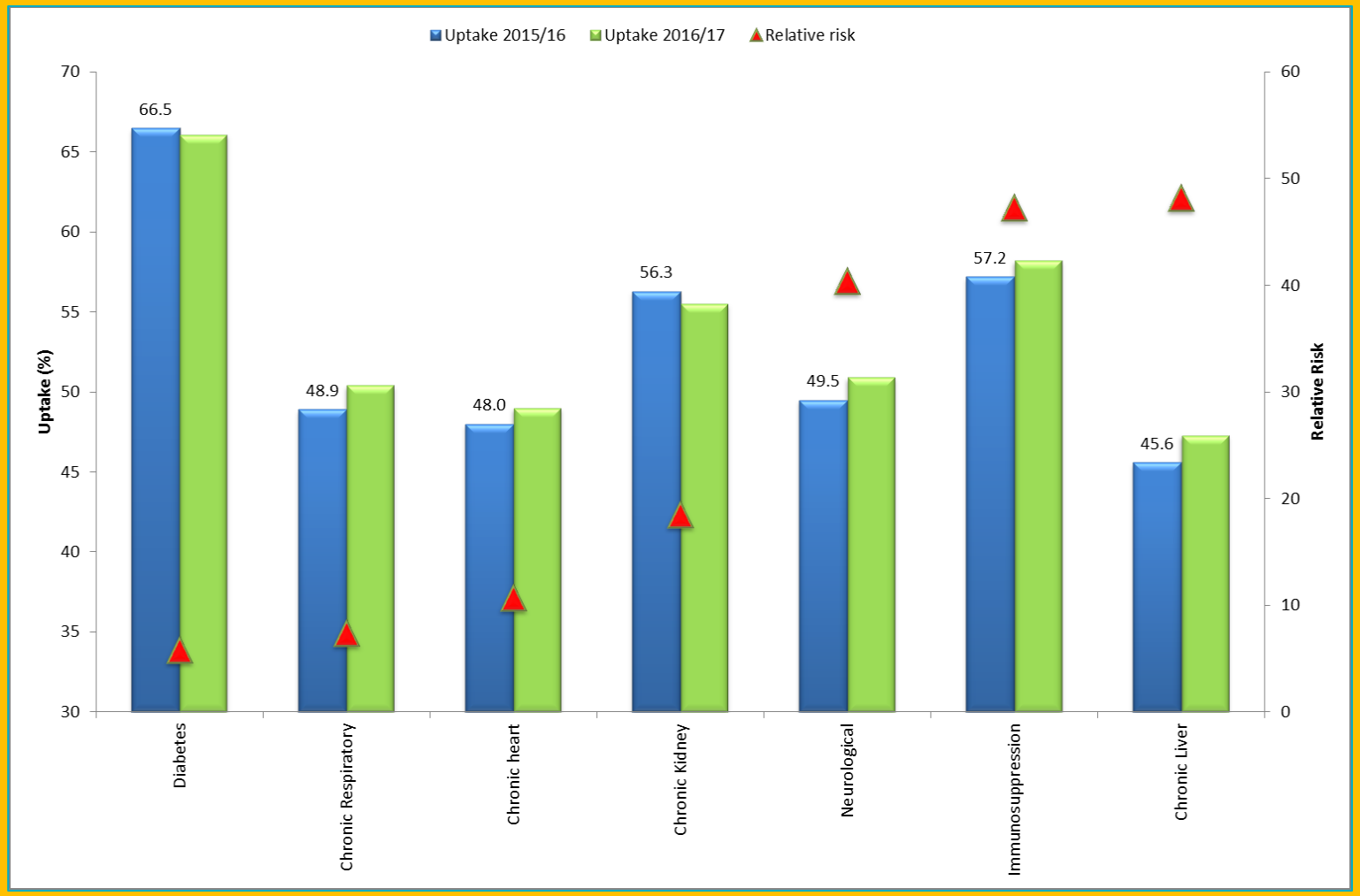
# Main Changes for 2017-18

- Morbidly Obese patients are including in clinical at risk groups;  now in GP contract.
- GP to offer flu immunisation to 2 & 3 year olds
- School based programme extended to include children in reception and school years 1,2,3 & 4.

# Commissioning in Berkshire

| Cohort | Provider | | | |
|---|---|---|---|---|
| | Primary Care | Pharmacy | Maternity Services | BHFT |
| People Aged 65 & over | ✓ | ✓ | | |
| Clinical at risk groups under 65 | ✓ | ✓ (aged 18 -64) | | |
| Pregnant Women | ✓ | ✓ | ✓ | |
| Carers | ✓ | ✓ | | |
| Children Aged 2&3 | ✓ | | | |
| Children in Reception & school years 1,2,3 & 4 | | | | ✓ |

# Uptake in clinical risk groups 2015/16 & 2016/17 and influenza related mortality ratios (Age adjusted relative risk Sept 2010-May 2011)



# Children's Flu Programme

Public Health England

NHS England

# Flu delivery in Thames Valley: The story in numbers

**Berks = 36,000 children**

**Bucks = 21,000 children**

**Oxon = 22,500 children**

**Berks = 334 schools** ***(8 special schools)***

**Bucks = 195 schools** ***(9 special schools)***

**Oxon = 300 schools** ***(8 special schools)***

Public Health England

# Performance

NHS England

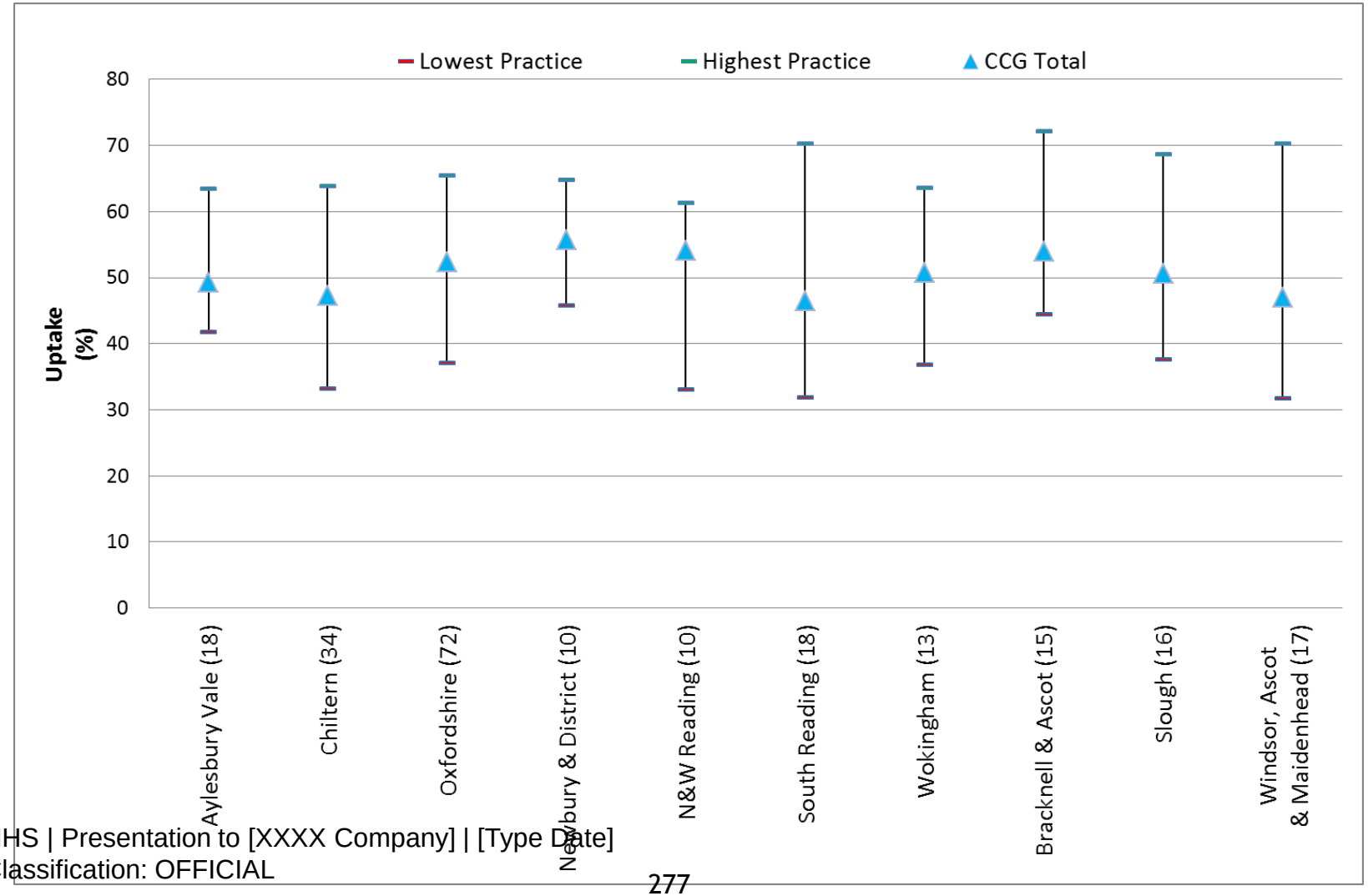
| 2016/17 childhood flu uptake | Y1 | Y2 | Y3 |
|---|---|---|---|
| BRACKNELL FOREST | 73.7 | 68.9 | 65.7 |
| WEST BERKSHIRE | 76.0 | 73.0 | 71.3 |
| READING | 64.8 | 59.4 | 59.0 |
| SLOUGH | 45.1 | 43.8 | 39.9 |
| WINDSOR AND MAIDENHEAD | 63.9 | 64.2 | 62.1 |
| WOKINGHAM | 73.2 | 71.4 | 70.5 |
| BUCKINGHAMSHIRE | 67.8 | 64.2 | 63.4 |
| OXFORDSHIRE | 68.3 | 63.9 | 62.8 |
| Total | 66.9 | 63.5 | 61.9 |

Consider how we can improve uptake and reduce variation between practices

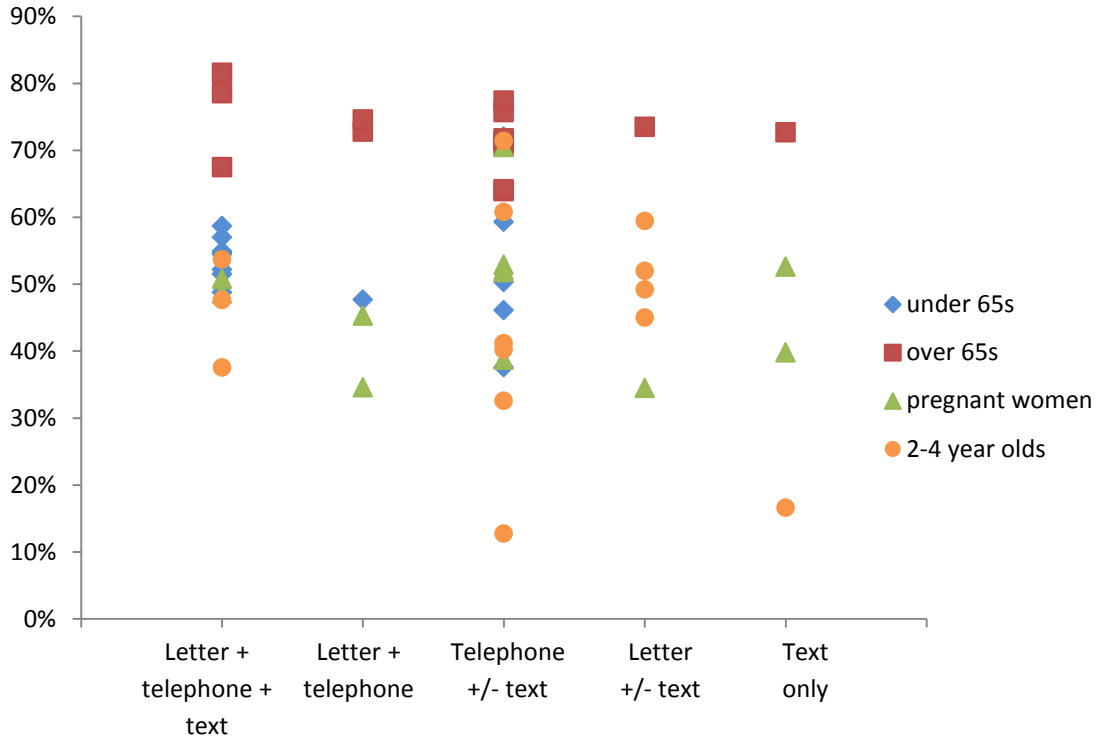
What can be do in practices do?
What can CCGs do?
What can commissioners do?
What can Local Authorities do?

# At risk groups aged under 65 years

Uptake of seasonal flu immunisation for individuals aged under 65 years in clinical risk groups showing range of uptake within the CCG and CCG average



# Survey into Practice Variation




reliance on text messaging as only method of communication/invitation and impact this may have on equity of access.

Work with flu leads as well as practice managers to **improve interaction** with and use of **Immform to monitor practice uptake**

Use practice staff with positive experience of and success in increasing accessibility to flu vaccine.

Work with pharmacies and their partner or feeding practices to strengthen relationships

# Examples of Good Practice in Berkshire

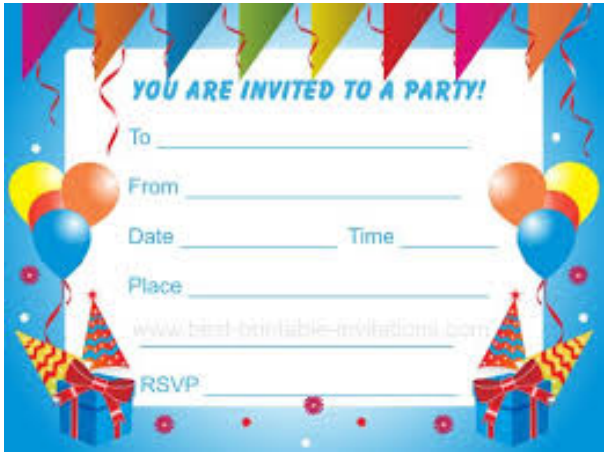
- National evidence
- Theale Medical Centre
- Balmore Park Surgery
- Using Immform Data
- Other example from audience

# What can be done in practices?

**GP practices and community pharmacists are responsible for:**

- educating patients, particularly those in at-risk groups, about the appropriate response to the occurrence of flu-like illness and other illness that might be precipitated by flu
- ordering the correct amount and type of vaccine for their eligible patients, taking into account new groups identified for vaccination and the ambition for uptake
- storing vaccines in accordance with national guidance
- ensuring vaccination is delivered by suitably trained, competent healthcare professionals who participate in recognised on-going training and development in line with national standards
- maintaining regular and accurate data collection using appropriate returns
- encouraging and facilitating flu vaccination of their own staff
- In addition, GP practices are responsible for:
- ordering vaccine for children from PHE central supplies through the ImmForm website and ensuring that vaccine wastage is minimised
- ensuring that all those eligible for the flu vaccine are invited personally to receive their vaccine

# What can be done practices?
# The Seven I's (and an L)





# What can be done in CCGs ?

Clinical commissioning groups (CCGs) are responsible for:

- quality assurance and improvement which extends to primary medical care services delivered by GP practices including flu vaccination and antiviral medicines




Slough & South Bucks OBSERVER

THE READING CHRONICLE

# What can commissioners?

NHS England is responsible for:

- commissioning the flu vaccination programme under the terms of the Section 7A agreements
- assuring that the NHS is prepared for the forthcoming flu season
- monitoring the services that GP practices and community pharmacies provide for flu vaccination to ensure that services comply with the specifications
- building close working relationships with Directors of Public Health (DsPH) to ensure that local population needs are understood and addressed by providers of flu vaccination services

# What can commissioners?

NHS England

ImmForm


PharmOutcomes




# What can Local Authorities do?

**Local authorities**, through their DsPH, have responsibility for:

- **providing appropriate advocacy with key stakeholders** and challenge to local arrangements to ensure access to flu vaccination and to improve its uptake by eligible populations
- providing leadership, together with local resilience partners to respond appropriately to local incidents and outbreaks of flu infection

**Local authorities** can also assist by:

- **promoting uptake of flu vaccination among eligible groups, for example older people in residential or nursing care, either directly or through local providers**
- **promoting uptake of flu vaccination among those staff providing care for people in residential or nursing care, either directly or through local providers**

# What can Local Authorities do?

NHS England



BRACKNELL FOREST VOLUNTARY ACTION

Slough & South Bucks OBSERVER


# Group work

- Prompts on table
- Planning template

- **Develop /modify time based actions that would improve flu uptake in your population (practice, CCG, LA)**

- **As a table add any suggestions , comments or ideas for wider sharing to the sheets on the table**

# FEEDBACK

**To:** Reading Health and Wellbeing Board

**Date:** 6 October 2017

**Title:** **Pharmaceutical Needs Assessment Update**

**Report By:** Public Health Services for Berkshire

**Purpose of Report:**
To update the Health and Wellbeing Board on the Pharmaceutical Needs Assessment (PNA) that is currently underway.

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Since April 2013, every Health & Wellbeing Board in England has had a statutory responsibility to publish a statement of the needs for pharmaceutical services in their area. This is referred to as the Pharmaceutical Needs Assessment (PNA). Each Health & Wellbeing Board had to publish their first PNA by 1st April 2015, and is required to undertake a revised assessment at least every 3 years. The refreshed PNAs therefore need to be signed-off and published by 31st March 2018.

Public Health Services for Berkshire have been leading the development of the 2018 PNAs across the 6 Berkshire Local Authorities. Part of this work has included conducting a survey of local pharmacies to identify the services that they provide or would like to provide. This closed in September with a total response rate of 82.4% of pharmacies across Berkshire. For Reading Borough Council, 30 out of 35 pharmacies responded (86%). An online public survey was also open from June to September to gather feedback about local pharmacy services. This received 184 responses across Berkshire and 44 of these were from Reading residents.

Public Health Services for Berkshire are now in the process of collating and analysing survey responses and mapping the local pharmacy services provided. These will be used to identify any possible gaps in service provision and will form the basis of the PNA. A draft PNA will be completed in October and is required to go out to a public consultation for 60 days, which will be across November and December. It is our understanding that the Director of Adult Care & Health Services, in consultation with the Chair and Vice Chair of the Health and Wellbeing Board, will approve the draft PNA prior to going out for consultation.

Following the public consultation, any necessary amendments will be made to the final PNA report in early 2018. This will then be formally signed-off by the Health & Wellbeing Board on Friday 16th March 2018, in line with the NHS Pharmaceutical Services and Local Pharmaceutical Services Regulations 2013.

**Actions for HWBBs:**

- **October 2017** - HWBB Chairs to sign off draft for public consultation
- **November and December 2017** - Support public consultation on the draft PNA
- **By 31st March 2018** – Agree final PNA at HWBB meeting in public, including any recommendations and publish in formal papers

**Recommended Action for Reading Health and Wellbeing Board:**

1. **That the Director of Adult Care & Health Services be authorised to sign off the draft Reading PNA for public consultation, in consultation with the Chair and Vice Chair of the Health and Wellbeing Board;**
2. **That public consultation on the draft PNA in November and December 2017 be supported;**
3. **That the final Reading PNA be submitted to the 16 March 2018 Board meeting for approval.**