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To: All members of the Health & Wellbeing Board

(Agenda Sheet to all Councillors)

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5 July 2018

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NOTICE OF MEETING – HEALTH & WELLBEING BOARD – 13 JULY 2018

A meeting of the Health & Wellbeing Board will be held on **Friday 13 July 2018 at 2.00pm in the Council Chamber, Civic Offices, Reading.** The Agenda for the meeting is set out below.

AGENDA

../Cont

5. PROGRESS REPORT ON THE DELIVERY OF THE SPECIAL EDUCATIONAL NEEDS AND DISABILITY (SEND) STRATEGY 11

A report giving a summary of progress made in delivering the SEND Strategy and the steps that have been taken to improve the transition between children's and adults' services.

6. BERKSHIRE WEST INTEGRATED CARE SYSTEM OPERATING PLAN 2018/19 21

The Berkshire West ICS (Integrated Care System) Operating Plan 2018/19 for Berkshire West CCG, Berkshire Healthcare NHS Foundation Trust and Royal Berkshire NHS Foundation Trust.

7. BERKSHIRE HEALTHCARE NHS FOUNDATION TRUST (BHFT) MENTAL HEALTH STRATEGY 2016–21 - PROGRESS UPDATE 83

A report giving details of progress on the BHFT's Mental Health Strategy 2016-21 to date.

8. OUR TOP THREE PRIORITIES – BY PEOPLE FROM GROUPS AND COMMUNITIES THAT ARE SELDOM HEARD, AND THE CHARITIES THAT SUPPORT THEM – HEALTHWATCH READING REPORT 94

A report giving a voice to 'seldom heard' people on their top three priorities, including reports by charities who support these people: Reading Mencap, Talkback, Reading Community Learning Centre, Reading Refugee Support Group and Launchpad.

9. WORKING WITH SERVICE USERS WITH MENTAL HEALTH NEEDS – HEALTHWATCH READING & READING ADVICE NETWORK REPORT - A REPORT OF THE 2ND READING ADVICE NETWORK FORUM ON 30 MAY 2017 149

A report of a Reading Advice Network (RAN) forum held on 30 May 2017 which brought together 14 different information, advice or support organisations to share experiences of working with local people with mental health needs.

10. HEALTHWATCH READING ANNUAL REPORT 2017/18 163

Healthwatch Reading's annual report, giving details of the work carried out by Healthwatch Reading in 2017/18.

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11. READING HEALTH & WELLBEING ACTION PLAN 2017-20 UPDATE AND DASHBOARD REPORT 191

A report giving an update on delivery against the Health and Wellbeing Action Plan, alongside the Health and Wellbeing Dashboard, populated with the latest published data in relation to the Board's agreed strategic priorities, giving an overview of performance and progress towards achieving local goals as set out in the 2017-20 Health and Wellbeing Strategy for Reading.

12. CHILDREN'S ORAL HEALTH IN READING 287

A report presenting an analysis of the 2015 children's dental health survey data for Reading (published in 2017), and making the case for the development of an oral health strategy for Reading to complement the Healthy Weight Strategy and provide a framework for raising the profile of oral health across other relevant policies and service specifications.

13. RBC & CCG RESPONSE TO HEALTHWATCH REPORT ON ANALYSIS OF TUBERCULOSIS (TB) CAMPAIGN & ACTION PLAN 297

A report giving an update on activities to understand and improve upon the knowledge and understanding of the local community in regard to active and latent tuberculosis (TB) and of local services that are available to identify and treat latent TB, and presenting a TB action plan.

14. A HEALTHY WEIGHT STATEMENT FOR READING – IMPLEMENTATION PLAN UPDATE 338

A report giving an update on the implementation plan for the Healthy Weight Strategy for Reading.

15. CREATING THE RIGHT ENVIRONMENTS FOR HEALTH – DIRECTOR OF PUBLIC HEALTH ANNUAL REPORT 2018 359

A report presenting the Berkshire Director of Public Health's Annual Report 2018, on Creating the Right Environments for Health.

16. READING HOMELESS HEALTH NEEDS AUDIT 383

A report presenting the findings of a Homelessness Forum partnership project into the physical, mental and sexual health needs of Reading's single homeless population.

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17. READING'S ARMED FORCES COVENANT AND ACTION PLAN – MONITORING REPORT 465

A report presenting an annual update on progress against the actions outlined in the Reading Armed Forces Covenant action plan, in particular the heath-related actions, and on the general development of the covenant.

18. INTEGRATION PROGRAMME UPDATE 477

A report giving an update on the Integration Programme, as well as progress made against the delivery of the national Better Care Fund (BCF) targets.

19. DATE OF NEXT MEETING – Friday 12 October 2018 at 2pm -

READING HEALTH & WELLBEING BOARD MINUTES – 16 MARCH 2018

Present:

Councillor Hoskin (Chair)	Lead Councillor for Health, Reading Borough Council (RBC)
Andy Ciecierski	Chair, North & West Reading Clinical Commissioning Group (CCG)
Councillor Eden	Lead Councillor for Adult Social Care, RBC
Councillor Gavin	Lead Councillor for Children's Services & Families, RBC
David Shepherd	Chair, Healthwatch Reading

Also in attendance:

Pat Bunch	Healthwatch Reading Manager
Darrell Gale	Acting Strategic Director of Public Health for Berkshire
Stan Gilmour	LPA Commander for Reading, Thames Valley Police
Kim McCall	Health Intelligence, Wellbeing Team, RBC
Sarah Morland	Partnership Manager, Reading Voluntary Action
Maura Noone	Interim Head of Adult Social Care, RBC
Janette Searle	Preventative Services Manager, RBC
Nicky Simpson	Committee Services, RBC
Councillor Stanford-Beale	RBC
Lewis Willing	Integration Project Manager, RBC
Cathy Winfield	Chief Officer, Berkshire West CCGs

Apologies:

Michael Beakhouse	Integration Programme Manager, RBC & CCGs
Seona Douglas	Director of Adult Care & Health Services, RBC
Councillor Lovelock	Leader of the Council, RBC
Mandeep Sira	Chief Executive, Healthwatch Reading

1. MINUTES

The Minutes of the meeting held on 19 January 2018 were confirmed as a correct record and signed by the Chair.

2. QUESTIONS IN ACCORDANCE WITH STANDING ORDER 36

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

a) Life Expectancy & Infant Mortality

"Can you give an update on life expectancy trends in Reading, with whatever information is available on variation across our community, and an update on infant mortality? Or alternatively, schedule this as an item for next HWB?"

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

"Life expectancy trends:

Life expectancy at birth (based on 2014-16 mortality data) for males in Reading is 78.9 years, which is slightly lower than the England average of 79.5 years. This has stayed close to but very slightly below the England average for around the last 14 years (figures taken from the Public Health Outcomes Framework).

Life expectancy at birth for women in Reading is 83.2 years, very similar to the England average of 83.1 years. This has stayed close to the England average for the last 14 years (figures taken from the Public Health Outcomes Framework)

There are differences in life expectancy between different people living in Reading, many of which are likely to be related to relative deprivation (encompassing income, education, employment, health, barriers to services and amenities and environment). We can illustrate this by looking at life expectancy and relative deprivation by ward.

LEAST DEPRIVED	
Mapledurham	85.1
Thames	82.3
Peppard	81.5
Tilehurst	79.0
Redlands	78.5
Park	78.2
Kentwood	78.4
Caversham	78.1
Southcote	79.2
Minster	75.3
Katesgrove	77.4
Abbey	74.1
Church	77.4
Battle	78.1
Norcot	76.5
Whitley	75.5
MOST DEPRIVED	

Infant Mortality

The rate of infant mortality in Reading remains similar to the national average (3.2 deaths of infants aged under 1 year per 1,000 live births between 2014 and 2016, compared to 3.9 per 1,000 live births in England). The rate in Reading has fallen year on year for the last ten years. For a more detailed discussion see Reading's JSNA (http://www.reading.gov.uk/jsna/infant-mortality) and to compare with other Local Authorities and regions see the Public Health Outcomes Framework (indicator 4.01). https://fingertips.phe.org.uk/profile/public-health-outcomes-framework/data#page/4/gid/1000044/pat/10039/par/cat-39-7/ati/102/are/E06000038/iid/20101/age/235/sex/4"

b) Diabetes Prevention Week

"16 - 22 April 2018 has been declared Diabetes Prevention Week. What will Reading be doing to communicate the facts about Type 2 Diabetes and what opportunities will there be for the voluntary sector to participate?"

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

"Public Health Programme Officers are currently in discussions with the Diabetes Prevention Programme Coordinator for Berkshire West to plan our involvement in supporting Diabetes Prevention Week in April 2018. We plan to look at how we can use social media and work with partners to raise awareness of type 2 diabetes, encourage people to find out if they are at risk by signposting them to the diabetes risk score online and encourage people to take up GP referrals to join the National Diabetes Prevention Programme. We are also exploring the opportunities for the voluntary sector to participate."

3. IMPACT OF FUNDING REDUCTIONS ON THE CAPACITY OF VOLUNTARY ORGANISATIONS TO CONTRIBUTE TO THE BOARD'S STRATEGIC PRIORITIES

Sarah Morland submitted a report highlighting how recent funding awards to local voluntary organisations by Berkshire West CCGs (Partnership Development Fund) and Reading Borough Council (Narrowing the Gap II) could impact on the capacity of voluntary organisations to contribute to the Board's strategic priorities. It also set out the possible impact of a reduction in preventative health and social care services delivered by Reading voluntary and community sector.

The report explained that Reading's voluntary and community organisations made a significant contribution to the Health and Wellbeing Board's strategic priorities. It stated that RVA had been pleased to hear at the previous meeting that, although Reading Borough Council and Berkshire West Clinical Commissioning Group both faced significant financial challenge, they wished to support the voluntary sector to the extent they could, and recognised the value that voluntary sector providers brought to how services were commissioned.

The report stated that RVA welcomed the opportunity to co-produce a voluntary sector strategy with health partners to clarify future ambitions for partnership working and commissioning across Berkshire West. They hoped that the discussions could be extended to include local authority partners at some stage in order that the voluntary and community sector had a clear "position statement" for future relationships with its two key statutory partners.

The report gave details of the local voluntary sector commissioning opportunities in 2018/19, explaining that there had been 59 applications to the Berkshire West CCG Partnership Development Fund (PDF) in 2018/19 and, although the final number of grants had not yet been advised, it was understood that only eight or nine grants would be awarded. In comparison, in 2017/18, 27 grants had been awarded through PDF, all to local voluntary organisations delivering health and wellbeing services to support the CCG's priorities.

It also stated that Reading Borough Council had commissioned voluntary organisations through Narrowing the Gap II, the outcome of which would be announced soon. Contracts covered a wide range of preventative services. There had been some overlap in the health and wellbeing outcomes of services commissioned from voluntary organisations by the Council and CCG and, in Narrowing the Gap II, a number of the services would now be joint-funded.

The report stated that RVA had wanted to understand how a reduction in the number of grants awarded through PDF could impact on voluntary organisations' continuing capacity to support vulnerable people in Berkshire West and prevent/reduce the demands on statutory services.

They had sent an online survey to all organisations which had previously received funding through PDF, or which they were aware had applied for 2018/19 funding. They had asked what the likely impact of no funding from the CCGs on the organisation and the people who used their services was, and about "the possible impact on statutory health and social care services if your service is reduced or closed". 17 responses had been received to the survey from organisations across Berkshire West. Ten organisations had given permission for their responses to be attributed to their organisation: Reading Refugee Support Group, Age UK Reading, Reading Mencap, Berkshire Youth, Me2Club, Cruse Bereavement Care (Thames Valley Berkshire), Dingley's Promise, Newbury Family Counselling Service, Reading Lifelines and Home-Start West Berkshire. Other responses had been anonymised.

The report gave details of the key results, in the following areas:

- Reduction in or loss of preventative services and longer waiting times
- Loss of opportunity to develop new, innovative services aligned with CCG priorities
- Counselling services across Berkshire West being significantly impacted
- Possible impact on statutory agencies
- Voluntary sector support for prevention and self-management

The report urged Reading Borough Council and Berkshire West CCG to continue investing in the preventative services delivered to vulnerable people by voluntary and community organisations, whilst recognising that the financial return on the investment might be difficult to quantify. It stated that RVA would continue supporting voluntary organisations to have robust systems in place to gather evidence, drawing on published research where relevant to demonstrate the impact of their services. They would encourage voluntary organisations to share the stories of, and learn from the experiences of, people who used their services to ensure that they received the most effective services to meet their needs.

Resolved - That the report and the results of the survey be noted.

(Councillor Stanford-Beale declared an interest in the above item as the organisation she worked for had, in the past, received funding from the Council.)

4. WHAT DO READING PEOPLE KNOW ABOUT TB? – HEALTHWATCH REPORT

David Shepherd and Pat Bunch submitted a report on the results of a knowledge, attitude and belief survey about TB (turberculosis), commissioned by Reading Borough Council Public Health Team, with funding from South Reading CCG, and carried out by Healthwatch Reading, to provide a baseline of public awareness against which to evaluate the success of current and future TB campaigns.

The report explained that the latest data from 2015 had shown that there were a higher than average number of notified TB cases in Reading compared with England and the South East of England. These cases mostly affected people who were aged, on average, 41 years, and living in Park, Abbey and Whitley wards. The Health and Wellbeing Board had therefore set a priority in the Health and Wellbeing Strategy 2017-20 to reduce TB incidence, and a number of actions had already been taken, including launching a local plan to increase primary care referral to a TB screening service, and holding awareness events for healthcare workers and the public.

The report explained that Healthwatch had been commissioned to carry out a survey from 1 August to 31 October 2017, by visiting 12 community groups or events to ask and/or assist people in completing an anonymous survey about TB, the questions and format for which had been decided by Public Health. The project aims had been: to provide a baseline against which to evaluate the success of current and future TB campaigns; provide insight into the knowledge, attitudes and behaviours of local populations around TB, with a focus on surveying population groups living in the areas of South Reading where TB was more common; and signpost people to further information, resources or local screening services. It had been aimed to survey at least 150 people, particularly 18-34 year olds who might have been born in, or had lived during the previous five years in, one of 58 countries outside the UK where TB rates were high.

The survey had had 326 respondents, 48% of whom had been aged 16-34, and the report gave further details of the ethnicity, birth country, time in the UK and residence of respondents. The main findings of the survey had been:

- 91% had heard of TB before the survey
- 80% or more knew that persistent coughing, or coughing up blood, were symptoms of TB; the least known symptom was swollen feet
- 60% correctly identified some TB risk factors, eg living in overcrowded homes
- 51% believed (wrongly) that a person with 'sleeping TB' could pass it on
- 32% believed (wrongly) that the BCG vaccine protected you from TB for life
- 25% did not know that you could carry TB germs even if an X-ray showed you had a clear chest
- 30% believed (wrongly) that having a TB test/treatment could affect your UK immigration status if you came from another country
- 36% would be embarrassed to tell family or friends if they had TB
- 41% did not feel that TB was relevant to them or their family
- Most people learned about TB from friends/family (36%), TV or school
- 83% believed NHS staff would treat TB-infected people with respect
- 65% of people did not feel that Reading residents knew enough about TB

The report gave further details of and discussion on the survey's findings, highlighted a selection of other initiatives from across England that Reading services might consider trialling, and set out the response from South Reading CCG and the Council. It stated that the results of the survey had been discussed at a Berkshire-wide TB workshop on 5 December 2017 and the outputs from the workshop would form an action plan, to be managed and implemented by the Latent TB Project Manager and monitored by the Berkshire TB Operational Group.

The meeting welcomed the report and noted how useful the results of the survey would be. Cathy Winfield reported that the CCG had heard that it had received funding from NHS England for TB work for a further year.

Resolved - That the report, and the fact that the results of the survey would be used to form a TB action plan, be noted and welcomed.

5. HEALTH AND WELLBEING DASHBOARD – MARCH 2018 UPDATE

Kim McCall and Janette Searle submitted a report giving an update on the Health and Wellbeing Dashboard, which was used to keep Board members informed of local

trends in priority areas identified in the Health and Wellbeing Strategy, and which was attached at Appendix A. An amended version of the report had been circulated prior to the meeting, which included additional information on updates to indicators for Priority 4.

The report set out details of updates to the indicators and targets, and updates to performance, which had now been included in the Health and Wellbeing dashboard.

The report set out the following areas where performance was worse than the set target, giving commentary on each area:

Priority 1 – Supporting People to Make Healthy Lifestyle Choices

2.06ii - % 4-5 year olds classified as overweight/obese
2.14 – Smoking prevalence – all adults
2.14 – Smoking prevalence – all adults – routine and manual professions
2.22 – Health check indicators.

Priority 2 – Reducing Loneliness and Social Isolation

1.18i - Adult Social Care users with as much social contact as they would like
1.18ii - Carers with as much social contact as they would like

Priority 3

2.18 - Admission episodes for alcohol related conditions

Priority 8

4.10 - Mortality rate from suicide and injury of undetermined intent

The report also listed indicators for which updates were expected to be available for the July 2018 meeting of the Board.

The meeting discussed the dashboard and particularly the issue of children's health and wellbeing. Janette Searle reported that, although the indicators in the dashboard for priority 2 on reducing loneliness and social isolation currently only related to adults, work would be continued to develop an appropriate measure for children.

Referring to target 2.22 on health check indicators, relating to the proportion of eligible population offered and received an NHS healthcheck, Maura Noone explained that, currently, anyone could ask for a healthcheck but, in future, it was planned to target healthchecks more to the population most likely to need them, hopefully resulting in a smaller number being offered, with a higher uptake.

Stan Gilmour raised the issue of adverse childhood experiences (ACE) and their long term effect on Health and Wellbeing issues. He said that work between the police and public health around ACE and developing a more trauma-informed approach to practice was important, and that investment was being made in this area. This needed a collaborative approach across a range of agencies and he reported as an example on work in Reading at Katesgrove Primary School where their "mini police" had been involved in an alcohol-awareness programme. He said that there was a Police and Public Health Research Group, and he would invite the Director of Public

Health to join this group for wider discussions about these sorts of preventative issues.

Stan Gilmour also said that, whilst the issue of child sexual exploitation was still important, and work was continuing in this area, the issue of child criminal exploitation now needed work, and projects were already running on this issue. All the agencies involved needed to make links and see how they could incorporate the work being done in this area.

Resolved - That the updates and the expected updates to the Health and Wellbeing Dashboard be noted.

6. INTEGRATION PROGRAMME UPDATE

Lewis Willing submitted a report giving an update on the Integration Programme and on progress made against the delivery of the national Better Care Fund (BCF) targets.

The report stated that, of the four national BCF targets, performance against two (limiting the number of new residential placements & increasing the effectiveness of reablement services) was currently good, with a trajectory that appeared to bring performance close to realising the targets.

It stated that partners were not currently reducing the number of delayed transfers of care (DTOCs) in line with targets, but recent DTOC rates for December 2017 had been lower than they had previously been in the financial year, which represented positive progress.

Reducing the number of non-elective admissions (NELs) in line with targets remained a focus for the Berkshire West-wide BCF schemes.

The report stated that meetings with Healthwatch to review and refine existing service user engagement metrics had been held and a further meeting with Healthwatch had been scheduled for 15 March 2018 to review the mechanisms used by services to gather service user feedback and ensure they reflected best practice. It was reported at the meeting that further actions had been agreed at the meeting with Healthwatch and site visits with Healthwatch colleagues were being planned.

Stan Gilmour noted the importance of the police also being involved in integration discussions, as many calls to the police involved social care issues and, as first responders, the police were often heavily involved in health and social care issues.

Resolved - That the report and progress be noted.

7. READING'S PHARMACEUTICAL NEEDS ASSESSMENT 2018-2021

Further to Minute 13 of the meeting on 6 October 2017, Darrell Gale submitted a report presenting the final Reading Pharmaceutical Needs Assessment (PNA) for 2018 to 2021 and seeking formal approval to publish the final PNA and appendices on the Reading Borough Council website.

The report had appended the Reading Pharmaceutical Needs Assessment 2018 to 2021 and the following Appendices:

Appendix A – Berkshire PNA Pharmacy Survey 2017
Appendix B – Berkshire PNA Public Survey 2017
Appendix C – Opening times for Pharmacies in Reading
Appendix D – Equalities Screen Record for Pharmaceutical Needs Assessment (Reading)
Appendix E – Consultation Report Reading Borough Council
Appendix F – Berkshire PNA Formal Consultation Survey 2017
Appendix G – Supplementary Statement – February 2018

The PNA also had appended the following maps, which would be published with the final PNA if approved:

Map 1 – Pharmaceutical Services in Reading
Map 2 – Reading pharmacies and Index of Multiple Deprivation
Map 3 – Reading pharmacies and population density by ward level
Map 4 – Reading pharmacies and weekend opening
Map 5 – Reading pharmacies and evening opening
Map 6 – 5 and 10 Minute Driving Times Reading
Map 7 – 15 Minute Walking Times Reading
Map 8 – Pharmacies inside and within 1.6km (1 mile) of Reading

The report explained that the PNA was the statement of the needs for pharmaceutical services of the population in Reading. It set out a statement of the pharmaceutical services which were currently provided, together with when and where these were available. The PNA also considered whether there were any gaps in the delivery of pharmaceutical services and would be used by NHS England to make decisions on which NHS-funded services should be provided by local community pharmacies. The PNA could also be used to inform commissioners, such as local authorities and Clinical Commissioning Groups (CCGs), who might wish to procure additional services from pharmacies to meet local health priorities.

Reading's Health & Wellbeing Board had published the last PNA in April 2015 and a revised assessment had been required to be completed by 31 March 2018. The report presented the key findings of the PNA for Reading for 2018 to 2021 and summarised the process undertaken to develop this, including public consultation on the draft PNA for a formal 60-day period from 1 November to 31 December 2017, responses from which had informed a review of and amendments to the PNA to produce the final version.

The report stated that the final PNA and appendices would be published on Reading Borough Council's website and would be accessible for the lifespan of the report (until 31 March 2021). If local pharmaceutical services changed during this time, such as the opening hours, address of premises or needs of the local population, the Council would need to publish supplementary statements to the relevant website. If other significant changes occurred which impacted on the need for pharmaceutical services during the lifetime of the PNA, this might result in the need to refresh the PNA, although no such changes were expected.

The meeting discussed the importance of pharmacies in providing primary care in order to reduce pressure on GPs and Accident & Emergency services, and of close working between GPs, NHS England and pharmacies in order to plug the gaps and potential future gaps in delivery in Reading, including looking at possible co-location of pharmacies and GP surgeries.

Resolved -

(1) That the report be noted;

(2) That the final Reading Pharmaceutical Needs Assessment 2018-2021 be approved for publication.

8. HEALTH AND WELLBEING BOARD - CHANGES TO MEMBERSHIP

Maura Noone submitted a report proposing the following changes to the membership and therefore terms of reference and powers and duties of the Reading Health & Wellbeing Board:

- To amend the Clinical Commissioning Group (CCG) membership of the Health and Wellbeing Board to reflect the merger of the four Berkshire West CCGs into one Berkshire West CCG with four localities from 1 April 2018;

- To co-opt a representative from Reading Voluntary Action as a non-voting additional member of the Health and Wellbeing Board, in order to facilitate partnership working with the voluntary sector.

The amended terms of reference and powers and duties and operational arrangements of the Board were set out at Appendix A to the report. If the changes were agreed, the amended terms of reference and powers and duties as set out in the Appendix to Appendix A would need to be introduced at the Annual Council Meeting, on 23 May 2018.

It was suggested at the meeting that Stan Gilmour, who was currently an invited participating observer as the Local Police Area Commander for Reading from Thames Valley Police, should also be co-opted as a non-voting additional member of the Board, in order to facilitate partnership working with the police.

Resolved -

(1) That the following amendments to the terms of reference and powers and duties of the Health and Wellbeing Board be agreed:

(a) That the CCG membership of the Reading Health and Wellbeing Board be amended to be two representatives from the Berkshire West Clinical Commissioning Group (CCG) from 1 April 2018;

(b) That a representative from Reading Voluntary Action be co-opted as a non-voting additional member of the Reading Health and Wellbeing Board;

(c) That a representative from Thames Valley Police's Reading Local Police Area be co-opted as a non-voting additional member of the Reading Health and Wellbeing Board;

(2) That it be noted that Cathy Winfield and Andy Ciecierski would be the two representatives from Berkshire West CCG, Sarah Morland would be the representative from RVA and Stan Gilmour would be the representative from Thames Valley Police.

9. DATES OF FUTURE MEETINGS

Resolved – That the meetings for the Municipal Year 2018/19 be held at 2.00pm on the following dates:

- Friday 13 July 2018
- Friday 12 October 2018
- Friday 18 January 2019
- Friday 15 March 2019

(The meeting started at 2.05pm and closed at 3.25pm)

READING HEALTH AND WELLBEING BOARD

DATE OF MEETING:	**13th July 2018**	**AGENDA ITEM:**	**5**
REPORT TITLE:	**Progress report on the delivery of the Special Educational Needs and Disability (SEND) Strategy**		
REPORT AUTHOR:	**Helen Redding**	**TEL:**	**74109**
JOB TITLE:	**SEND Improvement Adviser**	**E-MAIL:**	**Helen.redding@reading.gov.uk**
ORGANISATION:	**Reading Borough Council**		

1. PURPOSE OF REPORT AND EXECUTIVE SUMMARY

1.1 The SEND Strategy was discussed at the Health and Wellbeing Board on 19th January 2018 and the Board agreed to support its delivery. The Board requested an update on progress within 6 months, and also requested that the report includes an update on progress on the issues around transition from children's to adults' services. This report provides a summary of progress made in delivering the SEND Strategy and the steps that have been taken to improve the transition between children's and adults' services.

2. RECOMMENDED ACTION

2.1 To note and comment on the progress made and propose additional actions to be considered for its successful delivery.

2.2 To note and comment on the progress being made in improving the transition between children's and adult's social care.

2.3 That the learning from the work in Strand 4 to seek the views of young people and their families on the transition process, information, the annual review process, and where the gaps and barriers exist to achieving independence is brought to a future meeting of the Health and Wellbeing Board.

3. POLICY CONTEXT

3.1 Reading Borough Council's SEND Strategy was approved by ACE Committee in July 2017. It provides a framework for SEND improvement, and the delivery of the provision and support required across key agencies to deliver the Children and Families Act (2014) and SEND Code of Practice (2015) in a coordinated way, ensuring that children and young people's needs are met at the right time, making best use of the resources available.

3.2 It sets out key areas for improvement and development that will support universal and specialist provision across a range of agencies in meeting the needs of children and young people with SEND and their families now and into the future.

3.3 The SEND Strategy currently consists of 4 strands.

- Analysis of data and information to inform future provision and joint commissioning.
- Early Identification of needs and early intervention.
- Using specialist services and identified best practice to increase local capacity.

- Transition to adulthood

3.4 The strategy supports a coordinated approach that will support **all** stakeholders and partners to:

- understand the profile of children and young people's needs with special educational needs and / or disabilities (SEND) 0-25 within Reading and how that compares to other local authorities;
- have clarity regarding their responsibilities and their role in identifying and meeting the needs of children and young people with SEND;
- ensure that there is a continuum of provision to meet the range of needs of children and young people with SEND and their families which is flexible to the changing profile in Reading;
- understand the pathways to accessing more specialist support when required;
- have confidence that high needs spending and resources are targeted effectively and support improved outcomes for children and young people;
- understand what needs to be commissioned, recommissioned and decommissioned to meet the changing profile of needs across Reading both now and into the future.

4. PROGRESS TO DATE

4.1 Strand 1 - Analysis of data and information to inform future provision and joint commissioning.

4.1.1 Strand 1 has continued to analyse the data report and use that to inform actions for this strand group as well as other strand groups. For example, Strand 2 was asked to track the journey of children who have accessed specialist support in the early years, carry out an audit of pre-schools, look at the mental health pathway in the early years, and develop guidance for school readiness, and Strand 3 was asked to look at operational models for outreach and school to school support. Strand leads report back to Strand 1 on progress against these actions.

4.1.2 Feedback on school cluster funding identified inconsistencies across clusters on how they were using this funding. It has therefore been agreed to hold this budget and the managed moves budget at the centre so best use of it to support inclusion in mainstream schools can be identified. Effective examples from other Local Authorities are being drawn on to inform this. A protocol is being co-developed during the summer term for implementation in September 2018 to support this and will include a requirement to evidence impact.

4.1.3 Work has continued to ensure that spend from the High Needs Block is transparent and is used effectively to impact on outcomes for children and young people. High Needs Block budget information is reported regularly to Schools Forum, as is progress on delivering the SEND Strategy.

4.1.4 A survey has been carried out with schools regarding their commissioning of therapy and other services. The survey was carried out in order to establish what services schools are commissioning and funding themselves, and to see whether there was a more effective away of jointly commissioning some services in larger contracts, e.g. for speech and language therapy. In addition, Strand 3 of the SEND Strategy Board wanted to survey schools on the support they felt they needed to meet the needs and improve the outcomes for children and young people with Autistic Spectrum Condition (ASC) and children and young people with social, emotional and mental health difficulties (SEMH). These questions were included in the same survey.

4.1.5 The survey was initiated in January, and was extended until the end of March in order to encourage more schools to respond.

4.1.6 27 schools responded to the survey: 1 nursery school; 18 primary schools; 6 secondary schools; and 2 special schools.

4.1.7 The amount spent on additional therapies by those schools that responded went up in 2016/2017 to £285,088, and reduced to £268,345 in 2017/2018. Schools cited pressure on budgets as the main reason for stopping buying in therapies. There has been an increase in the number of schools buying in Play Therapy, with over £100k being spent on play therapy in each of the last 2 years.

4.1.8 The full report will be shared with members of the SEND Strategy Board in order to establish next steps.

4.1.9 The Educational & Child Psychology Service, which provides a range of therapeutic and educational assessments and support, continues to have increased buy back from schools, with an increased income predicted for the next academic year to over £200,000, with 90% schools buying the services offered.

4.1.10 The Primary Mental Health Workers continue to work closely with schools offering mental health assessments and therapeutic interventions. Demand for their service continues to increase. There is no cost to schools.

4.1.11 Work has continued with the schools with specialist provisions, including meeting with parents and students to get feedback, and reviewing starting points of children who go on to access specialist provision in order to determine when their needs aware first identified and destinations post accessing the provision. This has helped inform the work of Strand 3 who have looked at what is required in the development of provision in Reading.

4.1.12 Investigation has been carried out into effective models of building capacity in supporting schools in managing behaviour that is challenging and reducing exclusions. This work is being taken forward with the Teaching School (Churchend Primary School), Cranbury College and Local Authority Services. A parent guide to exclusions has been co-produced with parent / carers and shared with schools. This includes a section on internal exclusions.

4.1.13 As a consequence of feedback, primary and secondary SENCO groups have been re-established.

4.1.14 Reading Borough Council has been successful in meeting the requirements of the SEND grant from the Department of Education (DfE) to support SEND capital developments, which the SEND Strategy Board has agreed needs to be focused on supporting delivery of the SEND Strategy and in particular the improvements needed to enable Phoenix School to take girls. Currently girls with these needs are accessing school placements out of area in order to have their needs met.

4.1.15 It is anticipated that Strand 1 will be closed in September 2018 as a comprehensive data report has been produced which will be updated annually, once national and statistical neighbour comparisons are published. These are usually published towards the end of June, so the report will be updated over the summer and used by the SEND Strategy Board and the strand leads to inform actions for the next academic year.

4.2 Strand 2 - Early Identification of needs and early intervention.

4.2.1 In order to understand whether children and young people's needs are being correctly identified and provided with appropriate early intervention, an analysis of Early Years Education, Health and Care Plan (EHCP) Needs Assessments was undertaken. The vast

majority of Early Years (EY) statutory assessment requests were from the Portage Service, or from the Nursery Schools. The children who accessed this specialist support in the early years have been tracked and results indicated the Portage Home Visiting Service are correctly identifying the children they work with who need a statutory assessment and/ or specialist educational provision.

4.2.2 Further work is being done with partner agencies to ensure pre-school children are correctly identified by all partners for referrals into the Portage Service. Portage will provide SEN Team a termly identification report of children they have identified as meeting the guidance for an Education, Health and Care assessment and / or access to specialist educational provision in order to help with place planning.

4.2.3 In order to understand why there are so few requests for EHCP needs assessments from other EY providers, an audit of pre-school educational providers understanding of how to identify and provide appropriate support or signposting for EY children with SEN was undertaken and a training programme has subsequently been put in place from the findings of the audit, facilitated by the Nursery Schools and the EY Special Educational Needs Coordinator (SENCO).

4.2.4 An audit of the funding allocated at the Early Years Intervention Panel (EYIP), which provides funding to support early years settings meet the emerging SEN needs, was undertaken and found inequity of which EY settings applied for funding. The EY SENCO and Nursery Head Teachers are supporting settings in how and when to apply for funding. The EYIP will now meet monthly to ensure easier access for all EY settings. In addition, a system has been agreed to enable EY settings to access Educational Psychologist support and advice via the Panel.

4.2.5 Guidance on school readiness has been produced and is being circulated. Guidance on transition from pre-school to school has been completed. This will be extended to transition guidance for primary to secondary school and then linked to the Strand 4 transition to adulthood work. Guidance on deferring, offsetting and summer born children has been written and is being circulated.

4.2.6 An audit of the work of the Autism Advisor and the Sensory Integration and Massage Service has been undertaken and reported on, including numbers of cases and primary needs at referral. Annual reports will be produced to monitor needs addressed and outcomes.

4.2.7 Strand 2 is supporting an Early Help Project in the Whitely Cluster on supporting schools with early identification and early help with families.

4.2.8 The group is now focusing on developing clear pathways that set out expectations of what should be provided by universal services and at what point more specialist services might be required to provide further assessment, advice and support, and/or more specialist provision. Pathways for EY Emotional and Mental Health are being developed.

4.2.9 Dingley Specialist Nursery is working closely with Strand 2 to track the children who have attended Dingley, look at how many have received an EHCP and how many are in specialist/ mainstream settings. This data will be reported on in July.

4.2.10 Reading Families Forum has provided a report on parents/ carer views on early identification. The summary of the views given suggest that families' experience of early identification and support before any diagnosis is mixed with excellent support being put in place for some. However, this is not consistent. This feedback is being used to support further actions.

4.2.11 Strand 2 is working closely with Strand 3 and the broader group with the Teaching School and School Improvement services on meeting the needs of children and young people with SEMH and reducing exclusions in Reading.

4.2.12 Screening tools are being developed with the Speech and Language Therapy Service, the Educational Psychologist Service and Cranbury College to screen children and young people who have been excluded or are at risk of exclusion to help understand the profile and target support.

4.2.13 The Schools Link Mental Health Project has received funding from the Clinical Commissioning Group (CCG) to continue to help improve outcomes for children and young people with emotional and mental health issues. The project focuses on early recognition of mental health issues and providing improved support and access for children and young people with emotional and mental health issues. The project is closely linked with other partners and agencies and with the Strand 3 work. Quarterly reports will be shared.

4.2.14 Strand 2 has written and finalised Graduated Response Guidance for Early Years, Primary and Secondary schools. Post 16guidance will be produced over the summer. The Guidance gives clear information of what can be provided to meet the needs of children and young people.

4.3 Strand 3 - Using specialist services and identified best practice to increase local capacity.

4.3.1 Strand 3 has focussed on the two areas of greatest need identified through the data report and from feedback from parent/ carers and schools: children with autistic spectrum condition (ASC) and children with social, emotional and mental health (SEMH) difficulties.

4.3.2 In relation to children with ASC a proposal has been developed to meet local need. This is due to be considered by the SEND Strategy Group at its meeting in July and has already been considered by members of Strand 1 and Schools Forum, with both groups being supportive of the proposals. If approved, the proposal would be progressed through Committee with a recommendation to initiate the process for commissioning these, which would include the statutory consultation process.

4.3.3 Currently there is 1 x 21 place primary specialist provision at Christ the King Primary School in the south of Reading and 1 secondary specialist provision at Blessed Hugh Faringdon secondary school. Parents that we spoke to fed back the challenges of their child going to a primary school that was not in their community, particularly with regard to it inhibiting the development of friendships close to home. It was felt that this could lead to their child becoming increasingly isolated at weekends and in school holidays. It was also felt that having 1 large primary school provision placed significant pressure on 1 school.

4.3.4 The proposal identifies the need for a further 2 smaller primary specialist provision bases across Reading to enable children's needs to be met more locally. It is proposed that all 3 primary specialist provisions would provide capacity for at least 10 places and will provide specialist outreach to schools within their area, as well as being a hub for families to seek guidance and support. It is anticipated that if the proposal goes ahead, numbers at Christ the King would reduce over time, as current children moved on to secondary or other provision.

4.3.5 It is proposed that the secondary specialist provision at Blessed Hugh Faringdon, which is due to be expanded, would similarly be commissioned to provide outreach support to schools across Reading.

4.3.6 All specialist provision will have a service level agreement (SLA) in place which will be monitored. These will be reported on to Schools Forum annually.

4.3.7 A working group consisting of Churchend Teaching School, Cranbury College and Local Authority officers are taking forward the work to reduce exclusions, which will inform

proposals to support children and young people with SEMH needs. This will be progressed through Strand 3, and reported on to the SEND Strategy Board.

4.4 Strand 4 - Transition to adulthood

4.4.1 Since the Strand 4 action plan was developed in April, Strand 4 has focused on actions to deliver Outcome 1, which not only provides a basis for the other 4 outcomes but also underpins the operational work to transfer cases from the Children and Young people with Disabilities Team (CYPDT) to Adult Social Care (ASC).

4.4.2 Integral to the delivery of the Strand 4 action plan is joint working with partner agencies, the voluntary sector and families. The views of young people and their families are being sought on a range of their experiences including: the transition process, information, the annual review process, and where the gaps and barriers exist to achieving independence. It is proposed that this learning can be shared at a future meeting of the Health and Wellbeing Board.

4.4.3 **Outcome 1: We will work with families to develop a Transition to Adulthood Plan (14-25) that outlines how young people with SEND will be supported into adulthood, recognising the extra help that they may need to build their independence and clarifying pathways for accessing more specialist support and funding.**

- Current processes for supporting young people with SEND into adulthood are being reviewed in order to identify good practice and areas for development. Essential to this is an understanding of the experiences of young people and their families who have gone through the transition process, and this learning is being coordinated by Reading Voluntary Action, Mencap and Reading Families Forum.
- An *Approaching Adulthood Policy* has been developed and is being consulted on. A final version is anticipated to be completed by mid-June and will provide a framework for improving practice. The aim of this policy is to enable services to work together to identify early those children and young people and their families who may need support to prepare for adulthood, in line with agreed timescales and a holistic care pathway to access specialist support.
- The Strand 4 group identified the need for improved and earlier joint working between Children's and Adults' Services and work is underway to align the Council's information, data, finance and commissioning systems to facilitate a smooth transition process.

4.4.4 Outcome 2: Everyone who is involved in supporting young people as they approach adulthood will work together to have positive aspirations for them and support them in a way that helps young people to be as independent as possible and achieve their goals.

- Reading Voluntary Action is taking the lead on work to identify and promote areas of best practice (locally and nationally) where young people with SEND are supported to achieve their goals and be as independent as possible.
- The views of young people and their families about what barriers exist to achieving independence and what needs to improve are being sought.
- It is anticipated that by August the Annual Review process will be updated to ensure that it is informed by the experiences of young people and their families and that the voice of the young person is heard in transition planning.

4.4.5 Outcome 3: Clear and accessible information is available for young people and their parents/carers so that they know what to expect in the future.

- The Strand 4 group is currently seeking the views of young people and their families to help improve information about transitions to adulthood, so that it is relevant, easy to read and widely promoted. Integral to this is the *Local Offer* which is being updated to reflect findings of a peer review.
- Information requirements will be embedded into the new transitions pathway so that practitioners know what information young people and their families require and when.
- An information booklet to support transitions has been developed and is being consulted on and this will also be available as an online resource.

4.4.6 **Outcome 4: Young people from the age of 14 have a person centred approach which supports them to consider options for education, training, volunteering or opportunities for paid employment. Young people are encouraged to aim for the maximum achievable independence including, where possible, meaningful engagement in the world of work.**

- The actions for this outcome will be informed by the actions currently being undertaken.

4.4.7 Outcome 5: Local businesses and charities provide meaningful opportunities for paid work, education, training and volunteering.

- This work is being aligned with the Social Impact Bond (SIB) developments, to ensure that there is a joined up approach across services to support vulnerable young people into adulthood.

4.4.8 Services from across the Council and partner agencies will work together to deliver actions to support Outcomes 4 and 5, primarily to:
- Understand the local demand, effectiveness and sufficiency of current post 16 provision, and current gaps in provision for young people with SEND, and
- Develop the market to meet needs of individuals locally.

4.5 Transfer of cases from Children and Young People's Disability Team (CYPDT) to Adult Social Care (ASC) Locality Teams.

4.5.1 The Health and Wellbeing Board requested that this report included a section on progress on the issues around transition from children's to adults' services.

4.5.2 An *Approaching Adulthood Policy* has been developed and is being consulted on as set out in paragraph 4.4.3.

4.5.3 Since 1st March 2018, all new referrals for adults over the age of 18 years have been directed to the Adult Social Care Locality Teams. There are approximately 90 young people aged 18 – 25 years whose cases are to be transferred from CYPDT to Adult Social Care (ASC) by September 2018.

4.5.4 Resources have been identified and put in place to support the transfer of cases from CYPDT to ASC.

4.5.5 A sample of cases has been reviewed to determine the quality of cases and subsequent actions and timescales, and a checklist drawn up to highlight to CYPDT what is required for the cases to be transferred.

4.5.6 CYPDT social workers are preparing the cases for transfer by reviewing, quality assuring and completing any outstanding tasks.

4.5.7 Select cases have been identified for a phased transfer so that they can receive immediate support from adult social care.

4.5.8 Work is underway to ensure the data management system (MOSAIC) supports the transition process, including ensuring finance, data and reporting requirements are clarified and aligned.

4.5.9 An experienced Adults' social worker is providing advice and guidance to Children's workers on complex cases, and the Eligibility Risk and Review Panel has been extended to provide an opportunity for cases to be reviewed.

4.5.10 A communication to families will be developed and sent out to families by the end of July to ensure that the changes are explained and that there is clear information to families regarding next steps.

4.5.11 A staff training programme will be co-developed to ensure all staff fully understand the support needs for young people 18 – 25 with SEND

5. CONTRIBUTION TO READING'S HEALTH AND WELLBEING STRATEGIC AIMS

5.1 The SEND Strategy supports priorities Reading's 2017-20 Health and Wellbeing Strategy Priority 3 *Promoting positive mental health and wellbeing in children and young people*.

5.2 The SEND Strategy action plan supports Reading's 2017-20 Health and Wellbeing Strategy's three foundations - safeguarding vulnerable adults and children, recognising and supporting all carers, and high quality co-ordinated information to support wellbeing.

5.3 The SEND Strategy specifically addresses these in the following ways:

- Focussing on children and young people with special educational needs and disability and identifying actions which will lead to improved provision and outcomes for them and their families.
- Working alongside parents/carers and young people to develop and implement the strategy, listening to their views and feedback and using this to inform next steps.
- Ensuring that the Local Offer is of high quality and information is coordinated and clear and supports knowledge and understanding of the services available to support families.

5.4 The SEND Strategy involves a range of partners including health partners, and its delivery will support improving health outcomes for children and young people.

5.5 The annual SEND data report supports the interrogation and analysis of the range of data and information on the range and profile of needs and forecast future needs, to inform commissioning decisions. This will be used to support the Joint Strategic Needs Assessment (JSNA).

6. COMMUNITY & STAKEHOLDER ENGAGEMENT

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 Co-production with parents / carers and young people is at the heart of the Children and Families Act (2014) and SEND Code of Practice (2015). Parent /carer representatives from Reading Families Forum are represented on each strand group and have been instrumental in the development of actions and implementation of the SEND Strategy. They have also been involved in service improvement and review work.

6.3 In addition 'feedback' sessions have been held with parent/ carers and / or young people in some schools with specialist provisions, and the council officers have attended a feedback coffee evening arranged by Reading Families Forum on school exclusions. A parent guide to exclusions has been co-produced for parents and has also been shared with schools. Another coffee evening is taking place in June on short breaks.

6.4 In the last 12 months, our new SEND youth forum have held 4 events. They have chosen their name, Special United, and their logo. Each meeting is free for anyone aged 11 - 25 with SEND or their siblings to attend. 13 young people attended the last event with 8 having attended before.

6.5 Special United have contributed to some changes to the Local Offer and provided feedback for the regional Local Peer review on another Local Authority's offer, IASS, short breaks, school exclusions and a leaflet on preparations for adulthood.

6.6 There is always much lively discussion and the next event is planned for 12th July to discuss the role of Children with Disability Social Workers and plans to move young adults to the adult social care team.

7. EQUALITY IMPACT ASSESSMENT

7.1 Under the Equality Act 2010, Section 149, a public authority must, in the exercise of its functions, have due regard to the need to—

- eliminate discrimination, harassment, victimisation and any other conduct that is prohibited by or under this Act;
- advance equality of opportunity between persons who share a relevant protected characteristic and persons who do not share it;
- foster good relations between persons who share a relevant protected characteristic and persons who do not share it.

7.2 All elements of the work involved in delivery of the strategy will support improving outcomes for children and young people with SEND and their families.

7.2.1 Involving children, young people and their families in the development of services and support is key to the delivery of our equalities duty.

8. LEGAL IMPLICATIONS

8.1 The following Acts are central to the delivery of the SEND Strategy.

8.2 The Children and Families Act, 2014

8.2.1 The Children and Families Act placed a duty on local authorities to ensure integration between education, training and health and social care provision.

8.2.2 Local authorities and clinical commissioning groups (CCGs) must make joint commissioning arrangements for education, health and care provision for children and young people with SEND, both with and without education, health and care plans.

8.2.3 In carrying out the functions in the Children and Families Act, all agencies must have regard to:

- the views, wishes and feelings of children, their parents and young people;
- the importance of the child or young person and the child's parents, participating as fully as possible in decisions, and being provided with the information and support necessary to enable participation in those decisions; and

- the need to support the child or young person, and the child's parents, in order to facilitate the development of the child and young person and to help them achieve the best possible educational, health and broader outcomes, preparing them effectively for adulthood.

8.3 The Care Act, 2014

8.3.1 The Care Act requires local authorities to ensure co-operation between children and adult services to plan for meeting the future needs of young people as they move into adulthood and become more independent, along with achieving continuity of support between services to enable young people to access timely and appropriate support.

8.4 The Equalities Act, 2010

8.4.1 This defines the equality duties and includes SEN and disability. These duties are the statutory duty to promote equality of opportunity, eliminate unlawful discrimination, harassment and victimisation and foster good relations in respect of nine protected characteristics; age, disability, gender reassignment, marriage and civil partnership, pregnancy and maternity, race, religion or belief, sex and sexual orientation.

9. FINANCIAL IMPLICATIONS

9.1 There is now clear information reported regularly to Schools Forum on spend and forecast spend of budgets to support SEND.

9.2 The Council has received grant from the Department for Education (DfE) in 2018 to support strategic development of SEND, the allocation of which is approved through the SEND Strategy Board.

9.3 A SEND Capital grant (over 3 years) has been allocated to Reading by the DfE to support a small amount of capital development. In order to draw this down information on its use and how it fits in with a SEND Strategy is required to be published on the Local Offer and updated annually. The SEND Strategy Board agreed for it to be targeted to support implementation of the strategy, and in particular ensuring Phoenix school can meet the needs of a broader range of pupils, including girls, and the delivery of the specialist provision development. The DfE have confirmed that Reading has met the requirements and will be allocated the first tranche.

10. BACKGROUND PAPERS

10.1 Reading SEND Strategy
https://search3.openobjects.com/mediamanager/reading/enterprise/files/approved_send_strategy_august_2017.pdf

Royal Berkshire NHS Foundation Trust

Berkshire West Clinical Commissoning Group

Berkshire Healthcare NHS Foundation Trust

BERKSHIRE WEST INTEGRATED CARE SYSTEM

OPERATING PLAN: 2018/19

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1 EXECUTIVE SUMMARY

The Berkshire West Integrated Care System (ICS) is a high performing set of health and care delivery organisations which provide outstanding services to a population of 528,000 residents. The constituent organisations have an excellent history of collaboration and integration which are seeking to build on this in order to realise a stretching set of aspirations. The ICS strives to deliver the NHS Constitution by uniting patients and staff in a shared ambition for high quality care by putting these values at the heart of everything we do:

- Working together for patients.
- Respect and dignity
- Commitment to quality of care
- Compassion
- Improving lives
- Everyone counts

As a nationally recognised exemplar ICS we have been developing our system wide approach to progressing shared transformation opportunities which will also ensure our organisations are financially sustainable for the future. Recognising that we are stronger together, this theme of collaboration underpins our system operating plan for 2018/19.

At the heart of the ICS is the delivery of consistent high quality and safe care, ensuring the best possible outcome for patients. The commitments outlined in the ICS Memorandum of Understanding (MoU) provide the focus for our work with our local ICS Clinical Strategy acting as the cornerstone that underpins how we will transform and improve our services. This is supported by key enabling programmes such as digital transformation and a focus on our collective estates and back office functions to ensure these are fit for purpose and support our objectives.

The organisations which form the ICS are united in their commitment to:

- Deliver the *Five Year Forward View* further, faster and beyond the priorities set out in the *Delivery Plan: Next Steps* document published in 2017
- Manage our resources together, which includes our finance, workforce and physical assets as a collective with a commitment to operating a Financial System Control Total made by each of our statutory Boards
- Develop a new approach to service improvement based on the principles of Population Health Management, analytics and data which will inform improved planning and transformation
- Work as a single system, with a combined leadership which values the principle of collaboration

Financial sustainability is one of the key aims of the ICS and a significant amount of shared resource has been and will continue to be required to support this. The ICS has a forecast gap of £16.9m between what it has been allocated and what it is projected to spend in 2018/19. To mitigate this, our system has identified £11m of efficiency improvements which will not reduce the range or quality of services which our patients are able to access. This leaves a gap of £6m for which further schemes are being currently being developed through the ICS as a whole.

Our approach to Population Health Management (PHM) will ensure we are better placed to understand the needs of the local population as a whole with specific improvement actions identified through which we can improve both clinical and financial outcomes. This work is supporting our long term conditions (LTC) transformation which will align specialist, primary and community care in one coherent package. This will also take into consideration, along a

continuum of care, any palliative and end of life care needs. We plan to move towards a model which reduces fragmentation, and underpins care and support planning (C&SP).

Delivery in 2017/18 has focussed on six key clinical areas of transformation; these packages of work were defined during the financial year 2016/17 and have been developed for implementation during 2018/19 and 2019/20 including:

- Outpatient transformation
- Development of an integrated Respiratory Service
- High Intensity Users programme
- Design and development of an Integrated MSK service
- Maternity transformation
- Diabetes transformation

These, along with other programmes of work, are supported by key enablers including a review of back office functions and estates, understanding and modelling our collective bed base, exploring opportunities for a streamlined approach to medicines management, digital transformation as well as workforce development.

The ICS Quality Framework sets out how the ICS will use a strength based approach to 'System Wide Quality Improvement.' Berkshire West is leading the way nationally to demonstrate what can be achieved when Quality is placed at the heart of a collaborative model for service improvement. As a successful ICS we are working together with a shared vision to achieve agreed quality goals and an openness and willingness to challenge and scrutinise each other; to ensure examples of best practice, as well as learning from when things go wrong is shared across the system to achieve best outcomes.

This System Operating Plan provides the detail which underpins all of the above, demonstrating the strength of our collective system and the confidence our leadership has that we can achieve our vision and objectives.

2 BACKGROUND

2.1 About us

The ICS is collaboration between health organisations to improve services for our local population, delivering consistent high quality and safe care, ensuring the best possible outcome and experience for patients, whilst delivering financial stability across the system.

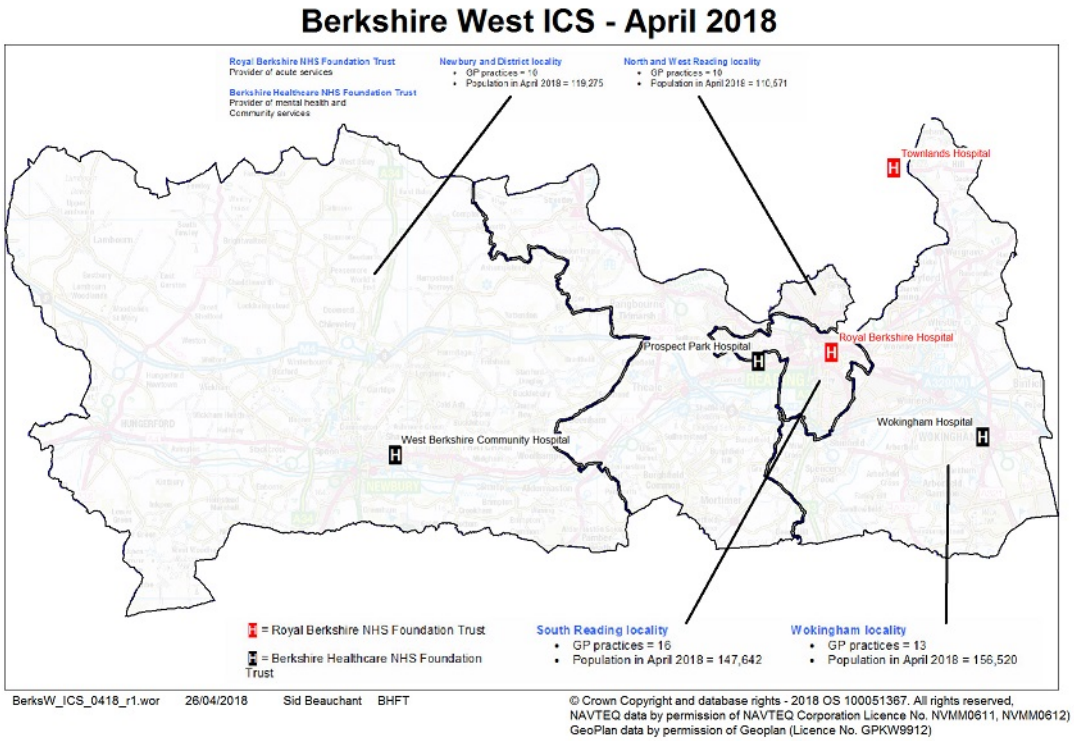
The ICS is comprised of the following constituent members:

- **Acute Hospital Provider** – Royal Berkshire NHS Foundation Trust (RBFT)
- **Community/Mental Health services Provider** – Berkshire Healthcare Foundation Trust (BHFT)
- **Primary Care Provider Alliances** – covering four distinct localities – South Reading, Wokingham, Newbury and North and West Reading Alliances
- **Clinical Commissioning Group** – Berkshire West CCG

Together with our Local Authority partners we are responsible for the health and wellbeing of 528,000 residents living across three Local Authority Areas:

- West Berkshire;
- Reading; and
- Wokingham.

Map 1: Berkshire West Geographical Footprint



The ICS footprint, with a population size similar to Frimley Health & Care STP, is a self-contained health economy with 80% of patient movement, and the majority of funding, being between the constituent organisations. There are three main urban areas – Reading, Newbury and Wokingham alongside vast areas of rurality, particularly in the far west of the area. The areas themselves are also quite distinct in terms of their demographic and health profiles.

The ICS is also a member of the Berkshire West, Oxfordshire and Buckinghamshire ("BOB") Sustainability and Transformation Partnership (STP) recognising the opportunities of working together with partners at this larger scale and progressing initiatives to improve quality and realise financial benefits for the wider system. Through its ICS improvement schemes and local initiatives Berkshire West contribute fully to the delivery of STP wide programmes, for example Maternity services, Urgent Care, Workforce and Prevention.

Generally, the health of residents of Berkshire West is good; however, there are some clear differences between the populations in each of the local authority areas and this is reflected in the differing health needs (full locality profiles can be found in Appendix 1 – separate attachment)

For most of Berkshire West the smoking rates are lower than the national rate in England, however in Reading the rates are higher and therefore a health priority. The number of people drinking alcohol above the recommended levels is fairly high, particularly in South Reading, and along with smoking is an area of focus for the ICS.

Obesity levels across the area are similar to the national figure as are rates of physical inactivity. The ICS works closely with public health colleagues to monitor and improve these levels with targeted interventions in place to support healthy eating and promoting healthy lifestyles.

Overall the health priorities for Berkshire West include:

- Reducing childhood obesity
- Reducing alcohol consumption to safe levels and alcohol related harm
- Promoting positive mental health and well-being
- Preventing and reducing early deaths from cardiovascular disease, diabetes, COPD, chronic kidney and cancer
- Reducing levels of infectious diseases e.g. Tuberculosis
- Promoting self-care and empowerment

2.2 Our aims and objectives

The commitments outlined in the MoU provide the focus for our work with our local ICS Clinical Strategy acting as the foundation that underpins how we will transform and improve our services. This is supported by key enabling programmes such as digital transformation and a focus on our collective estates and back office functions to ensure these are fit for purpose and support our objectives, as well as strong leadership from across ICS parties.

Focussed on the health and wellbeing of our local population, we are working together to develop a preventative model of working, improve outcomes and experience for patients and deliver financial stability across our system.

Our collective aspiration is aligned with our separate organisational strategic objectives, values, and vision statements, and is supported by the objectives within our MoU.

Our overarching objectives as an ICS are to deliver:

- **An improvement in the health and wellbeing of our population**
- **Enhancements to the experience of using health care services**
- **Value for money to local taxpayers and financial sustainability of services**

This will require us to:

- Make fast and tangible progress in urgent and emergency care reform, strengthening general practice and improving mental health and cancer services.
- Manage these and other improvements within a shared financial control total and to maximise the system-wide efficiencies.
- Integrate services and funding, operating as an integrated health system, and progressively to build the capabilities to manage the health of the ICS' defined population, keeping people healthier for longer and reducing avoidable demand for healthcare services.
- Demonstrate to other parts of the health and care system what can be achieved with strong local leadership and increased freedoms and flexibilities.

We will know that we have been successful if:

- People take more responsibility for their own health and well-being
- Care is being provided closer to home, wherever appropriate
- Clinical pathways are better integrated across providers to improve patient experience
- The capability and capacity of primary, community and social care is increased to provide multidisciplinary "wrap around" co-ordinated care that efficiently meets the patient's needs
- We have a better understanding of the clinical needs of our population and maximise the opportunity to prevent, and to intervene early to reduce the need for more intensive on-going care
- We have a high quality, fit for purpose acute and specialist hospital service
- We have a shared quality strategy with system wide approach to the delivery and monitoring of quality
- We operate to single budget for the whole health care system, making the most effective use of the Berkshire West pound and delivering financial sustainability
- People tell us that they are having good experiences of care and, importantly, people tell us when they have not had good experiences of care so that trends can be identified and quality improvement solutions co-designed to improve patient experiences.
- Staff and workplace wellbeing is improved, and we build a sustainable and highly skilled health and care workforce in Berkshire West
- We ensure that duplication and waste is reduced across front and back office services
- People will only be admitted into hospital, nursing or residential homes when the services they require cannot be delivered elsewhere
- All the services that respond to people with an urgent need for care will operate together as a single system, ensuring that people with urgent but not life-threatening conditions will receive responsive and effective care on the most appropriate setting and where possible outside hospital.

These commitments have been set out in a Memorandum of understanding between the members of the ICS and the NHS national bodies (NHS England and NHS Improvement).

2.3 Our constituent organisations

Most of the programme will be delivered through our constituent organisations each of which has refreshed its strategy and aligned to our collective vision.

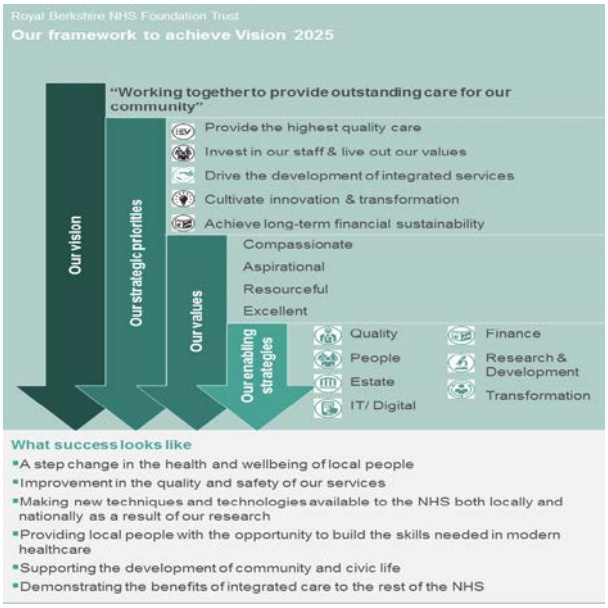
Royal Berkshire Foundation Trust

Royal Berkshire NHS Foundation Trust (RBFT) is one of the largest general hospital foundation trusts in the country. It provides acute medical and surgical services to the local population as well as specialist services such as cancer, dialysis and eye surgery to a wider population.

Across September – October 2017 the RBFT was inspected by the CQC and the **hospital site was rated as 'outstanding'** (overall the **Trust was rated 'good'** as the CQC did not inspect other locations at this time.) This was a remarkable achievement from the previous rating of 'requires improvement' in 2014. To date, RBFT is one of only two hospitals in the country who have achieved this; and one of only 18 acute hospitals who have been awarded an 'outstanding' rating nationally.

In light of our collective journey toward being a fully functioning ICS, RBFT's strategy and its clinical service strategy have been reviewed and updated and aligns with the ICS clinical vision. More broadly in refreshing the strategy it is recognised that the shared nature of the causes of the challenges that the health economy faces means it will be difficult for RBFT to remain a successful independent organisation unless it works in proper partnership with patients and colleagues from across the ICS. This is reflected in RBFT's new vision statement which is ***"Working together to provide outstanding care for our community"***

Figure 1 – Royal Berkshire Hospital Trust Strategy



RBFT is well placed to deliver on its strategy through:

- The hyper-acute stroke service is in the **top 10% nationally** and the heart attack centre consistently achieves the **fastest treatment times in the country.**
- RBFT achieved the best improvement nationally in the proportion of **cancer patients** receiving treatment within 62 days.
- Whilst the Trust has an excellent record in delivering our A&E Waiting Times significant challenges were experienced in the 2017/18 winter – however, we continue to work collaboratively with our regulators to return to full compliance for **A&E waiting time performance.**
- RBFT is **valued by patients** with consistently high levels of satisfaction The Friends and Family test, a national inpatient survey, places us in the top 10% of the country
- **RBFT is one of the most research-active District General Hospitals in the country.** The Trust had the second highest number of patients recruited to trials and are 21st out of 161 NHS trusts recruiting to clinical trials nationally. In 2016/17, the Trust has more than 5,500 participants in around 100 studies.

However, to meet future challenges there is a need to continually seek to change and innovate in order to provide health care in ways that deliver the vision and outcomes expressed above. RBFT has a strong record in participating in research and delivering transformative change and is continuing to build upon its capability to deliver improvement in an ever more challenging economy. To this end an approach of listening and learning in order to develop momentum and the required engagement with staff at all levels through the development of a success model will enable further development and continuous improvement. This will occur as part of an overall transformation programme for the ICS.

Examples at RBFT are: good track record in LoS (Length of Stay) reductions through pathway redesign; 5 year OTIS theatre project which has been highly successful in increasing efficiency in theatre, collaborative work with Local Authorities and Community colleagues to reduce long lengths of stay in hospital and increasingly we will be using benchmarked and digital data to support further developments. The Trust is proud of its achievements and continues to be committed to being an organisation of continual learning and improvement in order to deliver outstanding care to the community and across the ICS.

A major platform for transformation at the Trust is its position as a fast follower **Digital Exemplar site** linked to Oxford University Hospitals, with a 5 year programme of development to implement full clinical digital documentation, voice enabled EP, and the development of advanced analytics and actionable intelligence to support audit, research and clinical/operational service provision and the progression through to proactive population and personal health management positioning the acute services at the heart of the prevention and wellbeing agenda across the ICS.

Berkshire Healthcare Foundation Trust

Berkshire Healthcare Foundation Trust's (BHFT) vision is '***to be recognised as the leading community and mental health service provider by our staff, patients and partners***'. It provides a wide range of hospital and community

based services to people of all ages living in Berkshire. The Trust employs around 4,500 staff operating from many hospital and clinic sites across the county, as well as in people's homes and various community settings.

BHFT delivers integrated physical and mental health services, helping people to remain independent at home for as long as possible and providing the care and support that best meets the needs of patients, from early years to end of life, in the most suitable location. In addition to inpatient mental health and community physical health hospital services, the Trust provides a range of specialist clinics and services aimed at young people, adults and older people to support and treat mental health, physical health and sexual health conditions. The Trust works in close partnership with Berkshire's two acute hospital trusts, Royal Berkshire Hospital NHS Foundation Trust and Frimley Health NHS Foundation Trust, Berkshire's six local authorities and a diverse range of community and charitable organisations.

Berkshire Healthcare's overall **CQC rating is Good**, with the Trust's **older people's community mental health services rated as Outstanding**. Berkshire Healthcare is only one of two similar trusts in the country to be awarded a Good rating, and its ambition is to achieve an overall rating of Outstanding in 2018. The Trust is in **NHS Improvement segment one**, defined as "maximum autonomy and lowest level of oversight appropriate", reflecting a strong track record of effective financial management and its digital maturity and innovation has been recognised with the award of **Global Digital Exemplar** status.

As a community and mental health service provider, BHFT also recognises the key contribution they make in providing more care closer to patient's homes, working alongside our partner acute, primary care, community and voluntary sector providers. BHFT is committed to partnership working over the long term – delivering many integrated services with partner providers – and their strategic plans reflect their understanding that long term sustainability of services requires a system wide approach. The Trust is a committed partner in the two integrated care systems, making a major contribution to leadership and governance, as well as specific work streams. The Trust has developed appropriate structures and systems to enable it to work efficiently and flexibly with both integrated care systems. Its key objectives incorporate achievement of targets within national and local priorities as well as development of the capability required to fully exploit the opportunities presented by the ICS.

2.4 Our achievements

The Berkshire West local health economy is collectively recognised as high-performing and benchmarks well nationally on a number of key performance measures, including non-elective admission rates and prescribing. We are recognised across Thames Valley and nationally for leading the development of innovative approaches to improving clinical care and patient experience, for example Diabetes Care, Heart Service Stroke care, and Improving Access to Psychological Therapy services.

Together we have a long and successful history of working together to deliver common programmes, projects and goals. 2018/19 is the second year of a two year plan and examples of success in year one include:

Launch of Thames Valley Integrated Urgent Care Service (111)

The new Thames Valley IUC 111 service was launched in September 2017 and ensures that people can access a wide range of clinical care through a single call, including dental, pharmacy and mental health services. This new service is provided by South Central Ambulance Service in collaboration with BHFT, Oxford Health NHS Foundation Trust and Buckinghamshire Healthcare NHS Trust. The procurement and mobilisation of this pioneering service was led by Berkshire West CCG with expert opinion provided by senior clinicians in the ICS organisations.

Achievement of the Cancer 62 Day Waiting Time Target

In 2017, Berkshire West was recognised for outstanding improvements in the provision of timely access to cancer services. This improvement was delivered collaboratively between the CCGs and RBFT, with a significant programme of improvement within RBFT to deliver both capacity and process improvements, building on the excellent joint working arrangements in place between the organisations. This improvement was recognised in the form of a letter from the Secretary of State to acknowledge the progress which has been made for cancer patients in our system.

For the last 3 years improvement and robust delivery has been seen for routine patients accessing care via the RTT 18 week waiting time standard. This is involved collaborative working between the CCGs and RBFT and wrapped around a strong improvement programme within RBFT. This included a technological solution to support clinicians navigate the complex system of reporting RTT stages of treatment along the pathway, and thereby releasing time for both clinical and administrative staff

A&E 4 Hour Standard and Urgent and Emergency Care Delivery incl DTOC reduction

Berkshire West has a strong track record in delivering improvements in urgent and emergency care and increasingly via the A&E Delivery Board partnership working in this area has further developed. Evidence of this over recent years is a strong system of primary and community care services providing the right care, right place and right time to avoid attendance at hospital. In tandem, there have been steady improvements in opening up the 'back door' supported by Local Authorities, across all hospital sites – both acute and community. RBFT is a strong performer locally in Thames Valley, usually sitting in the top slot for performance for the 4 hour quality standard. However, a drop in performance in Q3/Q4 of 2017/18 has prompted a further review of all aspects of end to end emergency care directed at returning delivery of the 4 hour waiting time requirement to 95% by the end of 2018/19. This includes further collaborative work following a Local Authority review to take to the next stage improvements on long stay pathways, building on improvements in 2017/18.

Implementation of the Connected Care IT platform

Working in collaboration with Berkshire East CCGs and the Frimley Health and Social Care ICS, the Berkshire West system has led the way in the provision of integrated digital platforms which enable the sharing of information across health and social care organisational boundaries. As well as combining information held in different IT systems across the county, the shared record allows care professionals to create and update care plans, creating co-ordinated multi-agency care for individual patients and enables new ways of delivering services.

We are working in partnership with FHFT to deliver the goal of developing and deploying a Cancer Health Information Exchange (HIE) to enable both improvements to the flow of information between provider sites and increase the visibility of relevant information to the patient themselves.

In addition our organisations are regularly nominated for national awards which recognise the scale of our ambition, particularly with regard to our digital innovations (Connected Care), values (Mental Health) and research (Stroke, Nursing and Patient Involvement).

3 DELIVERING AN INTEGRATED CARE SYSTEM

Set out in the section below are the five domains against which the ICS will deliver. This are:

- Domain 1 - Deliver the 5 Year Forward View
- Domain 2 – Deliver local transformation priorities
- Domain 3 – Deliver financial sustainability
- Domain 4 – Embed a population health approach
- Domain 5 – ICS Governance and Leadership

These domains and how they interact with each are presented below:

Figure 2: Berkshire West ICS transformation programme

3.1 Domain 1 - Five year forward view

As one of the pillars of the ICS, delivery of the Five Year Forward View is central to improving the health of our local population. Each of the sections below sets out achievements to date as well as how the Forward View will be delivered by the ICS in 2018/19 aligned to the expectations of the MoU. Each of these areas of work has a developed project plan with clear milestones and is overseen by the ICS governance framework to ensure successful delivery.

3.1.1 Cancer

The approach to providing cancer services in Berkshire West in 2018/2019 continues to be delivered through the jointly agreed Berkshire West Cancer Framework. We continue to work closely with the Thames Valley Cancer Alliance and are fully engaged in all the emerging work streams. We have reviewed our progress against our objectives and agreed our local and Cancer Alliance priorities for 2018/2019 to continue the momentum of implementing the six priorities in the national Cancer strategy, the Five Year Forward View and the Thames Valley Cancer Alliance key ambitions by 2021. Please see **Annex 1** for more information.

3.1.2 Mental Health

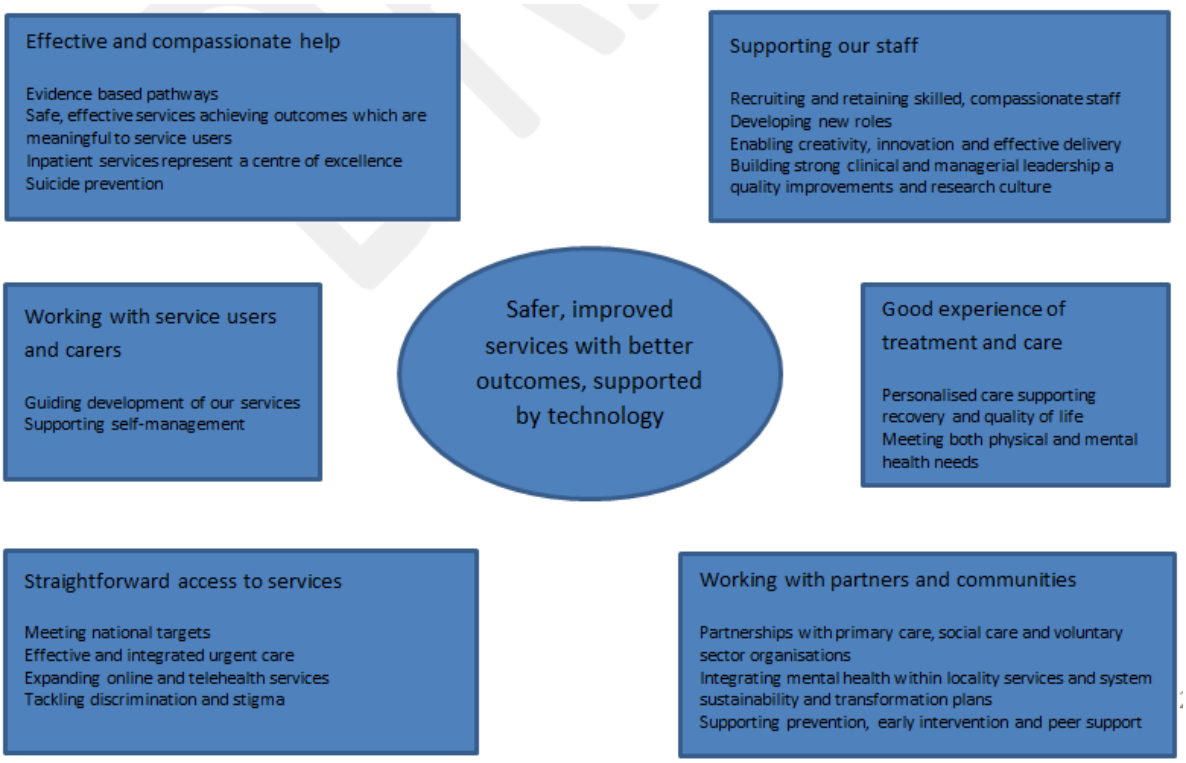
Improving mental health is a fundamental part of our ICS operating plan. The Five Year Forward View for Mental Health (2016) sets out a clear direction for the NHS to improve mental health and wellbeing, highlighting why change is required and what good will look like. Some of what is needed can be brought about by the NHS itself. Other actions require partnerships with local organisations including local government, housing, education, employment and the voluntary sector.

Berkshire West has a strong foundation of partnership working in mental health, with well-established collaborative approaches to strategic and financial planning. We plan to build on this through the establishment of a joint mental health strategy function within our ICS to drive the delivery of the Five Year Forward View ambitions.

The evidence is clear that improving outcomes for people with mental health problems supports them to achieve greater wellbeing, build resilience and independence and optimise life chances, as well as reducing premature mortality. We recognise that putting more focus on early intervention, investing in effective evidence-based care and integrating the care of people's mental and physical health will have significant gains for local people and support the achievement of ICS objectives.

Developed in partnership with commissioners, local authority partners and public health, the Berkshire Healthcare Mental Health Strategy outlines the key areas of focus for 2016 – 2021 which are summarised below.

Figure 3: Berkshire Healthcare Mental Health Strategy



Our Connected Care Programme for our shared electronic patient record, along with the work we are doing as Global Digital Exemplar for mental health are key enablers for us in the delivery of Five Year Forward View Targets. Use of technology is supporting the delivery of increased access through online delivery models, and effective use of staffing resources. Our Mental Health Workforce Plan, which will be completed in March 2018, will outline our key risks and mitigation of these – and progress will be monitored by the ICS Workforce Group as well as by the Berkshire Healthcare Workforce Strategy Steering Group.

Our multi-agency Mental Health Delivery Partnership Steering Group is responsible for ensuring delivery of the Five Year Forward View for Mental Health, and is accountable to the Unified Executive of our ICS. Full information on the following projects can be found in **Annex 2:**

- Increasing Access to Psychological Therapies (IAPT)
- Physical Health Check and Care co-ordination
- Early Intervention in Psychosis (EIP)
- Psychiatric Liaison service
- Individual Placement and Support services (IPS)
- Reducing suicide rates
- Perinatal Mental Health
- Eliminating out of area placements for non-specialist acute care
- Dementia
- Children and Young People
- Mental Health Investment Standard (MHIS)

3.1.3 Primary Care

The Berkshire West General Practice Forward View (GPFV) Local Implementation Plan sets out a vision for a sustainable primary care sector working at-scale and as an integral component of the ICS to offer an extended range of integrated and proactive services in the community. To achieve this vision, our practices have come together into Primary Care Provider Alliances, with all practices within them working in geographically-contiguous clusters which will interface with other services to meet the health needs of groups of 30-50,000 patients (Primary Care Networks). At a system-level, the alliances are working together in an 'Alliance of Alliances' which will look to maximise their impact within the ICS.

The ICS's GPFV programme for 2018-19 will include the following key components:

- Primary Care Networks – the network/alliance structure is to support delivery of primary care at-scale. Integrated health and social care teams within networks will use population health analytics to plan targeted care and will deliver a joined-up community response to acute presentations. The range of services provided in primary care setting are to be expanded through new ways of working with other ICS partners, e.g. through outpatients transformation and care and support planning for patients with long-term conditions.

- Access – delivery of Enhanced Access (100% of patients to have access to primary care in the evenings, at weekends and on bank holidays) and new ways of responding to same day demand through primary care access hubs.

- Workforce – systematic workforce modelling/planning, further development of skill-mix in primary care including clinical pharmacists, paramedics and physicians' associates, actions to improve GP recruitment and retention, continued professional development across the primary care workforce and development of clinical and managerial leadership capability.

- Workload – delivery of Time for Care programme with focus on active signposting, group consultations and quality improvement. Completing implementation of workflow optimisation and online consultation and supporting alliances to further explore sharing of back office functions. Wearable technology project as part of work to maximise impact of self-care.

- Estates and infrastructure – delivery of ETTF (NHSE Estates and Technology Transformation Fund) and non-ETTF premises schemes and further development of primary care estates strategy (see Enablers, below). Roll out of access to Connected Care Health Information Exchange (see Enablers, below) to primary care.

- Sustainability and resilience funding – further funding to be allocated in accordance with guidance to support future sustainability of primary care sector.

- Delegated commissioning – fully delegated commissioning processes to underpin delivery of GPFV which will be overseen by Primary Care Commissioning Committee. The approach to improving quality is to be reviewed in 2018/19 as part of development of ICS Quality Framework (see below).

Please see **Annex 3** for more information.

3.1.4 Urgent Care

The A&E 4 hour standard remains one of the key indicators of success for the urgent and emergency care system. Whilst the winter of 2017/18 has been very challenging we have a strong track record of delivery across the urgent care pathway and learning from 2017/18 has, and continues to be used to, inform plans for 2018/19 Whilst our system is proud to be achieving over 90% performance, which is a reflection of the whole system focus on patient safety-experience and maintaining flow through the acute site and recipient organisations, this is not sufficient. The drive to return to compliance at 95% is strong and is being supported by the Accident and Emergency Delivery Board who have developed a suite of improvement initiatives aimed at driving improvement against this constitutional standard. We will do this by delivering improved service provision in support of the principles of valuing patients' time by providing a combination of care at home wherever possible, the avoidance of overnight stays by increasing ambulatory options and reducing time in hospital where hospital admission is needed.

. Priorities include:

- Increased usage of ambulatory care pathways utilising the new protected Ambulatory Care area
- Increased use of hot clinics and telephone access to Consultants
- Maximising the potential of the Primary Care streaming service with the inclusion of paediatrics
- Continued drive on efficiency through the bed base across the system with red/green actions for all patients and a reduction in stranded patients
- A partnership model for managing bedded care across the system as a whole, ensuring right care, right place, right time including a system wide bed management system to create visibility and smoother access
- Integrated Discharge service working with medically fit patients on a case management approach to improve discharge flow
- Increased focus on discharge to assess and further development of the Trusted Assessor approach with roll out of the Standard Operating Procedure and single referral form
- Robust use of the Choice Policy with interim placements being seen as a part of the pathway

The Thames Valley Integrated Urgent Care (TVIUC) service successfully launched in September 2017. The service is provided by an Alliance led by South Central Ambulance Service NHS Foundation Trust, working in partnership with Berkshire Healthcare NHS Foundation Trust, Oxford Health NHS Foundation Trust and Buckinghamshire Healthcare NHS Trust. The service is based on a specification designed in 2016 and refined during a period of co-production between the Alliance and commissioners during Q1 of 2017-18. The new service incorporates a Clinical Assessment Service (CAS) with a range of specialist clinicians including GPs, mental health practitioners, nurses, prescribing pharmacists, dental professionals and currently 30% of calls receive advice from a clinician within the CAS. Call streaming also ensures that vulnerable groups such as the under 5s, over 85s and those receiving palliative care can benefit from immediate clinical advice.

Please see **Annex 4** for more information

3.1.5 Maternity

In February 2016 Better Births was published and it set out the Five Year Forward View for NHS maternity services in England. It set out a compelling view of what maternity services should look like in the future. The vision is clear: we should work together across organisational boundaries in larger place-based systems to provide a service that is kind, professional and safe, offering women informed choice and a better experience by personalising their care.

A national Maternity Transformation Programme has been established to take forward implementation of the vision. However, *Better Births* recognised that delivering such a vision would rely primarily on local leadership and action. Consequently, it recommended commissioners, providers and service users coming together as Local Maternity Systems to deliver local transformation.

A Local Maternity System (LMS) was established across the BOB STP in March 2017 as recommended by the Better Births Report: National Maternity Review published in June 2016. As a result of the capacity issues across Thames Valley maternity services is one of the main priorities for the BOB STP. The Senior Responsible Officer for Maternity is the Chief Executive of Buckinghamshire Healthcare NHS Trust who nominated the Chair responsibility to the Director of Nursing for Berkshire West CCG. The membership of the LMS Board includes representatives as recommended in the NHS E LMS Resource pack. The LMS Board meets quarterly with working groups set up to address the 5 main priorities:

1. Improving the safety of maternity care by 2020/21
2. Increasing Choice and Personalisation
3. Transforming the workforce
4. Improve access to Perinatal Mental Health Services
5. Improving Prevention

Please see **Annex 5** for more information.

3.1.6 Learning Disabilities

The Transforming Care Partnership (TCP) Board comprises 14 Health and Social Care partners across the county who hold a shared vision and commitment to support the implementation of the national service model for children, young people and adults with learning disabilities and/or autism, who have behaviour that challenges and may or may not have mental health issues and have come into contact with the criminal justice system. The model requires integration and collaboration by commissioners, providers and other sectors to enable this cohort of people to lead meaningful lives through tailored care plans that meet individual needs.

Please see **Annex 6** for more information

3.2 Domain 2 - Local transformation priorities

The work of the ICS can be categorised within two distinct areas – New Care Models and New Business Models (Enablers). These packages of work were defined during the financial year 2016/17 and have been developed for implementation during this phase of the programme. A second phase of workstreams will quickly follow, building on the work achieved to date to enable greater clinical transformation.

The objective of the New Care Models workstreams is to give the freedom and support to our clinical leaders for the design of service improvements for our patients. These clinical improvements will deliver the main programme objectives such as ensuring the requirements of the Five Year Forward View, improving the financial position and enhancing patient experience and outcomes.

The objective of the New Business Models workstreams are to find new ways of working collaboratively which support the infrastructure of the ICS for example contractual form and payment mechanisms to deliver better efficiencies in the way we work.

In defining the priorities of the ICS it is recognised that there are areas of clinical variation and high demand where transformation of existing ways of working and service delivery is required in order to fulfil our ambitions for excellent patient care as well as support financial sustainability. These cover the clinical areas set out below:

- Outpatient transformation
- Development of an integrated Respiratory Service
- High Intensity Users programme
- Design and development of an Integrated MSK service
- Maternity
- Diabetes transformation

These, along with other programmes of work are supported by key enablers including review of back office functions and estates, understanding and modelling our collective bed base, exploring opportunities for a streamlined approach to medicines management, digital transformation as well as workforce development.

3.2.1 Outpatients

Nationally and locally there are increasing demands on outpatient services with growth in referrals year on year putting demands on outpatient facilities, waiting times and clinicians. Across England there was an increase of 9% in referrals between 2016 and 2017, and locally the increasing volume of referrals to RBFT in some specialties has reinforced the understanding that there is a need to review our approach to outpatients and ensure that future models are safe and cost effective.

The vision for the outpatients transformation programme is to redesign outpatient services by:

1. Developing alternative options to complement current practice

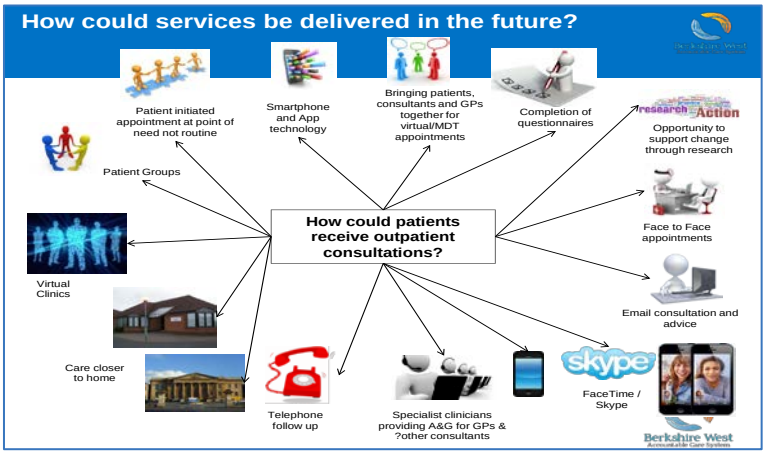
2. Optimising the use of technology advances
3. Truly integrating working across pathways
4. Developing care closer to home to improve patient experience and reduce the reliance on the acute RBFT site

The overall aim is to provide the optimum patient experience and best value for money for the Berkshire West pound.

This transformation programme is a strategic change programme delivered as a collaborative approach through the ICS with RBFT, BHFT, Berkshire West CCG and the emerging GP Alliances working together to achieve the changes. It builds upon an internal RBFT three year outpatients modernisation programme that started early in April 2017 and takes advantage of the ICS development to give the programme a wider perspective and gain greater benefits.

Following extensive pathway mapping, engagement of patients and clinicians, a menu of options for implementation have been developed which will be used in all clinical specialties at RBFT. The changes have been designed to achieve a combination of a significant shift of outpatient appointments on the main RBFT site to locality sites across the network so they are closer to patient's homes. Options include the introduction of patient initiated clinics to support a reduction in unnecessary follow ups, the further development of virtual clinics and one stop clinics and new offers such as skype consultations and easier access to Consultant opinions by GPs will reduce the need for patients to be referred in. For more information please see **Annex 7**.

Figure 4: How outpatient services could be delivered in the future



3.2.2 Integrated Respiratory Service

Work is under way to develop an integrated approach to managing patients with respiratory conditions. This builds on a previous case for change to increase access to specialist consultant skills across community and secondary care implementing an appropriate outcome based approach to meet local population needs.

The aim of the service is to reduce unplanned hospital admissions and demand for specialist outpatient services by achieving the following objectives:

- To provide a fully integrated service for primary, secondary and community care through virtual clinics and an MDT approach to respiratory provision in a community setting
- To promote early identification of COPD and Asthma self-management and intervention to improve the well-being of patients with respiratory disease
- To reduce reliance on specialist skills where alternative approaches can be adopted.
- To upskill primary and community to ensure the potential to support the patient population is maximised.

There are a number of current work-streams which form part of the Outpatient Transformation Programme and are focussing on revised pathways for managing both Sleep Apnoea and chronic cough. In addition work is in progress to review existing patients with COPD/Asthma, mainly in relation to current medication. This will continue to support discussions regarding most effective ways to meet the needs of the local population. For more information please see **Annex 8**

3.2.3 High Intensity Users

A substantial proportion of the healthcare budget is accounted for by relatively few patients. This indicates significant potential for reducing workload on urgent care services and the wider health economy via a targeted and proactive intervention. Learning from Blackpool has demonstrated that an approach of empathy and coaching rather than enforcement has the potential to reduce the volume of urgent care activity for this cohort and indeed improve outcomes for patients.

This model of support has been replicated locally through the implementation of a High Intensity User (HIU) service working across RBFT, BHFT, SCAS and primary care. The approach offers a robust way of working across the ICS to reduce activity to 999, NHS 111, A&E, GP contacts and hospital admissions, freeing up front line resources to focus on more clients and reduce costs. It uses a health coaching approach, targeting high users of services and supports the most vulnerable clients within the community to flourish, whilst making the best use of available resources.

The service will measure the impact directly on 999 call outs, A&E attendances and associated admissions as well as qualitative outcomes for clients. However, through the Connected Care technology the project will also have the visibility of how the work of the coaches impacts on the wider health system, for example primary care and mental health services. For more information please see **Annex 9**.

3.2.4 Integrated MSK

Musculoskeletal conditions (MSK) are one of the areas of greatest spend for Berkshire West with care currently split across primary care, intermediate services and acute provision. With an ageing population there are increasing levels of demand and variation in referrals and management of MSK conditions which supports an overall case for change. Further work is required to improve the service to patients through developing and implementing a more integrated and coordinated programme.

People with MSK conditions need to be able to access high quality support and a wide range of treatments. These range from simple behavioural or exercise advice to highly technical, specialised medical and surgical treatments. Multidisciplinary, integrated services are essential and need to incorporate rapid assessment and diagnosis.

The new integrated service aims to deliver the following outcomes:

1. An end to end pathway that encompasses de-medicalising MSK and promoting self-care and healthy living such as exercise and healthy eating as enablers to have a positive impact on MSK issues;
2. A community provision where primary and community care providers work closely with physiotherapists to provide direct access for patients with MSK conditions to physiotherapists. By ensuring all aspects of self-management are explored to manage the condition this will result in appropriate referrals to secondary care in line with clinical need;
3. Patients to participate in a shared decision making process before referral for a procedure to secondary care;
4. Reducing clinical variation and duplication through pathway coherence;
5. Ensuring that every MSK practitioner is consistent in their approach;
6. Addressing the issues and concerns identified by patients and improving the quality of patient experience;
7. Patients are given choices for treatments in line with the NHS Constitution
8. Providers will identify and eliminate waste from within the MSK pathway and supply chain (as outlined in the Getting it Right The First Time report) therefore delivering commercial efficiency for the Berkshire West system moving toward a whole-system approach;
9. Utilisation of IT solutions to provide integrated care

For more information please see **Annex 10.**

3.2.5 Diabetes

The overarching BOB STP plan for Diabetes Transformation focuses on improving the efficiency of the BOB area while bringing care closer to home and improving access to more appropriate and timely healthcare for their population. This plan shows the commitment of all the constituent CCGs to move towards a common goal of reducing variation in care across the whole STP area.

The projected rapid increase in numbers of people with diabetes and those at risk, combined with a transient population places considerable challenges on the health and care systems.

Table 1: Predicted Diabetes Populations in the next 5, 10 and 15 years.

Berkshire West	27,124	7.1%	2020

Buckinghamshire	37,134	6.9%	
Oxfordshire	34,302	8.0%	
Berkshire West	29,492	7.5%	
Buckinghamshire	40,597	7.2%	
Oxfordshire	37,524	8.5%	2025
Berkshire West	32,220	8.0%	
Buckinghamshire	44,493	7.7%	
Oxfordshire	41,052	9.1%	2030

The ICS within the STP footprint is committed to enabling people with diabetes to have access to appropriate, sustainable healthcare and support. Therefore the Diabetes Transformation fund provides us with the opportunity to create more flexible options to improve health outcomes for people with diabetes. Additional funds will accelerate the ability of the system to reduce variation in care delivered, increase the amount of care provided in the community and closer to home and improve access to secondary care services when needed for people with diabetes.

Across the ICS the recorded prevalence of Diabetes for adults is lower than the expected prevalence. This discrepancy varies across the geography with primary care management in Newbury & District, Wokingham and South Reading sitting within the lower quartile. The whole system approach being adopted by the ICS is aimed at reducing this variance, which we acknowledge cannot be attributed to population structures and deprivation alone. In 2012 the reports from the National Diabetes Audit of 2009-2010 identified the need for change with the 8 key processes for diabetes care being amongst the worst in matched communities in England.

Across Berkshire West significant improvements have been made in the last 5 years to improve the outcomes and experience, reduce variation and improve sustainability of resources. However there are still some unacceptable gaps in provision. Plans are in place to improve this through patient engagement, collaboration with other stakeholders, supporting Health Care Professionals (HCP) and investing in the use of technology and informatics. This includes the recognition within our Long term Conditions transformation programme that Diabetes is rarely a single condition and therefore holistic assessment and support is crucial. It is recognised that for many people with diabetes this is only one of many conditions they live with. Therefore our aim is to embed a truly patient centred, holistic approach, and we plan to continue to extend the focus of the current care and support planning to include review of other related conditions and aim to develop a single all-encompassing care plan for people with multiple needs. This will concentrate on what is important for the patient, enable joint decision making, to increase patient participation and self-management. For more information please see **Annex 11.**

3.3 Domain 3 - Financial Sustainability

Financial sustainability is one of the key aims of the ICS and a significant amount of shared resource has been and will continue to be required to support this. The allocations for 18/19 provide welcome additional funding for both providers and commissioners, but from a CCG allocation perspective Berkshire West now has the second lowest per head funding in the country.

Table 2: CCG allocation

Per Capita Funding*	
Berkshire West CCG	£1,059
SE England average	£1,196
England average	£1,254

*raw population

Compared with other CCGs, Berkshire West CCG is the 7th furthest away from target funding with a distance from target of c£25m.

The ICS has a Chief Finance Officers' Group which has developed a number of work streams to support our sustainability in 2018/19:

- **New payment mechanisms** (linked into national work streams) – The ICS has a shared ambition to move away from PbR, the final arrangements for this continue to be developed alongside the work on the system control total.
- **System control total** (linked into national work streams) – This is currently subject to discussion with NHSE/I and will be finalised post submission subject to individual Governing Body/Board approval.
- **Contractual form** – The ICS will be using the Standard NHS Contract which will be supplemented with an Alliance Agreement setting out the risk share arrangements for 2018/19.
- **New ways of working** – enabling finance, Business Intelligence and contracting staff to have different conversations focussed on identifying issues and solutions rather than focussing on reconciling different datasets.
- **Group Accounts** – the development of a consolidation model for group accounts giving full visibility of system income and costs and enabling the identification of inconsistent assumptions each month, which is assisting with contract alignment work.

The ICS system gap is calculated to be £16.9m for 2018/19. Against this gap the CCG has identified £5.6m of savings which do not impact on the wider system and where there is high degree of confidence on delivery - this includes prescribing initiatives, merger and contractual savings. The ICS has also identified £1.8m of savings which are the full year effect of schemes identified in 2017/18 and other schemes that have sufficient work up to allow confidence regarding delivery. A further £9.5m of new schemes including the opportunities identified by Right Care and linked to the 10 Point Efficiency Plan are currently being developed by the ICS. There are a number of mitigations available to the CCGs should it not be possible to fully close the gap with new transformation schemes in year.

Providers have the following CIPs:

- RBFT - £16m (4.6%) requirement against which there is a risk adjusted plan of £12.5m
- BHFT - £4.8m (1.9%) requirement against which there is a risk adjusted plan of £3.9m (Berkshire West's share being 60%)

The work on system transformation is focussed on addressing both demand and cost.

The ICS management teams are working together to develop a plan for long term financial sustainability. Using our ICS Group Accounts tool we are working with colleagues and our regulators to understand our unmitigated financial gap for the future period and identify the issues which are causing this.

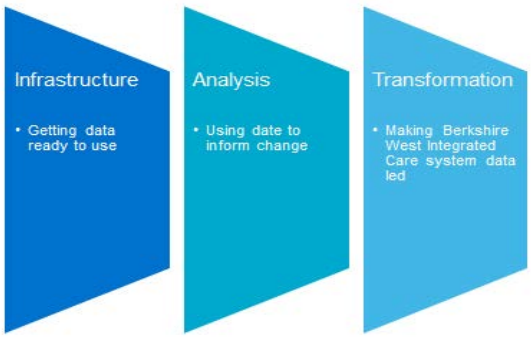
In order to generate additional transformation focus areas, the ICS will seek to work within the current *Five Year Forward View* performance framework to identify areas for improvement. These services will be benchmarked against comparators and examined in the context of our overarching Population Health Management approach to understand where opportunities may exist to improve services and reduce their cost. However, available benchmarking data does indicate that the system will need to be very creative and that real transformation will be required in order to close the underlying gap while funding is below target. Furthermore, the ICS has a focus on reducing cost and maximising value rather than shifting the gap between commissioner and provider with traditional QIPP schemes focussing on PBR.

The ICS Clinical Delivery Group which brings together our lead clinicians from across the ICS that will own this work and drive the delivery of transformation projects through well-established system programme boards to ensure that opportunities are realised. The ICS participants will continue to use available data and national programmes to inform the system wide efficiency programme which focusses on both new care models and new business models.

3.4 Domain 4 - Population health management and prevention

Population Health Management (PHM) is an approach to better understand the needs of the local population as a whole with specific improvement actions identified through which the local NHS can improve both clinical and financial outcomes. PHM is the aggregation of patient data across multiple health information technology resources, the analysis of that data into a single, actionable patient record, and the actions through which care providers can improve both clinical and financial outcomes. The overarching objective of population health management is to identify, predict, intervene and support patients to manage conditions cost-effectively, but also move the system from performance monitoring to outcome monitoring, through:

Figure 5: Population health management approach:



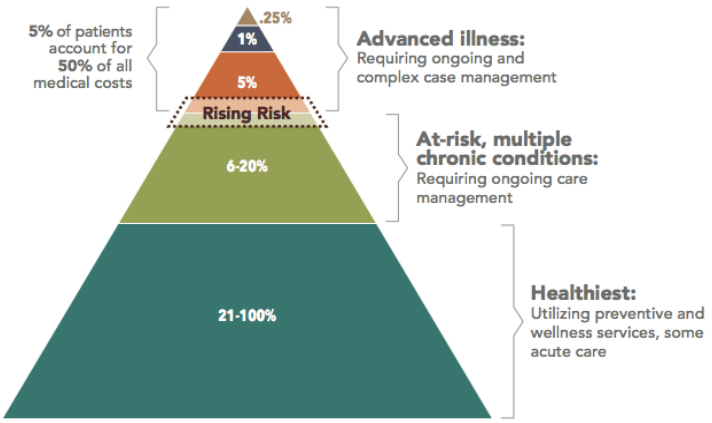
This approach will promote integrated care, centred on the patient, in order to provide better health outcomes and value for money. The ICS has already begun to work on PHM, with the use of Theograph to plan and monitoring High Intensity user patients, this approach will be adopted for New Models of Care across the system in 2018/19, through the uses of wider data sources.

Our developing approach to Population Health Management is to:

- Build and expand on the information within the Connected Care Health Information Exchange to support Direct Care, including effective shared care planning and to identify individuals within the population at greater risk to and provide early invention services
- Design both an Operational Dashboard and a Planning Dashboard that focuses the ICSs clinicians, operational and executive teams on meeting the Triple Aims moving from Performance to Outcome based Models of Care
- Use our population health management approach to accurately segment the local population to enable better service planning and delivery

During 2018/19, the ICS is working with NHS England as a National Population Health Dashboard Exemplar, linking with Cerner, North East London CSU and Imperial University College. During April 2018 the Berkshire West Integrated System will be completing NHS England Population Health Readiness Assessment and undertaking a deep dive on Data, Information Governance and Analytics in order to understand our system strengths, what we need to adapt and what we will need to procure to support a data led system.

Figure 6: Our population health management approach



People with Multiple Long Term Conditions: Demand for services is predicted to continue to rise with a growing older population and people living with more complex long term conditions. The utilisation of Population Health analytics has formed the basis of our work within the ICS which has commenced during 2017/18, aiming to transform care for people with multiple Long Term Conditions. Analysis of data within the Adjusted Clinical Groups (ACG) system ACG Tool (University (Johns Hopkins Adjusted Clinical Groups® (ACG®) System) has been utilised to support benchmarking and subsequent identification of resource requirements. Using profiling and risk stratification resources we are able to stratify populations to ensure resources are targeted more effectively and efficiently. It is recognised that there needs to be a fundamental shift from more traditional reactive, compartmental and unplanned approaches to one which is truly patient centred, proactive and anticipatory, enabling patients and carers to access services at or

as close to home as possible and which aligns specialist, primary and community care in one coherent package. This will also take into consideration, along a continuum of care, any palliative and end of life care needs. We plan to move towards a model which reduces fragmentation, and underpins care and support planning (C &SP). The Long Term Conditions Programme approach aims to identify effective and sustainable approaches to underpin the prevention of an avoidable increase in health need that may lead to a loss of independence and an increase in demand on services.

Prevention and self-management: Prevention and self-management sits at the core of our methodology to improving the health and wellbeing of the population in Berkshire West, consistent with a population health management approach. The increased prevalence of chronic diseases occurring in all Western economies requires a strong reorientation away from the reliance on acute and episodic based care, towards prevention, self-care, more consistent standards of primary care, and care that is well co-ordinated, integrated and anticipates and avoids/minimises deteriorations and complications.

Seeing systematic population level change in the health and wellbeing of the Berkshire West population will require a preventative approach, delivered from the community, which will address modifiable risk factors to ensure better health.

In embedding a focus on prevention and self-management, the ICS will:

- Ensure technology such as information provision and decision support is rolled out to assist patients to manage their own conditions
- Improve patient knowledge and education, particularly in relation to long term conditions, to empower patients to take control of their conditions and understand how to manage them effectively
- Focus on lifestyle factors such as a reduction in smoking and obesity and an increase in exercise to prevent the onset of disease
- Ensure that every contact with a health or social care professional counts, taking the opportunity to deliver health promotion messages at each opportunity where the setting of care enables this interaction to occur.

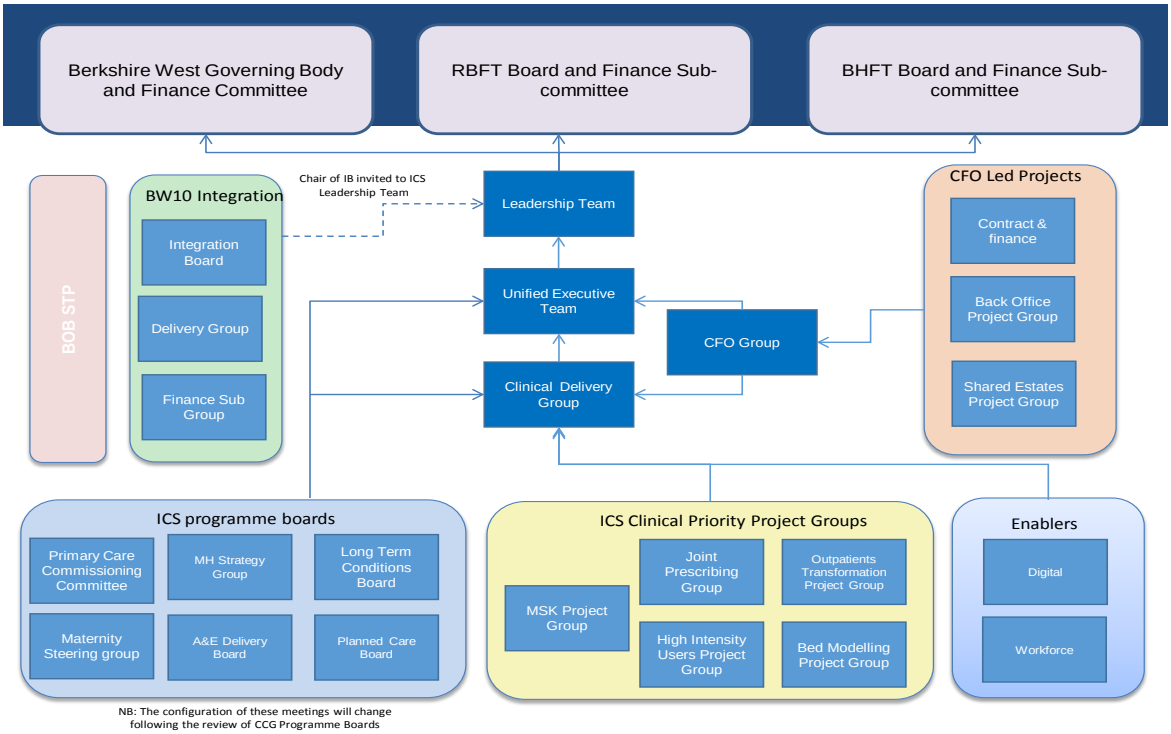
3.5 Domain 5 - Governance and leadership

The ICS has been in place since 2015 with a 'programme governance' structure that has been refreshed in 2017 to reflect both leadership and delivery within the ICS. The structure that has been set up enables us to monitor progress against delivery of the MoU objectives which drives the measures of success for Berkshire West. This is governed by a monthly programme dashboard which tracks this progress.

This approach has been founded on a number of principles, most importantly that of reaching joint consensus prior to any further decision which may be required at an organisation level. Other principles include:

- Maintaining strong clinical leadership through a clinically led process to ensure that decision makers can be confident that changes are being made in the best interests of patients
- Clear points of accountability for projects and deliverables
- Using business as usual / standard governance procedures as widely as possible to take decisions
- A commitment to wider integration with Local Government and other strategic partnerships which add value for the taxpayer
- Remaining transparent and open to scrutiny from patients and the public
- Providing assurance in a coherent manners to our regulators
- Ensuring Healthwatch are involved at ICS Programme Board level ICS and patient champions are involved with individual projects wherever possible.

Figure 7: Berkshire West ICS Governance structure



Escalation and scrutiny is provided by the ICS Unified Executive with clinical oversight, support and guidance is provided by the ICS Clinical Delivery Group. The latter also performs a critical function in ensuring that opportunities for cross-programme board working and the elimination of duplication are realised.

3.5.1 Integration of the ICS into the wider health and social care system

The Berkshire West ICS and partners have been working together as the Berkshire West 10 (BW10). This comprises of the CCG, three local authorities, RBFT, BHFT and SCAS since 2013 within a shared governance structure. The chair of the BW10 Integration Board is also a key member of the ICS leadership group, as well as a number of key clinical and managerial leads, which ensures there is strong collaboration between BW10 and the ICS. Social Care is recognised as an important part of our overall health and social care delivery system and working effectively together with further strengthen our ability to improve outcomes for residents.

The BW10 Integration Programme is an ambitious transformation programme involving fourteen projects/ programmes across these ten organisations. These operate both at locality level and Berkshire West wide to deliver the intended benefits. The collective objective is focused on improving outcomes for users and patients, and achieving long term financial sustainability.

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

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

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

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

These feature as a key part of delivering the five year forward view around urgent and emergency care. The work of the BW10 on this links closely with the A&E delivery board to ensure a consistent and joined up approach across the system.

One of main achievements in 2017/18 has been the significant reduction in the number of bed days lost due to patients waiting in hospital longer than they needed to be there. Much of this success can be attributed to the focused work we have undertaken through the BW10 Integration Programme and we will seek to build on this in 2018/19 so that each of localities has a realistic aspiration to meet the national target in this area.

Building on the success of recent years, 2018/19 will be an important year for us to move our collective aspiration on to greater integration achievements.

4 ENABLERS

4.1 Back office

There is a potential opportunity to integrate and implement a new delivery model for back office services across the ICS which enables the continuation of high quality delivery but at a reduced cost. The providers and CCG have been working together over the past year to review the options available, the phasing of the development of any shared capability and the potential savings. Phase 1 of the programme focusses on transactional services with a target saving of 15%. There is also a significant linked piece of work around re-procurement of core financial systems and the opportunity to move to a single system for providers.

During this 2017/18 the CCG have brought services in-house from CSU in a preparatory phase with further in-housing to occur in 2018/19 at a saving of approximately 20% in year 1 and a further 20% in year 2.

4.2 Estates

A high quality, modern, accessible and welcoming estate is critical to our ability to serve our patients. Our estate presents us with a number of challenges. Like many health and care systems our estate is a patchwork of bespoke buildings built in a range of different eras across multiple sites.

Within the RBFT portfolio, the Royal Berkshire Hospital (RBH) site comprises buildings that range from relatively new, supporting the effective delivery of services, through buildings built in the 1960s and 70s that require investment or replacement, to listed buildings that are expensive to maintain and run services from and no longer support the delivery of care in the 21st Century. . Equally a number of these facilities (including the emergency department) were commissioned prior to the increase in local population. With population set to expand again we face the prospect that these facilities will struggle to deal with the demands placed on them. There are significant infrastructure challenges which impacts upon the experience of patients, visitors and staff. Likewise progress should be made on reducing the impact of heating and powering the building on the environment and reducing the carbon footprint of our services and our buildings. RBFT are seeking to utilise estate away from RBH site, alongside evolving digital and technological solutions, reducing the requirement for patients to attend the acute hospital site.– delivering care at or closer to people's homes. RBFT is developing the estate masterplan to reduce the running costs, reduce backlog maintenance and ongoing maintenance costs and ensure that, where services need to be delivered from an acute hospital site, they can be delivered from premises that are fit for the delivery of 21st century hospital care We also have a range of opportunities notably the facilities BHFT already operates from across the county. Many of these buildings have the potential to provide more care – and are closer to people's homes.

Within the BHFT estate portfolio, a number of actions have already been taken to rationalise the number of smaller service locations within the Reading area, dispose of older buildings no longer fit for purpose and integrate services into a smaller number of modern well places locations that better serve the community.

There are a number of factors which have prompted the ICS to commit to further development of the Primary Care Estates Strategy in 2018/19. These include demographic change and growth as a result of significant housing development; new ways of working including the use of different workforce models and IT solutions; and the requirement to future proof new developments to enable potential new care models that shift work from hospital settings to primary care.

Together, the ICS participants also have an opportunity to review administrative estate linked to the Shared Back Office programme.

The aim of this work is to maximise effective utilisation (clinical and non-clinical) of our NHS estate portfolio and identify opportunities to deliver cash receipts through disposals and reduced annual revenue costs across the system. This will support and be shaped by the emerging estates requirements of the new care model and system changes identified via the ICS change programmes and ensure the estate portfolio is fit for the delivery of modern healthcare services that meets the expectations of patients/service users. For more information please see **Annex 12.**

4.3 Shared Bed Modelling

This project was established to ensure our 'bed base' across the ICS health economy 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 ICS programmes. The context for this work is that whilst maximising opportunities for patients to have care outside hospital and reduce time in hospital overall we want to ensure that bedded care is optimised across the system for patients whose clinical needs require it. By this we mean that bedded care is provided in the correct volume at the Acute Trust, and in other settings, with the underlying principle that time in hospital should be minimised to avoid the well evidenced risk of decompensation for patients as a result of prolonged hospital stays.

The project is mapping capacity and patient flow across provider organisations, sites and bed types. A key output will be a move to manage all bedded care across the system 'as one' supported by a system wide bed management system based on real time data. In addition, a work stream to improve the functional processes 'on the day' whereby available beds are identified, patients matched to those beds and transfers take place earlier in the day to settle patients into their onward care in a more timely manner.

At its heart is a redesign across the system of bedded care to deliver provision that can care for the right patient in the right setting as part of care pathways that provide alternatives to bedded care where appropriate. Current state for acute and community bedded care is complete, the next stages will pull in mapping of domiciliary, nursing and residential home care and include in the future state design alternatives to bedded care.

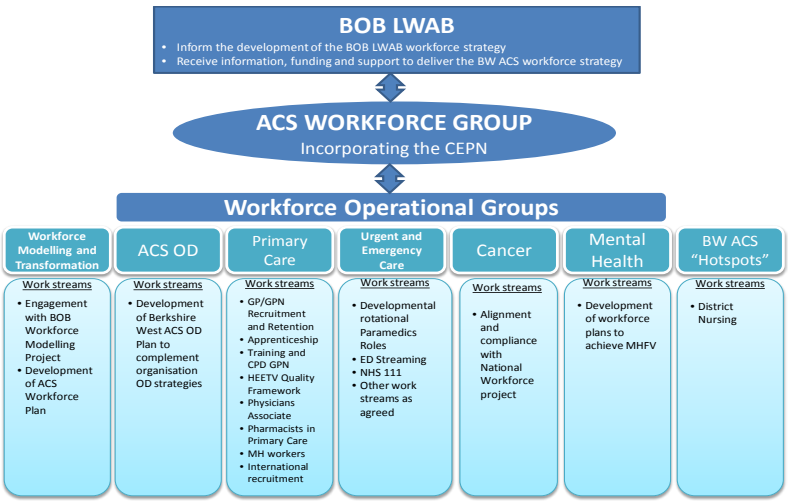
For more information please see **Annex 13.**

4.4 Workforce planning

A major part of our ICS ambition focuses on making improvements for staff across the area. As well as specific aims to improve workplace wellbeing there are ambitions to enhance leadership capability, up skill the workforce and create a shared workforce plan to increase opportunities for rotation across organisations – giving staff greater experience and enabling them to deliver better care.

Our aim is to develop a network which will facilitate partnerships between service providers and the education and training providers within the ICS footprint that will accelerate the development of a sustainable and highly skilled health and care workforce in Berkshire West. By working together we will develop the infrastructure and stakeholder relationships necessary to effectively identify workforce needs and secure the investment and innovative approaches required to address these. Please see **Annex 14** for more information.

Figure 8: ICS Workforce Group Structure and current work streams



4.5 Digital Transformation

The role of digital and technology will be a key enabler to support the vision, objective and transformational change required to truly deliver improved patient outcomes, organisational financial health and maintain high quality services for the ICS.

Our Digital transformation is overseen by the Digital transformation Programme Board which has representation from health and social care organisations from Berkshire West. The Board coordinate the Local Digital Roadmap and digital aspirations to harnessing technology for the Integrated Care System.

Berkshire West is well on track toward joining up and digitalising our health systems. We can provide clinicians with more timely access to accurate information, support service change to help improve health for all and provide patients with better access to their records and support service change which will improve health for all.

With BHFT and SCAS recognised as NHSE Global Digital Example[1], and RBFT part of the Fast Follower programme, our ICS is in a strong position to further improve patient care and strategic planning through innovative digital solutions.

Berkshire West collectively submitted a Local Digital Roadmap (LDR) in 2016 and the detail on the implementation continues to develop, encompassing 7 key themes –

Records sharing for cross-organisational care - Enable health and care professionals to have immediate and appropriate access to all relevant information about a person's care, treatment, diagnostics and previous history. This includes care plans and all necessary transfers of care information.

Citizen facing technology - Support and enable people to be actively involved in managing and making decisions about their care. This provides a strong basis for well-being and prevention.

Whole system intelligence - Health and care professionals across communities, geographic and clinical, have the data, analytics, decision support, information and insights they require to run an efficient and effective service. This includes risk stratification, care delivery, planning, targeting, monitoring, auditing, and research.

Infrastructure and network connectivity - A fast, reliable infrastructure, with shared connectivity, at a lower cost. Common ways of working support access to 'home' systems across localities and the ICS/STP regions.

Information Governance - A common set of processes to appropriately and effectively use information, in line with the expectations of patients and citizens. Information Governance becomes an enabler, not a barrier, to care planning, targeting and research.

Digital training and education - Delivering education and training to public, patients and staff as efficiently and effectively as possible to drive improvements in the effectiveness and quality of services.

Quality improvement and quality assurance – Regular analysis and feedback to individual clinicians, teams and services on their performance and quality to measure the effect of service changes and education and training.

[1] an internationally recognised NHS provider delivering exceptional care, efficiently, through the use of world-class digital technology and information

5 PATIENT AND PUBLIC ENGAGMENT

The ICS exists to serve the health needs of its population. The ICS will deliver the NHS Constitution by uniting patients and staff in a shared ambition for high quality care by putting these values at the heart of everything we do:

- Working together for patients.
- Respect and dignity
- Commitment to quality of care
- Compassion
- Improving lives
- Everyone counts.

The ICS consider working in partnership with patients and the public to be central to the way that we work. We are committed to ensuring that public and patient voices are involved as we develop and design services and monitor provider performance. We are also committed to effective communication with patients and the public, including a '*you said, we did'* approach.

Our Objectives

- To develop a compelling and coherent narrative that illustrates the ICS's overarching vision and how it is working to improve health and care for Berkshire West localities.
- To build a network of ICS patient representatives/champions who will be key partners in the ICS to create and deliver the core narrative to engage and build commitment with internal audiences whilst communicating benefits and change implications to staff, patients and the wider public.
- To disseminate, promote and publicise the vision and objectives of the BW ICS and its benefits for patients and healthcare across the localities to external influential organisations and stakeholder groups
- To build trust and commitment amongst patients and the public in general for the aims and vision of the ICS in their localities.

We are adopting a phased approach to communications and engagement which clearly defines the aim and objectives for each stakeholder group, both internal and external. (N.B. A phased approach does not necessarily mean that one phase will follow another and phases are interdependent on timescale for mobilisation) Phases for the ICS communications and engagement strategy for 2018/19 are:

Phase One – Producing a compelling narrative. To develop a compelling and coherent narrative that illustrates the ICS's overarching vision and how it is working to improve health and care for Berkshire West localities

Phase Two – Building commitment – internally. To build a network of ICS champions who can deliver the core ICS narrative with enthusiasm across all partners and internal audiences and build commitment throughout staffing groups.

Phase Three – Building commitment with external stakeholder groups such as patient forums.

To build commitment by delivering consistent key messages and compelling narrative to all our stakeholder groups. The communication of such messages and narrative should be accompanied by external engagement in a variety of formats including but not limited to:

- Speaker opportunities
- Event collaboration
- Media engagement

- Events/meetings

Phase Four – Building commitment with public and patients

To build commitment from patients and the public, we will involve them in our work and develop a programme of communication, engagement and involvement that will reassure them and build confidence in our partnership. We have three local authority HealthWatch officers who each have a crucial role to play in the development of the ICS and the reshaping of services. To enable local HealthWatch officers to be effective partners we have developed a new and innovative approach which is embedding HealthWatch within the ICS governance framework

What we have done so far

The approach outlined above has been adopted in the IMSK work stream. During the initial scoping of the project, patient workshops were held to understand what worked well and what didn't work well for our population. This feedback was then presented to clinical and management leads in further scoping workshops to prove the need for change.

Before the programme started, 4 patient leads were recruited by advertising through our local networks, patient groups and BW10 partners. These 4 patients became a central part of the redesign process, and attended a number of workshops throughout 2017. These workshops were attended by clinical and management leads from across the ICS and wider health system and designed the new IMSK service. The patients were fundamental partners during this redesign and their views and questions often led to innovation and new ways of thinking during the workshops. As the IMSK programme developed, the collaborative had to submit gateways to enable the programme to continue. The patient leads reviewed these gateways independently of the service providers, and their feedback was central to the board papers which the CCG used to decide if the project should continue.

Finally, one of the patient leads volunteered to sit on the IMSK oversight group (which is the central management and leadership group of the service) and during the first meeting it was proposed and agreed that he should be the chair of the oversight group going forward. This ensures patient voice is central to this new service going forward.

6 DELIVERING AND IMPROVING QUALITY

This ICS Quality Framework sets out how the ICS will use a strength base approach to 'System Wide Quality Improvement' adapting the 'signs of success' framework developed in Ontario, to deliver the quality objectives. We will move away from a traditional quality assurance approach, to a more collaborative system wide approach to quality, with shared responsibility and accountability across the system. We will ensure patient feedback is at the heart of our quality assurance approach.

As a successful ICS we are working together with a shared vision to achieve agreed quality goals and an openness and willingness to challenge and scrutinise each other; to ensure examples of best practice, as well as learning from when things go wrong is shared across the system to achieve best outcomes.

There are nationally set improvement targets that are mandated for all Integrated Care Systems to deliver from the respective five year forward view e.g. achievement of key cancer standards and clearly mandated mental health standards. An ICS Quality Dashboard is therefore under development and will allow for close monitoring by all partners across all of the required standards and most importantly, shared understanding of the issues when improvements are required and a system wide approach to making these improvements. In addition, locally agreed priorities will be included and monitored to ensure focus on agreed priority areas and subsequent delivery, so that the focus is on delivering and improving care.

The ICS will follow the *signs of success approach* which develops profile areas instead of collecting vast amounts of abstract data which is often inter-related but rarely connected. The profile development allows for the interconnectedness of abstract information to build a story that can make a difference. For example, taking a particular disease pathway and gathering information on what it's like from the patient's perspective, the family or carer, the staff delivering the service and the clinical outcomes for that disease. A full profile will then be built and used to make improvements where they are needed across the system to improve the patient experience and achieve best clinical outcome.

Our indicators of success will be that:

- The four dimensions of quality (and their congruence and balance) are discussed and recorded before major decisions.
- The whole ICS improves together (not one organisation failing and another succeeding)
- Voices from the grassroots are systematically heard across the system
- All organisations within the ICS demonstrate a culture that incorporates reflection, appreciation and shared learning
- The ICS will be delivering high quality services that best meet the needs of our population by engaging and listening to our local populations health needs.
- The ICS will move towards a joint ICS Quality Committee which will replace the individual Clinical Quality Review Meetings currently held with each provider. The ICS Quality committee will review the ICS Quality Dashboard to monitor progress against the key agreed indicators for quality and performance, but will focus on how as a system we can make improvements required, rather than using contractual levers, utilising signs of success approaches.
- Partners will contribute to the agenda setting, with opportunity to share examples of innovation and improvements made, to share learning across the whole system.

- A combined monthly 'Serious Incident Panel' will be established, to scrutinise root cause analysis and best benefit from a system wide approach to learning. The ICS Quality Committee will delegate safeguarding children and adult assurance to the already established ICS Safeguarding Committee, which will report to the ICS Quality Committee through a chairs report . A clear objective of the committee will be to reduce reporting and not duplicate.
- To further develop the established system wide infection prevention committee to encompass plans to reduce gram negative infections.
- To develop systems to ensure system wide learning from deaths.

The ICS Quality Committee will form an alliance of providers that collaborate to meet the needs of a defined population. The Committee will monitor, discuss and collectively take action to drive quality improvement as specified within the NHS Standard Contract between Berkshire West CCG, RBFT, and BHFT.

6.1 BHFT Quality Improvement programme

Berkshire Healthcare's Quality improvement Programme was introduced in 2017 to create a culture focused on continuous improvement and sustainability. It empowers and enables staff to make improvements, equipping them with the tools and techniques they need while aligning all teams on achieving the Trust's strategic objectives ("True North"). These are:

1. To provide safe services, prevent self-harm and harm to others
2. To strengthen our highly skilled and engaged workforce, and provide a safe working environment
3. To provide good outcomes from treatment and care
4. To deliver services which are efficient and financially sustainable

The Trust is being supported for an initial 18 months, by external partners with worldwide experience of implementing Quality Improvement programmes in healthcare organisations. At the end of this period, staff across the organisation will be fully trained and able to maintain and continue the work, with QI methodology being fully embedded.

Berkshire Healthcare has a robust internal process for identifying, investigating and learning from deaths of patients who are under the care of the Trust's learning disability, mental health and community services.

The Trust contributes to a system-wide approach to learning from deaths by:

- Engaging with the local Learning Disability Mortality Review (LeDeR) process (referring cases, nominating staff to support the LeDeR review process)
- Actively participating with the system- wide mortality review and assurance process, led by the Berkshire West CCG
- In cases where the Trust's mortality review process identifies multi-agency concerns, case are referred to the local adult safeguarding board and learning brought back to the Trust
- In cases where the Trust mortality review process identifies potential concern about the care provided to the patient by another healthcare provider, it is raised directly with the provider (acute hospital or primary care), to include in their own internal mortality review.

6.2 RBFT Quality Improvement programme

Ensuring safety and quality of care for every patient is RBFT's top priority. The Trust wants all its services to be outstanding every day of the week and to maintain its position as a top performer in delivering NHS access standards. RBFT also strives to be the one of the safest and most caring NHS organisations in the country. In 2018 the Trust refreshed its Quality Strategy (2018-2023) which provides the framework for the quality improvement work taking place across the Trust, based around the 5 CQC domains of safe, effective, caring, responsive, and well-led.

The Trust develops an annual Clinical Audit & Quality Improvement programme every year which consists of all mandatory national audit projects as well as locally agreed priority quality improvement projects, including those for the annual Quality Accounts. These priorities are developed through:

- Review of progress against last year's priorities, carrying forward any work streams which have scope for on-going improvement;
- Analysis of themes arising from internal quality indicators (complaints, incidents, clinical audits, mortality reviews, outcomes data);
- Patient engagement;
- Staff engagement;

- Key stakeholder engagement – seeking the views of our governors, regulators, Healthwatch and other community partners.

As a result, the Trust is confident that the priorities we have selected are those which are meaningful and important to our community.

In 2018-19 the Trust will be participating in all applicable National Clinical Audit Patient Outcomes Programme and Quality Account reportable national audits and all applicable national CQUIN projects. The Quality Account priorities have been agreed as:

- Reduction of avoidable falls with harm
- Reduction of avoidable pressure ulcers
- Reduction of mortality due to sepsis
- Improving recognition of the deteriorating patient
- Improving patient experience of car parking
- Improved effectiveness of transition from admission to treatment and discharge for complex patients
- Improving involvement of patients and carers in managing their own care

The Trust has a robust process of mortality surveillance and learning form deaths, and this is shared system wide

A RBFT consultation has taken place to identify any additional local priorities for clinical audit and quality improvement which have also been included on the 2018-19 Clinical Audit & Quality Improvement Programme. Progress against all of these projects will be monitored through the Clinical Outcomes & Effectiveness Committee chaired by the Medical Director.

This reports to the Quality Assurance & Learning Committee and up to the Quality Committee, chaired by a Non-Executive Director. There are additional monitoring mechanisms for the CQUINS and the Quality Account priorities. This allows appropriate scrutiny against the progress being made with these quality improvement initiatives, and also provides an opportunity for escalation of issues. This will ensure that improvement against each priority remains a focus for the year and will give the Trust the best chance of achievement.

In addition, clinical audit & quality improvement is promoted across the Trust through bi-monthly training sessions available to all staff; participation in promotional events through “Clinical Audit Awareness Week” held in November; and an annual Clinical Audit & Quality Improvement competition open to all staff to promote and celebrate best practice.

7 SUPPORTING APPENDICES

7.1 Annex 1 – Cancer

Responsible ICS partner: Berkshire West CCG and Royal Berkshire Foundation Trust

Overall Goals for 2017-2019

The approach to commissioning and delivering cancer services in Berkshire West in 2018/2019 continues to be delivered through the jointly agreed Berkshire West Cancer Framework developed by the Berkshire West Cancer Steering Group. This group is comprised of clinical and non-clinical representatives from Berkshire West CCG (including GP lead), Royal Berkshire Foundation Trust, Thames Valley Cancer Alliance, Cancer Research UK, and Macmillan. We have reviewed our progress against our objectives and agreed our local and Cancer Alliance priorities for 2018/2019 to continue the momentum of implementing the six priorities in the National Cancer Strategy, the Five Year Forward View and the Thames Valley Cancer Alliance key ambitions by 2021.

Progress in 2017/2018

- Our STP prevention work stream focuses on joint working across the footprint and launched the 'making every contact count' work stream and are working with our local Public Health teams to improve targets for smoking cessation, alcohol and obesity.
- Our teachable moment pilot went live in two GP practices in September 2017 and we will continue to review the uptake and impact of this pilot in 2018/2019.
- Focusing on South Reading to reduce the proportion of cancers which present as an emergency and improve cancer screening uptake we have worked with Macmillan to commission Rushmoor healthy living (a Hampshire based charity) to raise awareness of signs and symptoms of cancer particularly in hard to reach populations. To date 40 cancer champions have been recruited and they have engaged with over 1000 people.
- The majority of our 2 week referral proformas have been aligned to NICE guidance and jointly agreed with primary and secondary care clinicians.
- As per NICE Guidance we have ensured there is Direct Access for non-obstetrics ultrasound and chest x-rays.
- A focus on increasing the recording of staging data has meant that this has significantly improved (our overall baseline of 30% has increased to 70% - beyond the national target).
- For patients living with and beyond cancer we continue to assess the Macmillan funded Cancer rehabilitation service to ensure it is aligned with the requirements of the recovery package and we have also increased the number of electronic holistic needs assessments (HNAs) as 6/11 tumour sites are completing HNAs.
- We are working in partnership with FHFT to deliver the goal of developing and deploying a Cancer Health Information Exchange (HIE) to enable both improvements to the flow of information between provider sites and increase the visibility of relevant information to the patient themselves.

Deliverables for 2018/2019

- We will continue progress with the work streams outlined in 2017/2018 on prevention, teachable moments, South Reading project, staging data and living with and beyond cancer. We also plan to deliver the following objectives:
- Our Integrated Care System is currently meeting all eight waiting time standards for cancer; however we do have outliers in the far West of the area where patients are accessing other acute providers. We are seeing an improvement in this performance and will continue to work with all our providers to maintain and improve standards. We will also start to explore how we can work towards the 2020 target of a definitive diagnosis within 28 days.
- Working with the cancer alliance we plan to review the four main cancer pathways to ensure timely access for patients and we are exploring the pilot of multi-disciplinary diagnostics for vague or unclear symptoms.
- We are further developing our engagement with patients and working to utilise different modalities for follow ups.
- We will continue to work with PHE through our STP prevention work stream to increase the uptake of all screening programmes, including the roll out of FIT bowel cancer screening and considering the benefits of lung cancer screening.
- We plan to deliver risk stratified pathways as business cases for breast and urology have been developed and are currently in the sign off process.
- Through the Thames Valley Cancer Alliance we are working with partners to support the implementation of new radiotherapy services and upgrading machines.

Risks and issues associated with the delivery of this plan:	How does the ICS intends to work together to mitigate these risks and issues?
• Engagement with local partners for improvement of targets of screening, smoking cessation, obesity and alcohol. • Workforce capacity and/or provision of diagnostics may put at risk the provision of services, meeting national standards and delivery of transformational work streams. • Engagement with clinicians e.g. delivery of the living with and beyond cancer recovery package and risk stratified pathways.	• We work very closely with our public health partners through our Health and Wellbeing Boards and through the BOB STP prevention group to ensure delivery of these targets. • We work jointly within our ICS to ensure we will maintain the cancer national standards. Working with through our local steering group and the alliance groups we would ensure our workforce is maintained or increased to support delivery of all elements. We would also work with our partners to ensure we plan ahead for the diagnostic provision. • Working with our ICS partners and the cancer alliance we would understand the barriers to clinical delivery (primary or secondary care) and work jointly to overcome the issues.

What are the projects programmes we expect to contribute?

- The Berkshire West Cancer Steering Group priorities for 2018/2019 have been defined into local and Cancer Alliance work streams. As the emerging Cancer Alliance work stream objectives are confirmed we plan to obtain a local resource to implement the deliverables. Our local work streams have been identified as:
- Prevention – continue working locally with Public Health teams and through the STP prevention work stream to promote healthy lifestyle changes and improve the uptake of screening
- South Reading prevention – continue with our community engagement and education with a harder to reach demographic
- Living With and Beyond Cancer – aligning cancer rehabilitation with the requirements of the recovery package and delivery of risk stratified pathways
- Patient Experience – focusing on service user engagement and exploring different modalities of follow ups
- Cancer Staging – continue to improve the recording of staging information
- 2 week proformas – complete updating all our 2 week proformas
- Direct Access – tracking progress and exploring further options for Direct Access
- End of Life - Ensure that CCG commission appropriate integrated services for palliative and end of life care, in line with the NICE Quality Standard.

7.2 Annex 2 – Mental Health

Responsible ICS partner: Berkshire Healthcare Foundation Trust

Overall Goals for 2017-2019

Improving mental health is a fundamental part of our ICS operating plan. The Five Year Forward View for Mental Health (2016) sets out a clear direction for the NHS to improve mental health and wellbeing, highlighting why change is required and what good will look like. Some of what is needed can be brought about by the NHS itself. Other actions require partnerships with local organisations including local government, housing, education, employment and the voluntary sector.

Progress in 2017/18	Deliverables for 2018/19
Increasing Access to Psychological Therapies (IAPT) • Our performance against the national IAPT access, recovery and waiting time standards has been consistently strong, and includes innovative approaches to the use of online service delivery. Our service is an “early implementer” of enhanced access and services	• The focus for 2018-19 will be to have a fully integrated service that is cost effective while continuing to meet national access and waiting times and recovery standards with better access by BME communities. • We will also be using the results of our Long Term Conditions

for people with long term physical health conditions (LTC), which is showing very encouraging results in terms of reduced GP and A&E attendances by people receiving the service. • In 2017-18 there has been a focus on recruiting additional trained staff and trainees to be PWPs (psychological well-being practitioners) and high intensity therapists.	pilot to inform financial and activity modelling to support medium to longer term planning for use of resources across the system
Physical Health Check and Care co-ordination • We have made good progress in meeting Physical Health Checks target for people with severe mental illness in secondary care, and are achieving screening rates of 83% and 94% of those who required interventions as a result of screening.	• We will continue to develop partnership work across Primary Care and Secondary Care, maximising the opportunity presented by our GP Cluster teams, to enhance physical health screening and interventions
Early Intervention in Psychosis (EIP) • Our EIP service is NICE compliant and is meeting the national standards for access and treatment. We have been meeting the new waiting time standards which require 50% of patients experiencing a first episode of psychosis to commence treatment within two weeks of referral.	• Work is in progress to project future need and associated staffing requirements in order to maintain high levels of performance. This work will be overseen by our Mental Health Delivery Group and a review of progress will be undertaken at the end of the second quarter of the year.
Psychiatric Liaison service • We have a well-established service based in the local acute hospital (Royal Berkshire Foundation Trust), which has had a positive impact on the quality and responsiveness to people who attend the Emergency Department. Good levels of performance have been achieved in identifying people with previously un-diagnosed dementia, and enabling them to access appropriate help and reduce risk of delayed transfer of care. • The service model mirrors the 'RAID' (Rapid Assessment Intervention Discharge) model, and is supported by the Community Crisis Response teams and the Community Psychological Medicine Service working with high intensity service users and those with medically unexplained symptoms.	• We plan to develop the service to enable a timely response to people of all ages, and continue to support understanding and awareness of mental health within the acute hospital setting. A detailed plan for this work will be in place by the end of the first quarter of the year.
Individual Placement and Support services (IPS) • We have established a local service which is achieving good results in supporting people into employment – however, expansion and recurrent funding is needed to ensure that Five Year Forward View targets are met. A bid for NHSE funds is being submitted to expand the current model, which has "fidelity" status in terms of national guidance.	• The Berkshire West element of the BOB STP bid has been successful in achieving funding in wave 1, and we will continue to support partners in work to secure wave 2 funding. A plan will be developed by the end of quarter one to guide this work, building on the outline provided in the NHSE bid.
Reducing suicide rates • A partnership Berkshire Wide Suicide prevention strategy has been developed and approved by all six Berkshire Health and	• Over the next 2 years we will continue to work closely with Public Health and GPs to help more GPs recognise and manage those patients in high risk groups.

Wellbeing boards. In addition, Berkshire Healthcare has established a Zero Suicide initiative, which embraces the belief that suicide is preventable, and has achieved significant progress in provision of training, development of risk assessment and safety planning.	
Perinatal Mental Health • Our local service has secured "wave one" funding to develop access to evidence based services for local women. Over the next three years this funding will be utilised to ensure all elements of the perinatal targets are met and our aim is to ensure women are offered the full range of NICE compliant interventions. • We have developed an online service which provides a secure, anonymous and moderated Facebook type site for women during the perinatal period across the range of emotional disorders and distress. There are more than 260 activated users of this service and five peer moderators recruited from the users to support the clinical moderating team. A birth trauma pilot has been live for nine months and offers both individual and group work - referral numbers have exceeded those anticipated. Work is in progress to train perinatal clinicians in therapeutic techniques and integrate this with current provision to achieve a sustainable pathway. • We are on target to meet the increased access target trajectory of 450 patients for 2017/18, and plan to continue to develop training and recruitment of peer supporters during the next year to support sustainability.	• Our service will continue to meet access targets, prioritising the implementation of a sustainable approach to online and face to face provision. The plan for this work will be reviewed in quarter one, enabling any significant risks to delivery to be highlighted and mitigated.

Eliminating out of area placements for non-specialist acute care
• We are committed to ensuring that by 2020/21 no service users requiring non-specialist acute care receive their treatment in an out of area placement (OAP) setting . We recognise the challenges inherent in achieving this goal, as our inpatient service benchmarks as lower than average bed numbers for the local population. We have established a trajectory to enable us to plan improvements required each year. Our baseline has been established at 476 bed days for 2017/18 and we aim to reduce this by 33.3% in 2018-19.
	• We are committed to achieving the FYFV target to eliminate acute out of area inpatient placements by 2021, and to achieve a 33% reduction in baseline activity in 18/19. This is a key priority for the ICS in 2018/19.
	• A bed optimisation programme is in place to reduce avoidable admissions, reduce length of stay and out of area placements for non-specialist acute care:
	• **Bed flow and bed management**
	  ◦ dedicated resource, enhanced gatekeeping
	  ◦ Spring to Green aims to reduce occupancy of acute beds from 112% to 85%
	• **Reducing delayed discharge:**
	  ◦ System escalation calls routinely available
	  ◦ Swift agreement to social care packages with delegated authority to joint heads of community MH teams
	  ◦ Swift resolution of s117 aftercare funding with commissioners
	• **Reducing inappropriate admissions to hospitals**
	  ◦ Effective Psychiatric Liaison team at Royal Berkshire Hospital
	  ◦ End to end Personality Disorder clinical pathway

	reviewed and agreed, rolling out in 2018/19 • Exploring options for bed and non bed based alternatives for both admission avoidance and on-going recovery and rehabilitation • We have commissioned an independent review of bed numbers required for the population of Berkshire, for completion at the end of Q1
Dementia • Delivery of our dementia action plan across Berkshire West to ensure we continue to meet the National Dementia Diagnosis Standard is a priority for us: our current performance is 63% against a target of 66.7%. A number of initiatives are being put in place to ensure this target is reached by March 2018 and work will continue with GP practices to provide dedicated support to those practices that are underperforming, and also share good practice between practices. • Our local memory services are nationally accredited and achieving the national standard of six week waits. Through the Academic Health Science Network (AHSN) this best practice model of delivery has been shared and adopted across the Thames Valley. We have an award winning local service for young people with Dementia which is highly valued by local service users and staff. Although our memory clinic service delivery is very strong, we are aware that we need to plan for increased need, while maintaining high levels of performance.	• Review of 18/19 plan to meet diagnosis standard to take place in quarter one, with progress of targeted approach assessed and reported through both mental health delivery and primary care transformation groups to ensure engagement and ownership of continued progress. • Demand and capacity review to take place in quarter two to enable medium – long term planning of response to growth in demand.
Children and Young People • Our Local Transformation Plan has been developed collaboratively and co-produced with local stakeholders including children and young people and outlining the need to transform care and support on a whole system basis. It was refreshed in 2017, and includes 3 inter-related programmes of work: • Building the infrastructure, enabling the workforce to respond to young people's mental health and promoting anti-stigma • Promoting prevention, early intervention, resilience and promoting mental health and wellbeing • Targeting resources to those most at risk - those in crisis, Looked After Children and those known to youth offending services. • Local Child and Adolescent Mental Health services continue to experience high numbers of referrals which mean that meeting access and waiting time targets presents a significant challenge.	• We will need to work together with Local Authority commissioners to align commissioning and provision of services across the whole pathway in order to meet the national target of at least 32% of children with a diagnosable condition are able to access evidence-based services by April 2019. • In 2018/19 we will make further progress towards delivering the 2020/21 waiting time standards for children and young people's eating disorder services of 95% of patient receiving first definitive treatment within four weeks for routine cases and within one week for urgent cases.

Mental Health Investment Standard (MHIS) • In 2017-18 the Berkshire West projected expenditure on mental health related care is £67,863,000.	• The CCG plans to increase this expenditure in 2018-19 by at least 2% in order to meet our obligations under the Mental Health Investment Standard. The mental health related expenditure in 2018-19 is planned to be at least £69,342,000 • The ICS will support the use of these resources to enable delivery of Five Year Forward View targets – we have a strong foundation to build on, as well as the opportunity to shift resources to support further progress – which will be facilitated by our plans for integrated strategic planning for mental health as part of our ICS.

Risks and issues associated with the delivery of this plan:
• Demand growth is significant in some service areas and capacity has been constrained as a result of reduced funding available to Local Authorities
• Workforce supply is a key risk – this is a national issue but compounded locally by high housing costs and high employment
• IAPT LTC is showing evidence of reduced activity in A&E and Primary Care – but shifting recurrent resource to support continued development is challenging given demand pressures **in** those areas
	How does the ICS intends to work together to mitigate these risks and issues?
	• Specific Initiatives are supporting the collaborative management of demand pressures (see below)
	• Governance and joint planning structures are in place to enable risks and mitigation to be understood and agreed between partners:
	  • Mental Health Delivery Group
	  • IAPT Steering Group
	  • ICS Unified Executive
	  • Development of joint strategic planning/transformation team across commissioner and provider functions is currently in progress– this will be done on a Berkshire-wide basis, incorporating commissioners and partner providers in the Frimley ICS to develop a collaborative approach to strategic planning and effective use of resources.

<u>What are the projects programmes we expect to contribute?</u> • Out of Area Placements • Common Point of Entry • IAPT Increased Access/LTC • High Intensity Users • Child and Adolescent Mental Health Future in Mind • Mental Health Workforce Planning	

7.3 Annex 3 - Primary Care

Responsible ICS partner: Berkshire West CCG
Overall Goals for 2017-2019 The Berkshire West General Practice Forward View (GPFV) Local Implementation Plan sets out a vision for a sustainable primary care sector working at-scale and as an integral component of the Berkshire West ICS. To achieve this vision, our practices have come together into Primary Care Provider Alliances, with all practices within them working in geographically-contiguous clusters which will interface with other services to meet the health needs of groups of 30-50,000 patients (Primary Care Networks). At a system-level, the alliances are working together in an 'Alliance of Alliances' which will look to maximise their impact within the Berkshire West ICS. The GPFV programme describes how the CCG will support the Primary Care Provider Alliances to work to address sustainability challenges and build an expanded and integrated primary care sector which meets same day demand in the most appropriate way and works proactively to support patients in the community.

Progress in 2017/18	Deliverables for 2018/19
Primary Care Networks • Primary Care Provider Alliances made up of clusters (networks) of practices serving 30-50,000 cover all but two of our practices (which are engaged in discussions). • The four locality alliances are working together in an 'Alliance of Alliances' which will look to maximise their impact within the Berkshire West ICS. • Process and criteria in place for making the remainder of the £3 per head primary care transformation monies (£2 per head in 2018-19 as we invested £1 per head in 2017-18) available to alliances to support delivery of business plans which are aligned with key system priorities (e.g. delivery of extended access to primary care, engagement with pathway redesign and further development of integrated teams at a cluster level) and demonstrate how alliances will move towards being self-sustaining from 2019-20. • Integrated cluster working implemented in the Wokingham locality where the Community Health and Social Care (CHASC) teams have been working with GP practices and others to support proactive care planning and multi-disciplinary team (MDT) review for complex patients linked to our Anticipatory Care CES.	• Further development of alliance business plans to underpin allocation of £2/head. Funding allocation and progress to be overseen by Primary Care Commissioning Committee. Appointment of management lead for Alliance of Alliances and further OD input at all levels. • Development of cluster/network 'visions' for primary care aligned with GPFV programme/estates strategy. • Roll-out of Insights Population Analytics (IPA) to be used this year to support delivery of Anticipatory Care CES. Further development of ongoing approach to use of population health management in primary care through Connected Care. • Further development of CHASC model in Wokingham and roll-out of integrated health and social care team approach to other clusters/networks with Anticipatory Care CES as an initial focus. • Further develop role of integrated care teams in meeting acute care needs, building on GP Consultant and ECP pilots and exploring opportunities to integrate these more closely with existing rapid response teams • Going forward the alliances and associated clusters will serve as a vehicle for delivery of an extended range of services in primary care and new ways of interfacing with other services (e.g. through the MSK and Outpatients transformation and care and support planning work described elsewhere in this document).
Access • Across Berkshire West 89.2% of patients currently have access to evening appointments on some weekdays, 92.53% to weekend (Saturday) appointments and 84.52% to both. Practices are currently delivering 36.6 minutes of extended hours' capacity per 1000 population. • Practices in South Reading are considering how best they can work together to meet same day access demands building on a baseline mapping of demand, capacity and staffing.	**Enhanced Access** • In accordance with the planning guidance we intend that 100% of patients will have full access to evening and weekend appointments by 1st October 2018. Our planning trajectories show a phased implementation process over the next six months which should achieve full compliance with the seven core requirements by October 2018. Arrangements will include some same day appointments as well as slots bookable in advance (in this way primary care will form part of our broader urgent care offer and we will look to ensure NHS 111 can book into these slots at the earliest opportunity) and will ensure that appointments are available on days when practices are usually closed e.g. bank holidays. • As individual practices will not be able to deliver the level of capacity required, each of the alliances is working with their member practices to develop a plan for delivery of the additional capacity within clusters with potential wider collaboration through hubs at weekends. Our existing Enhanced Access CES allows for collaborative provision to expand hours of availability and sub-contracting where practices do not want to provide capacity themselves and in the first instance we will look to vary this CES to incorporate the requirements above. • The Enhanced Access CES was previously deemed to only be capable of provision by existing primary care contractors; we will review this position during 2018-19 and agree a procurement approach as appropriate. • The CCG will work with providers to put in place appropriate operational arrangements e.g. for access to patient records. The CCG will also ensure that services are appropriately advertised and that an equalities impact assessment is undertaken and any findings acted upon. We will test out

	staffing models to ensure that these are robust and that any risks to other services have been mitigated; we anticipate a more skill-mixed model will be used than for existing extended hours provision. Practices across Berkshire West are also implementing Footfall and we envisage that this will be one of means of accessing services outside of core hours as well as a source of advice on self-care. **Same day access** • New models of delivering same day care in-hours to be developed further in South Reading with the Walk-in Centre acting as a first hub. This work will inform future commissioning intentions around the current Walk-in Centre as well as the development of same-day access models across Berkshire West.
Workforce • Working proactively to address current and future workforce constraints in a key tenet of our GPFV programme. We have established a Primary Care Workforce Group involving the CCG, NHSE and HETV colleague and working as part of our overall ICS workforce workstream. • We are working in partnership with the University of Reading to deliver a Physicians' Associate (PA) programme with a significant level of primary care training placements. Eight students from the university programme were placed in primary care settings as part of the course in 2017/18 and two practices employ a PA. • Clinical pharmacists working a number of practices. • We have a number of practices using Emergency Care Practitioners (ECPs) for home visiting and have funded a pilot service in Wokingham. • Berkshire West has bid for 18 international GPs as part of the national programme. • Two of our GPs have already attended General Practice Improvement Leaders' Programme and a further ten GPs and others have expressed an interest in future cohorts. Each of our alliances has also engaged organisational development support to develop a stronger understanding of roles and opportunities within these new provider organisations and ensure clinical leaders work together effectively to maximise their impact.	• **Primary care workforce modelling** – gathering intelligence around current and future pressures and interfacing with emerging primary care demand and capacity tools to model modelling the impact of potential solutions. The information we have received to date from NHSE does not clearly indicate what proportion of the additional staffing resource set out in the GPFV we would expect to employ within Berkshire West, however we would look to progress these discussions as a matter of urgency in order to inform our future workforce planning. • **Supporting skill-mix** - We are actively promoting Physicians' Associates via the CCG and students will once again be placed within practices this year as part of the programme. For 2018-19 we will look to increase the number of qualifying PAs who choose to remain in primary care in Berkshire West and are working with a local PA Ambassador to achieve this. We hope that the Berkshire West joint alliance bid for national clinical pharmacist funding will significantly increase the impact that pharmacists can have in primary care. We are also now exploring the recently-announced national scheme for clinical pharmacist in care homes and would look to submit an ICS-level bid. During 2018-19 the CCG and alliances will continue to work with SCAS and others to consider the ongoing role of ECPs in primary care and how best to resource this. We will also be looking to further develop the role of mental health therapists in primary care, interfacing with the IAPT service as further clarity emerges around the GPFV investment in this area. • **GP recruitment and retention** – Over the coming months we will be working with NHSE leads to progress our international GP recruitment bid. We also continue to encourage GPs and practices to utilise the returner and retainer schemes. We currently have an over-supply of training practices but over the coming year intend to work with the Deanery to explore more diversified training models whereby registrars would spend time in practices that have not traditionally provided training opportunities. We also intend to develop an 'offer' aimed at retaining more GPs from the local programme than is currently the case based on a combination of additional support and development opportunities. Finally we are keen to explore the potential of rotational and portfolio posts across the ICS to attract and retain GPs. • **Continued Professional Development** – we are committed to providing excellent development opportunities for all primary care staff both in terms of formal learning, practical experience and portfolio posts and intend to use Community Provider Education Network funding to better align education and training

	provision with new models of primary care delivery. • **Development of clinical leadership in primary care** – we will work with NAPC and others to build the 'primary care voice' within our ICS. We will continue to take up national offers around leadership development in primary care. • **Practice Manager Development** - we are using GPFV funding to develop a locally-bespoke development offer for practice managers working as part of alliances and clusters. We are also encouraging practice managers to take up national development offers around primary care at scale. • **Staffing approaches –** we will support our alliances to further explore joint approaches to recruitment, shared posts and locum banks.
Workload • Practices have been working through alliances to undertake training on and implement workflow optimisation processes using GPFV funding. Newbury practices have taken a slightly different route and are further establishing a GP administrative assistant role to be funded through national apprenticeship monies. • Following a successful Time for Care showcase event in November 2017, alliances are also working with national facilitators to implement active signposting. Some will also be implementing group consultations • We have adopted a three-stage approach to implementing online consultation, starting with practice engagement to identify a preferred solution and moving onto procurement and adding functionality. We are in the process of procuring Footfall for all practices with CSU support for implementation thereby ensuring opportunities to maximise impact and interface with extended hours and other integrated services are fully utilised.	• Time for Care / Workflow Optimisation / Online Consultation work to be completed during 2018-19. • It is intended to commission the *Time for Care* team to run a quality improvement programme for practice staff in 2018-19 in addition to sessions on active signposting and group consultations. Whilst the exact mix of initiatives will vary, we can be confident that all practices will be implementing at least two of the Time for Care High Impact Actions by the end of 2018-19. • During 2018-19 we will look to build upon Footfall through add-on functionality and by exploring an alternative app-based solution such as Sensley. We will also be working to consider how we link online access to practices with the implementation of NHS 111 online and direct booking. • During 2018-19 we will work to maximise the impact of social prescribing, building on existing arrangements and ensuring these are a potential disposition from active signposting and Footfall. • We will also undertake a number of projects aimed at supporting self-care e.g. our wearable technologies project, roll-out of health pods in surgeries and selection and promotion of appropriate apps.
Estates • Four of our Estates and Technology Transformation Fund (ETTF) premises development schemes have been completed. • The first tranche of development of our primary care estates strategy focussed on assessing additional capacity required to meet the future considerable housing growth forecast in Berkshire West; this is being continually updated as new proposals for development come forward.	• A further eight ETTF schemes are on-track and scheduled to complete in 2018-19 and we have one remaining scheme for which we are working to agree a start date. Revenue implications have been assessed and accepted by the CCG. We have also provided in principle support for a further premises development in South Reading which will replace outdated premises and provide capacity for population growth. • During 2018-19 we intend to commission an updated six-facet survey and actual/potential capacity review of existing primary care premises and to undertake further opportunity location around sites which may lend themselves to joint development with ICS and other local partners. In so doing we intend to better align our approach to primary care estates with our broader ICS estates strategy therefore ensuring that we have the estates infrastructure required to underpin delivery of new models of care. • Our Connected Care programme is described in more detail

	below. Priorities for primary care in 2018-19 will include the roll-out of the Health Information Exchange to GP practices and further development of the role of population health management in delivering proactive care.
Sustainability and resilience funding • All GPFV sustainability and resilience funding received to date has been invested in supporting vulnerable practices in Berkshire West.	• Further funding to be allocated in accordance with guidance to support future sustainability of primary care sector.
Delegated commissioning • The CCG will continue to discharge delegated commissioning functions relating to primary care services in accordance with the Delegation Agreement in place with NHSE. All activities will continue to be overseen by the Primary Care Commissioning Committee to which NHSE is invited.	• Terms of Reference have been updated for 2018-19 to reflect the CCG merger. The committee and its associated functions were the subject of internal audits during 2016-17 and 2017-18. Completion of resulting actions is overseen by the CCG's Audit Committee. • During 2018-19 we will review and develop our approach to quality improvement in primary care, aligning this to the key principles of the ICS Quality Framework.
Risks and issues associated with the delivery of this plan: • Recruitment and retention of primary care clinical workforce • Lack of GP engagement in delivery of the plan • Implementation of the primary care estates strategy – availability of sites and funding and need to align plans to new clinical models. • Delivery of technical solutions e.g. online consultations • Lack of patient engagement/awareness of new models of care	**How does the ICS intends to work together to mitigate these risks and issues?** • Workforce planning and development strategy being developed across BW. • Engagement with the local Alliances and where appropriate with the Alliance of Alliances. • Engagement with the One Public Estate initiative locally and with local councils around population growth and estates opportunities. • IM&T infrastructure development being delivered as part of broader ICS Digital Strategy. • New ways of working in primary care to form part of ICS narrative and engagement plan.

What are the projects programmes we expect to contribute?

- Further development of Alliances/Networks/Alliance of Alliances to ensure sustainability and expand range of service provision in primary care through ICS workstreams
- Delivery of Anticipatory Care CES using IPA and through integrated health and social care teams
- Review of ECP pilot and opportunities for integration to meet acute care needs
- Enhanced Access – to be delivered by October 2018
- Same day access hubs (in hours) – piloting approaches
- Primary care workforce modelling
- Skill-mix in primary care – ECPs, clinical pharmacists, physicians' associates.
- Recruitment and retention in primary care (GPs and others)
- Continued professional development for primary care workforce and clinical leadership development
- Time for Care – active signposting, group consultations and quality improvement
- Workflow optimisation implementation
- Supporting self-care
- Online consultation
- Further development of primary care estates strategy
- Delivery of ETTF premises schemes and further work-up of non-ETTF schemes
- Roll-out of access to Connected Care HIE and development of population health management approach in primary care

7.4 Annex 4 – Urgent Care

Responsible ICS partner: Berkshire West CCG and Royal Berkshire Foundation Trust

Overall Goals for 2017-2019

The ICS and A&E Delivery Board are committed to delivering the next steps in the 5YFV for urgent & emergency care to support a return to achievement of the 95% standard. The system will continue to build on existing improvements to patient flow through the system with a focus on increasing the number of patients treated on ambulatory care pathways, a partnership model for bedded care across the system and front door streaming on arrival at ED. The ICS will continue to work closely with ASC colleagues to minimise delays for medically fit patients moving to onward care with a firm focus on the "home first" principle supported by trusted assessment processes reducing duplication. Integrated Urgent Care will move closer to a "consult and complete" model with 50% of calls being transferred to a clinician and direct booking into a greater number of services. NHS 111 online will be implemented by Jul-18. The MIU at West Berkshire Community Hospital provided by BHFT, will become a fully designated UTC with interoperability to support direct booking in place by Q2. The system will continue to support SCAS on implementing the recommendations of the Ambulance Response programme putting an end to long waits.

Progress in 2017/18	**Deliverables for 2018/19**
Integrated Urgent Care • The Berkshire West urgent care system achieved over 90% performance for 2017-18 • Data from Nov-17 shows that the percentage of calls closed within the service increased by 4.4% (compared to Nov-16), ambulance dispatches reduced by 1.4% and ED attendances reduced by 1.5%. Direct booking is in place for GP out of hours and there are plans to pilot direct booking in two Practices in Berkshire West. • Commissioners and the Alliance have agreed a robust Service Development Plan to enhance and monitor delivery of this service. This will allow the service to respond to local and national needs and priorities.	• The ICS will continue to work with SCAS in 2018/19 to reduce the number of people conveyed to hospital • As lead Provider for IUC SCAS will enhance their clinical co-ordination and IUC approach by; • Increasing the range of specialist providers in the CAS to include midwives, AHPs and the third sector (including palliative care and social care) • Developing closer integration with Single Points of Access for out of hospital services • Rolling out direct booking to Urgent Treatment Centres (UTCs) • Piloting direct booking into GP Practices in-hours • Supporting Health Information advice with text messaging • Increasing capability and number of care home using Skype technology building on an existing 999 pilot. • Work actively with NHS England to look at opportunities to pilot software for new online symptom checkers and shape the future design of on-line services. • Pilot direct booking into 'in hours' GP Practices once the new EMIS/Adastra links are established. A scoping exercise has identified that a maximum of 5 appointments would need to be booked per day and 2 Berkshire West practices will participate in the pilot.
Primary Care streaming • Primary Care streaming at the RBFT emergency department (ED) was launched in October 2017 in response to the requirements in the Urgent and Emergency Care Delivery Plan (NHS England, 2017). The service is provided by BHFT and operates daily between 0800 and 2300. • The service, which is being run as a six month pilot, is based on the GP streaming model at Luton & Dunstable Hospital and is co-located with ED. A senior nurse assesses all ambulatory care patients arriving at ED and identifies those appropriate for further triage or treatment by a Primary Care physician or nurse	• The Primary Care streaming service operating at the front door of the RBFT ED has recently been evaluated against the key deliverables set out in the Business Case. The A&E Delivery Board considered the outcomes of the review at its Mar-18 meeting. A briefing paper was presented to the ICS Unified Executive on 12th April and it was agreed that a Task and Finish group will be convened to rapidly review the operating model for the service and redesign the service to ensure greater patient throughput at lower cost whilst retaining patient satisfaction with the service.

whilst those requiring clinically greater assessment of care are directly booked into ED. • The service is currently being evaluated and a recommendation will be made to the A&E Delivery Board in March 2018. Initial indications are that the current model is not financially sustainable and that the numbers being streamed to the service are lower than planned.	
Integrated Discharge service (Getting Home) • In 2017 the RBFT Service Navigation Team and the BHFT Integrated Discharge Team were combined to form a new Integrated Discharge service (Getting Home) under a single manager. The new team provides a single point of contact for all complex discharges operating with a new e-referral system. The team are working closely with Adult Social Care colleagues to support a seamless discharge flow to out of hospital services. • Also under the Getting Home programme a Trusted Assessment pilot has been operating with positive results and excellent feedback from Adult Social Care on the standard of assessments and care plans provided by RBFT Occupational Therapists (OTs).	• In 18-19 the Integrated Discharge Service will move to "business as usual" within the Trust although this does not mean that the service will not continue to develop and evolve. The team will fully roll out the new e-referral system across the Trust and hold an official launch on 17th April which will showcase best practice in discharge and have Liz Sergeant as a guest speaker. The team will continue to work on the discharge pathways with the aim of simplifying the pathways and having increased consistency across Berkshire West. The team will also work with ASC colleagues on the best model for integrating social workers into the team. This is aimed at supporting achievement of the 3.5% target for DToC and reducing the number of stranded patients in the Trust through a focus on simplifying pathways, hone as the default discharge destination and community services pulling patients out of bedded care. • The Trusted Assessment pilot continues and in 18-19 with the aim of reducing the current duplication is assessment for patients. In 18-19 the focus will shift to Care Homes and how the use of the Trusted Assessment approach could reduce the delays experienced waiting for Care Home assessment. • The next stage of the Discharge to Assess pilot is the use of a single "home visit" assessment form" with a duplicate being left in the patient's home.
Minor Injuries Unit (MIU) • Current service provision at the Minor Injuries Unit (MIU) at the West Berkshire Community Hospital has been reviewed in light of the guidance on designation of Urgent Care Treatment Centres (UTC). The existing service already meets many of the conditions of a UTC but developments required include; upskilling the workforce in minor illness, establishing additional premises requirements, interoperability and introducing an appointment booking system. Additionally the extent of GP presence at the UTC is yet to be determined but opportunities presented by the more integrated approach to on the day management of urgent need are being explored.	• The unit will be in a position to achieve full UTC designation by December 2019. • Full interoperability will be in place by q2 to support direct booking • Agreed set of PGD (Patient Group Directives) in place

Delayed Transfers of Care
• In 17-18 Commissioners, Providers and Local Authority partners focused closely on delivery and robust monitoring of BCF schemes with DToC numbers remaining at some of their lowest levels during Dec-17 and Jan-18.
• The new Integrated Discharge Service launched their new operating model, working with medically fit patients on a case management approach and liaising closely with
	• In 2018-19 the ICS will work with Adult Social Care colleagues to implement the recommendations from the Local Government Association (LGA) review completed in February 2018 including:
	  • Focus on home first and discharge to assess
	  • Joint H&SC commissioning, demand and capacity planning and workforce strategy across all authorities

ASC on complex discharges.

- The Trusted Assessment pilot went live on Hurley ward with a new Berkshire West Standard Operating Procedure, single referral form and OTs acting as Trusted Assessors for care needs post discharge.
- The Specialist Support to Discharge team (CHS) provided individualised support to self funding patients and their families to facilitate timely discharge and materially decreased the number of days delayed for this cohort of patients.
- There was continued focus on discharge to assess and full use of D2A capacity and on flow through Community Hospitals with ongoing work on the time taken to transfer patients from acute to community beds.

- Providing social work service and community support seven days a week
- Simplifying and clarifying access to care pathways
- Successful implementation of the High Impact Changes.

Continuing Healthcare (CHC) service

- The Continuing Healthcare (CHC) service has continued to try to increase the number of patients who are interim funded pending a full CHC assessment, a process which began in September 2017. However the complex needs of some patients have meant we have not always been able to do this in a timely way. In Q4 N&W Reading met the percentage projected in the Improvements Plans (9%). North and West Reading achieved 20%, 5% over the Improvement Plan target. Newbury and District CCG's percentage increased to 33% from 14% in Q3. Wokingham's percentage remained at 25%. due to an inability to place patients identified for interim funding and assessment then needing to take place in hospital

Risks and issues associated with the delivery of this plan:

- Actions are not sufficient to deliver the submitted A&E trajectories
- Anticipated impact of bed modelling project not realised
- IUC service does not deliver the expected channel shift impact on downstream services
- DToC rates will remain above the 3.5% threshold target across acute and community beds

How does the ICS intends to work together to mitigate these risks and issues?

- The A&E Delivery Board will continue to take oversight of the transformational programme of work for UEC. The Board has a clear remit in holding partners to account for delivery and addressing risks and issues to support achievement of the A&E 4 hour target.
- External support is being commissioned to support the bed modelling work and ensure achievement of key deliverables
- The CCG will work closely with the IUC Alliance of Providers to support achievement of the Business Case deliverables
- The BW 10 Partnership Board will also continue to have an important role on oversight of delivery of key BCF schemes recognising that not all Local Authority partners are currently part of the ICS.

What are the projects programmes we expect to contribute?

- High Intensity Users
- Bed modelling and flow
- Streaming at the front door of ED
- Ambulatory Care
- Specialist support to discharge
- Suite of BCF schemes including Discharge to Assess, Falls and Frailty, Mental Health Street Triage

- Implementation of the LGA Peer Challenge on Delayed Transfers of Care

7.5 Annex 5 – Maternity

Responsible ICS partner: Berkshire West CCG

Overall Goals for 2017-2019

A Local Maternity System (LMS) was established across the BOB STP in March 2017 as recommended by the Better Births Report: National Maternity Review published in June 2016. As a result of the capacity issues across Thames Valley maternity services is one of the main priorities for the BOB STP. The Senior Responsible Officer for Maternity is Chief Executive of Buckinghamshire Healthcare NHS Trust who nominated the Chair responsibility to Director of Nursing for Berkshire West CCG. The membership of the LMS Board includes representatives as recommended in the NHS E LMS Resource pack. The LMS Board meets quarterly with working groups set up to address the 5 main priorities.

There are 3 acute Trusts in the BOB LMS, all providing maternity services. There are 4 main types of care settings for women giving birth: home, freestanding midwifery units (FMU), alongside midwifery units (AMU) and Consultant led Obstetric units. Within BOB LMS every Trust provides a home birth service, there are five FMUs, three AMUs and three Obstetric Units.

Progress in 2017/18

- The Implementation plan for the BOB LMS provides the detail to date of the 3 year maternity transformation programme. The BOB LMS has agreed the 5 main priorities; this requires each Locality to have a Local Maternity steering group and a Maternity Voices Partnership that will be represented on the LMS board in order to understand how each local maternity steering group is implementing all aspects of Better Births.
- The BOB LMS plan concentrates on workforce, capacity and safer care. The need to develop the digital agenda is highlighted as this is pivotal to accurately record outcomes using robust data.
- LMS Board 5 main priorities are:
- Improving the safety of maternity care by 2020/21
- Increasing Choice and Personalisation
- Transforming the workforce
- Improve access to Perinatal Mental Health Services
- Improving Prevention

Deliverables for 2018/19

- Achieve 20% of all deliveries within the Alongside Midwifery Unit
- Increase Home Births to 3% by end of 2017/18 and 4% by Q4 2018/19
- Continue progress towards 20% reduction in stillbirths, neonatal death and maternal death and brain injury during birth by 2020
- Ensure Diversion policy is activated less than 1-3 time per month and for as short a time as possible
- High HMU to be open and caring for postnatal mothers requiring additional support, unblocking delivery rooms and freeing up midwives.
- Every woman being cared for by small midwifery teams of 4-6 midwives, with a named lead obstetrician per team

Risks and issues associated with the delivery of this plan:

- Inability to recruit to midwife vacancies

How does the ICS intends to work together to mitigate these risks and issues?

- Participate in BOB LMS workforce day to develop plan for 2018/19 and beyond and monitored at LMS
- Local Berkshire West action plan in place and monitored at local Maternity Steering group

What are the projects programmes we expect to contribute?

- BOB LMS
- STP Governing Body

7.6 Annex 6 – Learning Disabilities

Responsible ICS partner: Berkshire West CCG and Berkshire Healthcare NHS Foundation Trust

Overall Goals for 2017-2019

The Transforming Care Partnership (TCP) Board comprises 14 Health and Social Care partners across the county who hold a shared vision and commitment to support the implementation of the national service model for children, young people and adults with learning disabilities and/or autism, who have behaviour that challenges and may or may not have mental health issues and have come into contact with the criminal justice system. The model requires integration and collaboration by commissioners, providers and other sectors to enable this cohort of people to lead meaningful lives through tailored care plans that meet individual needs.

This reflects the national Transforming Care Partnerships (TCPs) that CCGs and STPs are expected to deliver. We have achieved the following in line with the national programme.

Progress in 2017/18	**Deliverables for 2018/19**
Berkshire Transforming Care Plan • The Berkshire Transforming Care Plan has 4 key aims: • More care in the community, with personalised support provided by multi-disciplinary health and care teams • More innovative services to give people a range of care options, with personal budgets, so that care meets individuals needs • Early, more intensive support for those who need it, so that people can stay in the community, close to home • Inpatient care, but only as long as is needed and is necessary • To achieve those aims the TCP Board has established a programme and governance structure built around a number of work streams, with children and young people and those in transition being a core component of each.	• There are seven work streams in place that support these aims and form our priority actions for 2018/19: 1. **Joint commissioning and integration** – aligning financial processes, explore joint commissioning, jointly managing the market 2. **Communication and engagement** – stakeholder identification, creation of communications plan, effective communication and engagement 3. **Workforce development and culture** – cultural audit, workforce development programmes for staff, creating a cultural change programme 4. **Children and young people** – engaging services, developing new joint ways of working and person led plans 5. **Autism** – engaging with service users, including people in developments, enhancing support 6. **Service reconfiguration** – deliver intensive support team service, reducing reliance on bed based care, growing housing and support services, developing meaningful day accommodation and employment opportunities, enhance services to meet needs of children and young people in transition, further support for people with autism 7. **Risk management** – shared financial, quality, relational risk plan, mitigate risks through a programme management approach.
Reduce inappropriate hospitalisation • We have continued to reduce inappropriate hospitalisation of people with a learning disability, autism or both, so that the number in hospital reduces at a national aggregate level by 35% to 50% from March 2015 by March 2019. • There are continuous efforts to move people out of long stay hospitals into appropriate community settings. Berkshire CCG and	• The TCP Board has set a plan to reduce Berkshire East CCG and Berkshire West CCG commissioned in-patient beds to 10-15 beds per million population by the end of 2018/19.

BHFT, working with the NHS England Specialist Commissioning Team, are on track to reduce CCG and NHS England commissioned bed capacity from 44 to 28 within the time line. Working with the best of local experience, skills and knowledge a new service model has been created that incorporates Positive Behavioural Support and increased level of community based provision resulting in a reduction in beds.	
Improve access to healthcare • We have continued to improve access to healthcare for people with a learning disability, so that the number of people receiving an annual health check from their GP is 64% which is higher than in 2016/17. The TCP Board is working in partnership with GP practices to ensure that reasonable adjustments are made to enhance access for annual health checks. GP practices are encouraged to ensure that the right coding is used to ensure that people have timely access to annual health checks. We are presently on track to meet this target.	
Avoiding hospitalisation • We have made further investment in community teams to avoid hospitalisation. Berkshire West has developed an intensive support team, the remit of this team has been developed to ensure that people are supported in the community to manage risks and avoid hospital admissions. Berkshire West CCG and BHFT are working closely together to continue the development of this team. • We have ensured more children with a learning disability, autism or both get a Community care, Education and Treatment Review (CETR) to consider other options before they are admitted to hospital. We are continuing to work with our partners on this to ensure that the earliest intervention point is realised to gain better outcomes for our children. We are also working with NHS England on developing joint CETR for cohorts that are currently in tier 4 provision.	• To continue funding the intensive support team for the financial year 2018/19 • To develop a protocol working with NHSE for Tier 4 cohort clinical treatment reviews
Premature mortality • We continue to develop the work on tackling premature mortality by supporting the review of deaths of patients with learning disabilities, as outlined in the National Quality Board 2017 guidance. Berkshire West CCG has implemented the LeDeR programme that oversees the review of all deaths and have appointed reviewers.	• To continue to routinely review deaths of patients with learning disabilities, linking in with BHFT Quality Improvement Programme
Risks and issues associated with the delivery of this plan: • The risks and issues associated with this plan are mitigated through our risk register, board	**How does the ICS intends to work together to mitigate these risks and issues?** • This is a national programme of work dedicated to people with learning disabilities. We are proud of the work undertaken so

meetings and operational group meetings. By working together as a system we can identify and minimise the risks	far and for the support of partners. We look forward to a continued positive relationship with our partners through our ICS.

What are the projects programmes we expect to contribute?

- Transforming care board
- Berkshire West CCG Governing Body
- East Berkshire CCG Governing Body
- West Berkshire, Reading and Wokingham Local Authorities

7.7 Annex 7 – Outpatients

Responsible ICS partner: Berkshire West CCG, Royal Berkshire Foundation Trust, Berkshire Healthcare Foundation Trust,

Overall Goals for 2017-2019

The vision for the outpatients transformation programme is to redesign outpatient services provided to Berkshire West patients in ways that every contact for patients counts by:

1. Developing alternative options to complement current practice
2. Optimising technology advances
3. Truly integrating working across pathways
4. Developing care closer to home to reduce inconvenience for patients who may need to travel significant distances

The overall aim is to provide the optimum patient experience and best value for money for the Berkshire West pound.

This transformation programme is a strategic change programme delivered as a collaborative approach through the ICS with RBFT, BHFT, Berkshire West CCG and the emerging GP Alliances working together to achieve the changes. It builds upon an internal RBFT three year outpatients modernisation programme that started early in April 2017 and takes advantage of the ICS development to give the programme a wider perspective and gain greater benefits.

Progress for 2017/18	**Deliverables for 2018/19**
Programme Overview	
• Develop a vision and direction to scope all outpatient services. • Good engagement between the three organisations and the GP alliances to identify early specialties for inclusion in Phase 1 specialties. • Engaged meds management across the organisations to support the areas of change where meds management has a key role. • Identified the need for advanced advice and guidance to support secondary expertise in primary care. • Explored the role of digital technology and support management • Developed business cases to implement a new way of working with an advice and guidance solution. • Developed a business case to implement DAWN for multi-specialties to support the	• During Q1/2 2018/19 implement the pilot for a new Advice and Guidance (A&G) solution between primary, secondary care and mental health teams. • Go live with the implementation of consultant-led telephony triage of Rapid Access Chest Pain Clinic (RACPC) referrals in Q3 2018/19 following the implementation of the A&G solution • During Q2 2018/19 will see the introduction of a streamlined ambulatory care pathway for RACP patients • A chronic cough pathway using an integrated approach to the management of patients with a cough lasting ≥8 weeks will be implemented in Q1 2018/19. • In Q3 2018/19 a primary care led sleep apnoea service to manage patients within primary care and streamline referrals to secondary care where further intervention is required. • Introduction of virtual management of renal patients and their long term care planning. • Following technical enablement during Q2 2018/19 the use of electronic monitoring of patients results and telephone consultations for patients requiring long term disease

remote monitoring of patients bloods in response to management of their long term care. • Identified three areas of mental health to improve communication and streamline patient care. • In all areas where there will be changes to patient pathways workgroups have been developed with representation from operational teams, clinical teams from secondary care (RBFT or BHFT), GP and CCG. • Q4 2017/18 commence a pilot for virtual discharge planning between GP and Mental Health Team MDT for mental health inpatients to ensure primary care are part of discharge plans for patients and minimising the risk of patients going back into crisis management, readmission or re-referral. • Q4 2017/18 workshop and planning commences to explore the potential of a primary care based service to care for patients who have mental health and physical health problems.	modifying drugs in Gastroenterology, Respiratory, Dermatology and Neurology. • End of Q1 2018/19 an improved and streamlined dementia pathway and memory clinic working towards the delivery of the 6 week of diagnosing dementia. • Q1 2018/19 phase 2 of acute specialty reviews will commence and a rolling programme of specialty and outpatient services reviews continuing throughout 2018/19 and implementation of approved changes. • Q1&2 relocate the first cohort of outpatient services from the main RBH site to satellite clinics.
Project development • During 2017/18 a significant benchmarking exercise was undertaken across all RBFT outpatient departments, reviewing the detailed workings of the hospital outpatient departments within the main acute site and its satellite sites. A key priority is to reduce the variation ensuring patients receive a standard and equitable service for their outpatient care. The standardisation will support the elimination of any processes that are unnecessary and do not add value to the patients. Through working as an ICS primary care and secondary care clinicians will develop pathways, protocols and guidelines for referrals which will support this reduction in variation**.**	• This transformation is currently being developed across all RBFT specialties with planning already underway with Phase 1 specialties including: Cardiology, Respiratory, Renal, ENT, Gastroenterology, Rheumatology and Neurology. The careful phasing of changes and clinic moves starts on a small scale to ensure that patients are not compromised and learning from changes and innovation can be embedded before further rollout. During the course of the transformation programme, it is expected that every specialty and outpatient service will undergo a review with clinicians and management alike across primary and secondary care and patients co-designing the changes.
Optimising Clinic Space • In tandem with reviewing clinical pathways RBFT have developed on line room booking provision across all sites to ensure clinic space is maximised and used flexibly to support patient access. In line with the seven day working focus from NHSI/E providing clinics out of hours will be scoped and the general outpatient's management structure and skill mix reviewed. With workforce skills, needs and training underpinning any changes to service provision.	• Finalise outpatient data by patient postcode to determine the level of clinic appointments required per hospital location. • Commence a phased approach to moving specialties across the hospital outpatient sites. outpatient sites . • Develop the clinic utilisation tool to accurately record clinic booking. • Complete a skills review required to manage outpatients and new ways of working.
Using Technology to enable new ways of working • Focus has been placed on moving away from traditional models of outpatient services being held by consultants within a hospital outpatient setting and exploring the role of digital technology and new ways of working to provide more cost effective and timely ways of	• In parallel the clinical and operational teams of BHFT have been scoping changes for mental health services with an ICS focus starting with the Dementia/Memory service, virtual consultation between GPs and Psychiatrists as well as exploring a different model to support mental health patients

delivering outpatient care for example using remote monitoring, telephone and video conference appointments. The changes and New Models of Care have taken into account the release in clinician's timetables which could be used in more effective ways to modernise and adapt services to meet the emerging patient needs and expectations.	with physical health needs, with further RBFT and BHFT/Primary Care services following in 2018/19.
Putting patients at the centre • A key driver for the outpatients transformation programme is putting patients at the centre of the change. The different ways patients will communicate with the clinical teams managing their care and treatment will vary and put the patient as an active and informed participant of the management of their outpatient journey. This will require robust and continued focused communications with the community, voluntary sectors and targeted communication strategies to patients and carers. They will be kept informed of the changes being explored as well as having a voice in the shape of the future of outpatient services. It is a vital element of the change programme that patients are empowered to make informed choices as well as supporting them to embrace change and not be fearful of the New Models of Care as the health economy move forward with the change in delivery. Engagement has commenced with one of the local Patient Engagement Group as well as planned patient representatives being included in the project workstreams.	• Introduce new ways of communicating with patients: • When exploring changes at specialty level, we will be engaging patients to ensure they understand the change, have the opportunity to influence the process, be involved in patient comms. • Undertake before and after patients surveys before changes are made and 6 months post implementation of change in all specialties offering new ways of engaging with patients. • Engage with the ICS comms teams to engage with and influence the communications matrix to ensure patients are aware of the changes and have an opportunity to be involved. • Use existing patient groups as a forum to inform, engage, gain feedback and involve patients.
Risks and issues associated with the delivery of this plan: • Capacity to incorporate new ways of working within clinical areas. • No reduction in activity realised despite various intervention.	**How does the ICS intends to work together to mitigate these risks and issues?** • Ensure workstreams have representation from each area to ensure the workload changes are managed accordingly. • Ensure pace of change is manageable through phasing of rollout and close monitoring to minimise risk of failure of the project workstreams. • Close monitoring of all KPIs – activity PODs, staffing and quality benefits will be monitored to readily identify issues and analyse accordingly.
<u>What are the projects programmes we expect to contribute?</u> • Long Term Conditions Programme Board • Planned Care Programme Board • Outpatient transformation steering group • DTB Clinical Delivery Group • Medicines Optimisation Group • GP Alliances working group • Royal Berkshire Foundation Trust outpatient group • Mental Health Programme Board • Dementia work stream • Virtual Mental Health work stream • Mental Health/Physical Health work stream	

7.8 Annex 8 - Integrated Respiratory Service

Responsible ICS partner: Berkshire West CCG, Royal Berkshire Foundation Trust, Berkshire Healthcare Foundation Trust

Overall Goals for 2017-2019

Work is under way to develop an integrated approach to managing patients with respiratory conditions. This builds on a previous case for change to increase access to specialist consultant skills across community and secondary care implementing an appropriate outcome based approach to meet local population needs.

The aim being to reduce unplanned hospital admissions and demand for specialist outpatient services, with the following aims:

- To provide a fully integrated service for primary, secondary and community care through virtual clinics and an MDT approach to respiratory provision in a community setting
- To promote early identification of COPD and Asthma self-management and intervention to improve the well-being of patients with respiratory disease
- To reduce reliance on specialist skills where alternative approaches can be adopted.
- To upskill primary and community to ensure the potential to support the patient population is maximised.

Progress in 2017/18

- There are a number of current work-streams which form part of the Outpatient Transformation Programme and are focussing on revised pathways for managing both Sleep Apnoea and chronic cough. In addition work is in progress to review existing patients with COPD/Asthma, mainly in relation to current medication. This will continue to support discussions regarding most effective ways to meet the needs of the local population.

Deliverables for 2018/19

- Reduction in non-elective admissions for defined respiratory conditions
- Refresh of RightCare approach, and validation of opportunities, with agreed priorities and outcomes to reduce variation.
- Increased numbers of patients reviewed annually and assessment of breathlessness undertaken using validated approach
- Increased number of patients prescribed cost effective inhalers
- Implementation of sleep apnoea pathway
- Implementation of chronic cough pathway
- Development of community hub, to support diagnostic assessment and optimises prescribing costs

Risks and issues associated with the delivery of this plan:

- There is a need to identify a sustainable approach to reducing reliance on specialist skills and developing integrated pathways. A number of approaches have been identified over an extended period of time, which have not come to fruition, and therefore a re-fresh of outcomes, opportunities and skills and functions required to meet these is required.
- There are a number of inter-dependent approaches which are highly reliant on co-ordination to avoid duplication and overlap.

How does the ICS intends to work together to mitigate these risks and issues?

- The Long Term Conditions Programme Board has membership from ICS partners and has responsibility for delivery
- The respiratory work-streams are overseen by the Long Term Conditions Programme Board (LTCPB) which has membership from all ICS partners (both clinical and managerial), as is the case for the Respiratory Steering Group, which is a sub group of the LTCPB. This enables risks to delivery of the transformation plans to be identified, and mitigations developed through the Steering Group, with clear escalation plans to LTCPB**.** The LTCBP formally reports to the Clinical Commissioning Committee, and has reporting to the ICS Clinical Strategy Group (CSG) , with escalation to the ICS Unified Executive
- Equally the respiratory Outpatient Transformation work-streams are overseen by the LTCPB and also reports its overarching programme into the ICS Clinical Delivery Group. This ensures there is mitigation of the risk of duplication or overlap with other projects.
- There are identified clinical leads from each ICS partner organisation which significantly contributes to co-production of integrated pathways.

What are the projects programmes we expect to contribute?

- The Long Term Conditions Programme has a number of inter-dependent work-streams which will contribute to the transformation and integrated management of respiratory conditions. This includes consideration of other conditions which impact on both physical and mental health, and are often reviewed in isolation of the respiratory condition/s.
- Outpatients Transformation Programme – including Chronic cough and Sleep Apnoea pathways
- Care and Support Planning (this is being extended to focus on patients with respiratory and other long term conditions) to support increased confidence and self-management, and reduction in duplication of approach.
- Improving Access to Psychological Therapies for patients with Long Term Conditions (IAPT-LTC) work stream focusing on improving confidence and self-management for people living with long term conditions, ensuring that both physical and mental health needs are addressed.

7.9 Annex 9 – High Intensity Users

Responsible ICS partner: Berkshire West CCG

Overall Goals for 2017-2019

A substantial proportion of the healthcare budget is accounted for by relatively few patients. This indicates significant potential for reducing workload on urgent care services and the wider health economy via a targeted and proactive intervention. Learning from Blackpool has demonstrated that an approach of empathy and coaching rather than enforcement has the potential to reduce the volume of urgent care activity for this cohort and indeed improve outcomes for patients.

This model of support has been replicated locally through the implementation of a High Intensity User (HIU) service working across RBFT, BHFT, SCAS and primary care. The approach offers a robust way of working across the ICS to reduce activity to 999, NHS 111, A&E, GP contacts and hospital admissions, freeing up front line resources to focus on more clients and reduce costs. It uses a health coaching approach, targeting high users of services and supports the most vulnerable clients within the community to flourish, whilst making the best use of available resources.

The service will measure the impact directly on 999 call outs, A&E attendances and associated admissions as well as qualitative outcomes for clients. However, through the Connected Care technology the project will also have the visibility of how the work of the coaches impacts on the wider health system, for example primary care and mental health services.

Progress in 2017/18

- The ICS service started in October 2017 initially for a period of 8 months to establish if the same results can be replicated locally. Two coaches are working with up to 40 people in this timeframe after which an initial evaluation will take place to establish if there is a business case for a full roll out. Achievements to date include:
- Marked reduction in ED attendances for those patients on the HIU caseload (47%).
- Reduction in the volume of 999 calls
- Detox completed for a number of patients who remain free from the use of drugs and alcohol.
- Excellent links made with the local community, particular charitable and voluntary sector organisations who are providing vital support to patients
- The service is working directly with key stakeholders in the acute hospital, ambulance service and the police to ensure there is a

Deliverables for 2018/19

- In 2018/19 the focus will continue to be building the caseload of patients who are most likely to benefit from this different approach to support, undertaking a robust evaluation of the impact of the work to date including how the approach might be utilised in other areas of healthcare.

joined up approach to delivery of this support to patients. In addition it is likely that the initial phase will draw out gaps in our current service provision, not only within statutory health and social care services but also the voluntary sector services. It may also indicate where existing services need extra capacity to provide the relevant support. The latter will also be included as a key part of the evaluation.	
Risks and issues associated with the delivery of this plan: • Continuing requirement to ensure that our interoperability systems (e.g. Connected Care) enable our health coaches to access patient data in different care settings • IG requirements make it challenging for the CCG / ICS to have visibility on a specific cohort of patients thus raising a difficulty in creating a baseline of activity and measuring changes against this to evaluate the success of the intervention	**How does the ICS intends to work together to mitigate these risks and issues?** • In 18/19 we will experiment with embedding our health coaches directly into provider services (e.g. A&E) so that information systems can be accessed directly and health coaches can build networks with other care practitioners who also regularly treat these patients • Working with ICS partners to ensure robust data and information is being collected which is both useful and compliant with statutory IG requirements
What are the projects programmes we expect to contribute? • High Intensity users is a project in its own right but has dependencies with Connected Care and the A&E Delivery Board	

7.10 Annex 10 – Integrated MSK

Responsible ICS partner: Berkshire West CCG, Royal Berkshire Foundation Trust, Berkshire Healthcare Foundation Trust	
Overall Goals for 2017-2019 Musculoskeletal conditions (MSK) are one of the areas of greatest spend for Berkshire West with care currently split across primary care, intermediate services and acute provision. With an ageing population there are increasing levels of demand and variation in referrals and management of MSK conditions which supports an overall case for change. Further work is required to improve the service to patients through developing and implementing a more integrated and coordinated programme. People with MSK conditions need to be able to access high quality support and a wide range of treatments. Needs range from simple behavioural or exercise advice to highly technical, specialised medical and surgical treatments. Multidisciplinary, integrated services are essential and need to incorporate rapid assessment and diagnosis	
Progress in 2017/18 • Through a fundamental re-design of the MSK pathway (completed in 2017/18) patients will be able to have greater control over their treatment and pathway. The CCG will be able to accurately predict annual spend on MSK and providers will be incentivised to improve quality of clinical care, identify and eliminate waste from within the MSK supply chain and deliver a seamless integrated experience of care to the patient. • To support a change in direction for MSK, it requires moving away from the traditional view of a single disease under the medical model, moving towards a holistic approach, seeing the	**Deliverables for 2018/19** • The overall vision is to provide an integrated system of MSK care taking a holistic approach that will deliver high value care using hospital facilities only when necessary, empowering primary care, improving patient experience and enabling better self-management. • The new MSK integrated service model (due in October 2018) 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 for MSK services for any patients registered with a GP in Berkshire West. • The new integrated service aims to deliver the following

patient as a whole rather than the condition they seek help for. With the right changes, right partnerships, and right investments Berkshire West will be able to achieve the holistic approach as set out in the Five Year Forward View. Through embedding shared decision making and adopting evidence based practice looks to break down professional boundaries ensuring the patient is on the right pathway receiving right care at the right place and at the right time.	outcomes: 1. An end to end pathway that encompasses de-medicalising MSK, promote self-care and healthy living such as exercise and healthy eating as enablers to have a positive impact on MSK issues; 2. A community provision where primary and community care providers work closely with physiotherapists to provide direct access for patients with MSK conditions to physiotherapists and ensuring all aspects of self-management are explored to manage the condition and there in guaranteeing appropriate referrals to secondary care in line with clinical need; 3. Patients to participate in a shared decision making process before referral for a procedure to secondary care; 4. Reducing clinical variation and duplication through pathway coherence; 5. Ensuring that every MSK practitioner is consistent in their approach; 6. Addressing the issues and concerns identified by patients and improving the quality of patient experience; 7. Patients should be given choices for treatments and the providers must have regard to the NHS Constitution Patient Choice; 8. Providers will identify and eliminate waste from within the MSK pathway and supply chain (as outlined in the Getting it Right The First Time report) therefore delivering commercial efficiency for the Berkshire West system moving toward a whole-system approach; 9. Utilisation of IT solutions to provide integrated care
Risks and issues associated with the delivery of this plan: • Agreeing the cost envelope for the service that is within CCG budget and provider cost • Getting to contract sign • Mobilisation of new service	**How does the ICS intends to work together to mitigate these risks and issues?** • Work together to design the optimum MSK service for patients • Ensure the ICS Exec working Group to kept up to date on the project progress and risks are escalated to this group
<u>What are the programmes we expect to contribute?</u> • Planned Care Programme Board • ICS Management, Finance and Clinical committees	

7.11 Annex 11 – Diabetes

Responsible ICS partner: Berkshire West CCG, Royal Berkshire Foundation Trust, Berkshire Healthcare Foundation Trust
Overall Goals for 2017-2019 The overarching BOB STP plan for Diabetes Transformation focuses on improving the efficiency of the BOB area while bringing care closer to home and improving access to more appropriate and timely healthcare for their population. This plan shows the commitment of all the constituent CCGs to move towards a common goal of reducing

variation in care across the whole STP area.

Our vision for better management of Diabetes is based around the NHS Year of Care process enabling genuine person centred care for people with long term conditions (LTCs) including diabetes. Our three areas of focus are centred on improved structured Education, 7 day access to specialist diabetes nurses within secondary care and reduced variation in the achievement of the three national treatment targets. Services are provided by both RBFT and BHFT working collaboratively with the CCG.

Progress in 2017/18	**Deliverables for 2018/19**
Diabetes Education • The uptake of structured education by patients varies across Berkshire West. A wide range of issues are known to influence the uptake and reasons for low attendance. There is a need to get people involved in their care in a way that is relevant to them, be that level 1, 2 or 3 of education. This can be both at and post diagnosis when there are other 'teachable moments' such as a change in medication or onset of a complication. • We have recognised locally that the current capacity within the Diabetes Specialist Nurse team was insufficient to effectively meet the needs of in-patients with diabetes. The enhanced service introduced during 2017/18 enables more targeted approaches to identify patients "at risk" earlier, and aims to reduce complications; improve patient reported outcomes and experience, reduce the level of medication errors and ensure people only stay in hospital when they need to. The team also provide on-going ward based training for staff aimed at improving knowledge. In the Maternity Unit, the team aim to identify and identify and reduce the risk of complications associated with diabetes. Additionally, the nurses manage those women attending clinic with diabetes providing specialist care including screening for gestational diabetes.	• The ICS is therefore committed to improving referrals and uptake to increase attendance over the next 3 years. Year one funding has allowed the CCG to commission a new "Carbaware" course for our population alongside additional training course for people with type I Diabetes. During this second year we will continue to develop a programme of work, which includes a "suite of education modules" that provides a variety of options for education based on individual learning needs. Each option is designed to move people towards structured education at the pace that is most appropriate for them. Each option will also be evaluated as an integral part of the process to ensure value for money and long term return on investment. • In addition to improved use of existing technology, for example Eclipse software, we have also recently commenced a programme of care support, specifically targeted at those with "complex diabetes" involving the use of specialist staff to support a multi-disciplinary approach to targeting and managing these complex patients in order to achieve better control and avoid repeat admissions and attendances at A&E for Hypoglycaemia or other manifestations of poor control. This will be further expanded and assessed during 2018/19 to better understand the impact on patient outcomes.
Risks and issues associated with the delivery of this plan:	**How does the ICS intends to work together to mitigate these risks and issues?**
• The national transformation funding is time limited, and has only recently been confirmed for 2018/19. This has impacted on the pace of delivery of the planned outcomes. • A sustainable approach to funding of each work-stream beyond this is required. This poses risks where longer time scales are required to demonstrate behaviour change and clinical outcomes to support return on investment. • Developing a sustainable approach to meeting the needs for specialist skills and ensuring optimal use of scarce resources e.g. dietician, consultant, diabetes specialist nurses.	• The Diabetes work-streams are overseen by the Long Term Conditions Programme Board (LTCPB) which has membership from all ICS partners (both clinical and managerial), as is the case for the Diabetes Steering Group, which is a sub group of the LTCPB. This enables risks to delivery of the transformation plans to be identified, and mitigations developed through the Steering Group, with clear escalation plans to LTCPB**.** The LTCBP formally reports to the CCG Governing Body and also reporting to the ICS Clinical Delivery Group (CDG) , with escalation to the ICS Unified Executive • A task and finish approach is in place to progress the work streams, which is driven by ICS membership. • The diabetes transformation proposals were co-produced by ICS partners with agreement at executive level from each respective organisation, a clear process is in place for review of progress on a quarterly basis, this is equally reported to NHSE.

What are the projects programmes we expect to contribute?

- The Long Term Conditions Programme has a number of inter-dependent work-streams which will contribute to the transformation of the management of diabetes; this includes
- Community clinics for people with complex needs as a result of their diabetes
- Care and support planning approach (this is being extended to focus on patients with diabetes and other long term conditions) to support increased confidence and self-management, and reduction in duplication of approach.
- Development of the Diabetes specialist nurse roles, and integrated pathways to optimise skills across primary, community and secondary care.
- Development of a suite of options to support increased knowledge and confidence self manage diabetes, this includes exploration of digital approaches and technology.
- IAPT-LTC work stream focusing on improving confidence and self-management for people living with long term conditions, ensuring that both physical and mental health needs are addressed.
- National Diabetes Prevention Programme (NDPP)
- National Diabetes Eye Screening Programme

7.12 Annex 12 – Estates

Responsible ICS partner: Berkshire Healthcare Foundation Trust and Royal Berkshire Foundation Trust

Overall Goals for 2017-2019

An efficient, effective, high quality, modern, accessible and welcoming estate is critical to our ability to serve our patients and contribute to the recovery and healing process. Our estate presents us with a number of challenges. Like many health and care systems our estate is a patchwork of bespoke buildings built in a range of different eras across multiple sites and with challenges associated with aging and expensive infrastructure, both in terms of replacement and on-going running costs

The aim of this work is to maximise effective utilisation (clinical and Non-Clinical) of NHS Estate portfolio and identify opportunities to deliver cash receipts through disposals and reduced annual revenue costs across the system. This will support and be shaped by the emerging estates requirements of the new care model and system changes identified via the ICS change programmes and ensure the estate portfolio is fit for the delivery of modern healthcare services that meets the expectations of patients/service users

Progress in 2017/18	**Deliverables for 2018/19**
• Initial scoping and planning of the project	• Taking the next step along the outpatient transformation journey RBFT are leading on the further development of Bracknell Healthspace atBrants Bridge as an Integrated Ambulatory and Community Health care centre with services provided by RBFT, BHFT and 3rd sector providers for patients in Bracknell and the surrounding area in 2018/19 and beyond. Alongside this RBFT will be increasing the amount of ambulatory care provided away from the acute hospital site for patients in other parts of the county from locations in Henley and Thatcham, making better use of and developing the premises in those locations with system partners as appropriate. • BHFT is leading on the development of a clinical services hub at the University of Reading Whiteknights campus for BHFT and RBFT Children, Young Peoples and Families Services and Adult Mental Health services from February 2018 with a 2 year roll out. • BHFT are nearing completion of a new 2- storey building at their Community Hospital which will house a Renal Dialysis Unit on the ground floor for occupation by RBFT and a Cancer Care Unit on the first floor will be occupied by Sue Ryder, RBFT, BHFT and the Cancer Care Trust. Opening in May 2018 to services will support patients in Newbury who

	previously had to travel to Reading for treatment. The unit has been fully funded by charitable donations through the support of the Newbury & Thatcham Hospital Building Trust and the Cancer Care Trust. • RBFT will be developing the masterplan for the acute hospital site, supporting new models of care and potentially the shared back office agenda, during 2018/19
Risks and issues associated with the delivery of this plan: • Alignment with other ICS schemes – consider using space differently before disposing. Programmes such as shared bed modelling must help inform what to do with the estate. • Access to redevelopment funding • Alignment with STP and OPE agendas/stakeholders	**How does the ICS intend to work together to mitigate these risks and issues?** • Established working groups for key programme deliverables with appropriate estates management and clinical representation from across the ICS. • A formal programme management structure that identifies and manages risk and dependencies with regular highlight reporting to CFO Group. Monthly scrutiny and oversight by ICS unified executive. • ICS finance directors and estates colleagues working with NHSPS to complete the STP (BOB) estates strategy workbook. Draft ICS estates strategy document to be ready for May for inclusion at STP level to align for STP level capital bid prioritisation.
What are the projects programmes we expect to contribute? • Other ICS clinical programmes - in particular outpatients, integrated MSK and bed modelling – as they explore options for care delivery in community / non acute settings. • Other ICS 'new business' work programmes - in particular back office and any estates requirements in relation to shared / co-located functions. • Primary Care estates / ETTF • BOB STP estates strategy	

7.13 Annex 13 – Shared Bed Modelling

Responsible ICS partner: Royal Berkshire Hospital Foundation Trust	
Overall Goals for 2017-2019 This project was established to ensure our 'bed base' across the ICS health economy 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 ICS programmes. The project is mapping capacity and patient flow across provider organisations, sites and bed types. A key output will be a move to manage all bedded care across the system 'as one' supported by a system wide bed management system based on real time data. At its heart is a redesign across the system of bedded care to deliver provision that can care for the right patient in the right setting as part of care pathways that provide alternatives to bedded care where appropriate.	
Progress in 2017/18 • Current state for acute and community bedded care is complete, the next stages will pull in mapping of domiciliary, nursing and residential home care and include in the future state design alternatives to bedded care. • This will help 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. In addition, the project will look to deliver shared 'live' bed capacity visibility to support patient flow and bed management. The work	**Deliverables for 2018/19** • **Phase 4** - the final phase of the programme will deliver 3 key outputs: • A synthesis of the outputs of the work completed to date • Benchmarking of these outputs with international comparators to create an assessment of Berkshire West's bed base, including the ratios of beds between different settings of care • A fully designed set of costed interventions which are likely to mitigate the financial effects of any projected growth in beds.

has been divided into a number of phases, with the final element due by the summer of 2018. Work completed to date includes:

- **Phase 1** – An assessment of the current acute & community physical health beds in the Berkshire West system
- **Phase 2** – An indicative model of likely growth in demand for these beds and therefore future requirements
- **Phase 3** – An assessment of local mental health inpatient bed requirements for the next 10 - 20 years

Risks and issues associated with the delivery of this plan:	**How does the ICS intend to work together to mitigate these risks and issues?**
• Capacity of existing MI systems to support 'real time' bed management & patient flow reporting • Availability of community alternatives to bedded care – particularly domiciliary	• Established dedicated project group with appropriate representation from across the ICS. • Formal programme management structure, including risk identification / mitigation and escalation, with regular highlight reporting to A&E Programme Board. Monthly oversight by dedicated ICS clinical and senior executive groups. • The Berkshire West Digital Transformation board, that brings together senior ICT representation from across the ICS, will support the development of MI systems.

What are the projects programmes we expect to contribute?

- A&E Delivery Board and the Berkshire West 10 Integration Programme- oversee the delivery of a range of initiatives focused on reducing avoidable hospital admission and promoting more timely discharge. These initiatives will impact on future capacity and patient flow requirements.
- Other ICS clinical programmes that identify alterative care models and different delivery methods / locations.
- Estates programme - mutual dependency to consider using space differently before disposing. Shared bed modelling programme must help inform what to do with the estate and vice versa.
- ICS Workforce strategy – mutual dependency as alternative care models and bed provision may require a different roles.

7.14 Annex 14 – Workforce planning

Responsible ICS partner: Facilitated by Berkshire West CCG working in collaboration with all ICS partners

Overall Goals for 2017-2019

A major part of our ICS ambition focuses on making improvements for staff across the area. As well as specific aims to improve workplace wellbeing there are ambitions to enhance leadership capability, up skill the workforce and create a shared workforce plan to increase opportunities for rotation across organisations – giving staff greater experience and enabling them to deliver better care and ensuring that we have the workforce we need to deliver the New Models of Care while maintaining the current service in the transformation period.

Our aim is to develop a network which will facilitate partnerships between service providers and the education and training providers within the ICS footprint that will accelerate the development of a sustainable and highly skilled health and care workforce in Berkshire West. By working together we will develop the infrastructure and stakeholder relationships necessary to effectively identify workforce needs and secure the investment and innovative approaches required to address these.

Progress in 2017/18	**Deliverables to date 2017/18 include:**
• To deliver on our aims we have established an ICS Workforce Group to support workforce development and transformation across the Five Year Forward View priorities areas. This	• Formation of the ICS Workforce structure as detailed below. • Engagement with NHSE/HEETV HEE Leadership Academy for funding and professional guidance. Scoping of all workforce initiatives and teams within the ICS footprint.

group's function is to enable the Berkshire West workforce agenda to be delivered within the ICS model of collaborative partnership between organisations in Berkshire West, ensuring our services meet the health and care needs of the local population. To enable the group function and support the workforce aims and function of the providers within the ICS, the group membership includes Health Education Thames Valley (HEETV) NHS England (NHSE) The Health Education England Leadership Academy (HEELA) and the Health Education Regional Workforce Team.

- The group will inform the STP Workforce programme, which is delivered by HEETV via the Berkshire Local Workforce Action Boards (LWAB). The ICS group will also facilitate the delivery of the Local Workforce Advisory Board and national objectives.

Aims and Objectives of the ICS Workforce Group:

- Identify the workforce requirement across the ICS
- Develop an ICS Workforce Plan
- In line with NHSE policy, secure the Berkshire West capitated share of all national funding to support delivery of the workforce plan
- Provide assurance to funding parties e.g. HEE/NHS England (NHSE) that funding is appropriately deployed
- Set strategic direction and oversee the work of the workforce sub groups
- Develop innovative and transformational approaches to role design
- Ensure mobility of the workforce around the ACS system to retain staff within Berkshire West and optimise the deployment of key skill sets
- Commission appropriate levels of pre-registration and CPD training
- Establish or access the HETV workforce intelligence function to provide accurate workforce data and workforce modelling capability.
- The ICS Workforce Group has within its structure underpinning operational groups whose function is to bring together the key stakeholders for the various work streams. In its current incarnation the work streams are based on the key priorities areas as laid out in the NHS England (NHSE) and HEETV plans.

- Development and engagement with a draft BOB STP workforce plan.
- In 2018/19 it is expected that a whole system analysis of our short, medium and longer term workforce requirements will be mapped out in order to form the basis of our action plan for Berkshire West.

Risks and issues associated with the delivery of this plan:

- Without the collaborative partnerships between service providers facilitated by the ICS model allowing collective workforce planning and development, we would be instead be in a competitive workforce market driving providers to compete against each other for dwindling workforce resource.

How does the ICS intends to work together to mitigate these risks and issues?

- Via the ICs Workforce model there will be full ICs partner and stakeholder engagement in the plans and strategic level sign off for all workforce planning and development moving forward.
- The ICS workforce model enables transformation and innovative workforce planning to be piloted and modelled system wide within the ICS health and social care arena.

• There must be strategic level sign up from all partner organisations to the ICS Workforce model to enable a system wide approach to workforce planning and development	

What are the projects programmes we expect to contribute?

- A/E Board. Newly set up UEC Task and Finish operational group which will report into A/E board
- Long Term Condition Programme Board and Long Term Condition Steering Group
- ICS Provider Stakeholder Workforce Function. BHFT, RBHFT, BW10 providers
- ICS Outpatient Transformation Group Meeting
- ICS Workforce Operational Groups. Cancer/MH/Primary Care/UEC

Berkshire Healthcare NHS
NHS Foundation Trust

Mental Health Strategy 2016 – 21

Progress Update

July 2018

Berkshire Healthcare NHS Foundation Trust

Healthcare from the heart of your community

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 Mental Health Strategy – progress since December 2016

The Trust Board approved our strategy in December 2016, ensuring it was aligned with our vision, values and key strategic objectives. The priority areas of focus were confirmed as:

Safer, improved services with better outcomes, supported by technology

Progress updates were provided to the Trust Board in May and November 2017, and this paper provides an overview of changes since then:

- Developments in national policy/local operating context since Nov 2017
    - Mental Health Workforce
    - System working
- What we have done in terms of:
    - Ensuring effective governance
    - Taking forward key initiatives and strategic intentions
    - Progress against national targets
- Planned next steps

Developments in national policy since November 2017

We have continued to submit Mental Health Delivery Plans to NHS England through our Sustainability and Transformation Partnerships . In addition, we have provided Mental Health Workforce Plans via Health Education England. These are now being triangulated with Mental Health Investment Plans to ensure delivery of the Five Year Forward View for Mental Health (FVMH), to ensure planned investment is reaching services., resulting in staff increases in line with national commitments.

As anticipated, there has been a continuation of the process used by NHSE to provide non-recurrent funding to support progress against FYFVMH targets. At the time of the last progress update, working with partners on bids for Individual Placement Support Services which facilitate people with serious mental illness into employment, and have been successful in securing funding to develop services in both Berkshire West and Frimley.

We are part of a group of Integrated Care System Mental Health Leads established in October 2017with support from Claire Murdoch, national mental health director for NHS England, who visited Berkshire West in May 2018. Very positive feedback was provided following this visit, which provided an opportunity to outline some of our key achievements as well as discuss areas of work presenting the biggest challenge. Claire Murdoch will attend the Mental Health Steering Group for the Frimley ICS in July, when a similar approach will be taken.

Mental Health Strategy and system working

Berkshire Healthcare NHS
NHS Foundation Trust

Developments in Berkshire-wide Initiatives

Mental Health has continued to attract a higher profile in **A&E Delivery Boards** in both halves of the county, and work on reduction of delayed transfers of care includes mental health as well as community and acute beds. However, significant pressure on inpatient services has continued, with high bed occupancy and longer lengths of stay, along with greater number of compulsory admissions to Prospect Park Hospital. More recent work has started to achieve positive progress, however, sustained change presents a significant challenge. We have completed a bed modelling exercise to analyse the needs of our local population over the next few years and inform medium – longer term planning.

Our **Early Implementer IAPT Programme** to increase access and develop services for people with long term physical health problems is demonstrating evidence of impact in terms of reduced GP and A&E attendances. A Thames Valley Suicide Prevention and Intervention Network is well established and linked with the Crisis Care Concordat and our own Zero Suicide Strategy. The **Connected Care** Programme has progressed well and Berkshire Healthcare staff are now accessing shared electronic records as planned.

We have secured NHS England funding to expand our Individual Placement Support service across Berkshire to enable people with serious mental health problems to secure employment.

We are continuing to work on the establishment of a joint commissioner and provider team to lead strategic planning and transformation in mental health across Berkshire, aligned with Surrey and Hampshire organisations for the Frimley Health and Care Sustainability and Transformation Partnership (STP)

Berkshire East

The Frimley Health and Care STP has established a Mental Health Steering Group to oversee delivery of FYFVMH targets as well as to ensure focus on all 7 STP priority initiatives to develop:

- **Support for peoples own responsibility for health and wellbeing**
- **Integrated decision making hubs**
- **A new model of General Practice at scale**
- **The support workforce across the system**
- **Social Care market analysis and management**
- **Analysis and reduction of clinical variation**
- **A Shared Care Record accessible across the system**

Mental Health Delivery Plans and Workforce Plans have been completed in partnership with Surrey and Borders Partnership Trust and local commissioners. Workshops have been held to identify work required to reduce out of area placements, and to consider the interface with GP Transformation work in progress. A mental health reference group has been established to enable engagement of service users and voluntary sector organisations.

Berkshire West

Our mental health service staff continue to be part of the following clinical work streams of the **Integrated Care System**:

- **The system-wide bed review**
- **The response to high Intensity service users.**
- **The analysis and approach to physical and mental health co-morbidities.**

The **Berkshire West 10 Integration Programme** has increased its focus on mental health and has facilitated improvements in the decision making progress for funding support for people subject to section 117 of the Mental Health Act.

We have contributed to mental health delivery plan submissions for the B**uckinghamshire, Oxfordshire and Berkshire West (BOB) STP**, trajectories for decreasing numbers of out of area placement, and also completed our local mental health workforce plans. Our Berkshire West Mental Health Delivery Group continues to oversee delivery of FVFVMH targets and report progress to the ICS and Integration Boards.

Work is in progress to confirm key priorities for action for BOB STP, to be coordinated by our Director of Corporate Affairs and the Chief Executive of Oxford Health.

Mental Health Strategy priorities and governance

Berkshire Healthcare NHS
NHS Foundation Trust

Key priorities
There is a good alignment between our vision, values, organisational priorities and our mental health strategy priorities:
Safer, Improved services with better outcomes, supported by technology

Our Trust Board Vision metrics that are specifically relevant to our mental health strategy priorities include:

- Patient assaults
- Use of restraint
- Inpatient deaths
- Suicide rate for people under mental health care
- Bed occupancy

As part of our Quality Improvement Programme, we have identified a number of "True North" metrics that are specific to our mental health services:

- Number of self harm incidents
- Violence and aggression incidents to staff

We have also prioritised implementation of our Quality Management Improvement System within Prospect Park Hospital.

We have used our Strategy Deployment process to help us prioritise key initiatives, which is now starting to incorporate local projects and initiatives.

This will guide our project resourcing decisions and guard against individual clinical or corporate services being over-burdened at any one time.
The following slide shows the significant initiatives within our mental health strategy, which will be enabled by technology and use of quality improvement methodology. This is followed by an outline of progress regarding each of the initiatives, a summary of our plans for technology enabled service delivery, the targets against which we will measure our progress and our planned next steps.

Governance
Our **Mental Health Programme Board**, accountable to the Business and Strategy Executive continues to oversee implementation of the Mental Health Strategy, Prospect Park Development Programme and Mental Health Pathways and Clustering. This group enables project leads to address interdependencies between initiatives.

Our IAPT service development is now implemented as "business as usual", reporting progress into Trust Business Group and Quality and Finance Executive meetings. There are also 2 Steering Boards in East and West Berkshire with commissioners.

The **Zero Suicide** initiative reports to our Quality Executive and is linked to the Berkshire suicide prevention steering group.

Urgent Care developments are managed through our operational management structures and our membership of A&E Delivery Boards. The management of "acute overspill" **out of area placements** is managed through a project board led by the Director of Nursing and Governance.

Our Trust Business Group provides oversight of contractual arrangements for the provision of **Longer Term Care.**

A **Global Digital Exemplar Board, chaired by our Chief Executive is well** established and oversee delivery of objectives set out within our bid.

The following slide provides the high level implementation "road map" for the key initiatives included in the strategy approved by the Trust Board

Mental Health Strategy

Implementation roadmap December 2016

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

Progress on Key Initiatives

Berkshire Healthcare NHS
NHS Foundation Trust

Prospect Park Hospital Development

Bed Optimisation:
This project was established to achieve:

- No Out of Area Placements (OAPs) as a result of acute overspill
- Acute adult bed occupancy consistently below 90%

A "spring to green" initiative has been successful in reducing placement numbers and work is in progress to ensure sustainable ways of maintaining low numbers. This includes the introduction of robust procedures for approval at Executive level. Support is needed from partner providers and commissioners to achieve our objectives and reduction of out of area placements is a key area of focus in both STP Delivery Plans. This project is now part of the "Eliminating Overspill , Optimising Recovery and Rehabilitation" described on page 8.

Staffing:
The Staffing Project has primarily focused on new roles and new approaches to recruitment. New Band 4 and Band 6 roles were established and filled. A benchmarked review of safe staffing was undertaken and work on the overall skill mix completed.. Further work is planned to address remaining challenges regarding vacancies in Band 5 nursing posts and further reduce turnover. This will be informed by a "deep dive" understanding of the challenges being experienced by front line staff, and their views about how to improve our current staffing challenges. Although good progress has been made, we will need a sustained focus to reduce vacancies in the long term.

Centre of Excellence:
Definition and confirmation of scope was deferred to enable prioritisation of Bed Optimisation, Staffing and Quality Improvement Initiatives. However, work has been completed to seek the views of service users, which will inform planning to be completed by October 2018. A physical health lead has been appointed and good progress made in addressing issues which contribute to health inequalities experienced by people with serious mental health problems.

IAPT

Our key initiatives are now incorporated into regular operational management and reporting arrangements. These include:

- Early Implementer pilot
- Skype pilot
- Development of online packages in partnership with Silvercloud
- Surrey AQP
- Healthmakers

Good progress is being made, and the Early Implementer pilot is continuing to show reductions in A&E and GP attendances of patients receiving Talking Therapies. Agreement was reached with commissioners to identify 18/19 funding beyond the non-recurrent NHSE funding.
Development of employment advisor roles is continuing, with additional funds secured from Department of Work and Pensions.

Zero suicide

This include four key priority areas of focus :

- A reduction in the rate of suicide of people under mental health care
- Increase in positive staff attitude and a proactive approach to suicide prevention
- An optimised RiO system for recording risk
- Families, carers and staff will feel supported and know where they can get support after a suicide

Progress updates provided to our Quality Executive have highlighted progress in terms of:

- meeting target of 10% reduction from 2015/16 baseline, but this need to be viewed over a sustained period.
- 3 day suicide awareness course continues to be well evaluated and attended.
- Risk audits continue to show steady progress
- Carer training on suicide awareness available.

BHFT will host a Zero Suicide Conference in December.

Progress on Key Initiatives

Berkshire Healthcare NHS
NHS Foundation Trust

Pathways and Clustering

This programme was set up to optimise service delivery and to understand and improve outcomes for service users, while also positioning the Trust to meet anticipated changes to commissioning arrangements. There is no longer a strong policy focus on the link with potential changes to payment mechanisms, as this has shifted to population based funding as part of the development of Integrated Care Systems.

Since November 2017, work has focussed on reducing the number of people within clusters 1-3 (representing mild – moderate mental health problems) receiving our services, and transferring back to primary care. As at May 2018, numbers had reduced by 60%.

Resources allocated to this initiative were redirected to focus on improvements required in record keeping and risk assessment at Prospect Park Hospital, but, work will continue on clusters 1 -3 from June 2018and expand through 2018/19 with C4, 11, 12 and 18 prioritised.

A full set of pathways has been completed for all secondary care clusters, and "Pathways on a Page" are published on our intranet.

Emotionally Unstable Personality Disorder (EUPD) End to End Pathway QI Project

This initiative has been prioritised to enable effective support to be provided to people who are over-represented in our inpatient and crisis services. Project resourcing and planned benefits are confirmed, to achieve an evidence based pathway throughout our services, along with:

- Reduction in occupied bed days for people with EUPD
- Reduction in self harm incidents, OAPS expenditure and re-referrals relating to inpatient services
- Improvement in friends and family recommendation scores and staff engagement within inpatient services.

Longer term care

The **Eliminating Overspill, Optimising Rehab and Recovery** seeks to address the 5YFV aim of eliminating acute out of area placements as well as development of a range of rehabilitation & recovery options. This includes specialist placements, but also looks to develop the provision so that bed-based options become the final resort rather than the rule. A revised approach to assessing and approving out of area placements has been piloted and rolled out, and the position at Q2 shows rate of placements has almost returned to target trajectory.

The regional work to develop a New Model of Care for people needing **low and medium secure services** has progressed well and the number of people repatriated to Oxford is higher than planned. Year 2 of the pilot will focus on reducing length of stay in specialist placements and will be informed by an analysis of need across the areas covered (Oxfordshire, Bucks, Berkshire, Hampshire and Dorset) Berkshire work will focus on development of step up and step down services.

Urgent Care

Work is continuing to optimise the performance of our Common Point of Entry, Crisis Response Home Treatment Services, and our Inpatient Wards. This is in response to ongoing high levels of demand and capacity challenges within other parts of the system which is resulting in:

- High referral numbers of people to CPE
- Increased length of stay at Prospect Park Hospital

Action is being taken to address these issues, which needs to be continued into the medium/long term, and supported by commissioners and partner providers to ensure sustainable solutions.
We have undertaken a review of our CRHTT, using a "tender" model to review our use of resources in this service, which has been experiencing high referral numbers leading to significant cost pressure. This has identified a number of key actions being taken forward by the operational managers and progress reported into Trust Business Group.
We are working to ensure that accurate data is used to inform agreed actions. through our A&E Delivery Boards in East and West of Berkshire, including numbers of bed days lost due to delayed transfers of care.

Technology enabled service delivery

Berkshire Healthcare NHS
NHS Foundation Trust

The use of technology to enable the delivery of a new model of care in mental health is at the centre of our ambition as a "Global Digital Exemplar" for mental health, confirmed in April 2017.
The table below provides a summary of progress against the key initiatives as at June 2018.

Initiative	Progress	RAG
Skype platform to support clinical Consultations enabling IAPT & EIP services to offer Skype as standard	The solution will be trialled July-Sept with IAPT & EIP services	A
Digital Appointment Correspondence	Procurement completed, and system implementation commenced. Adult MH services live with digital appointment correspondence	G
E-observations	Implemented into Mental Health wards – Phase 1	G
Real time capacity monitoring	Messaging enabled and dashboard developed. Implemented in inpatient and crisis services	G
EPMA - inpatients	Implemented and in use in all MH Wards	G
EPMA - outpatients	Revised go-live date in August	A
Care Pathways	Clinical delivery and audit to evidence NICE concordant treatment	G
Enhanced care home support	Pilot completed in 5 Care Homes. Further work needed as a result of WiFi survey	A
Supervision and training via web conferencing	Online access to clinical support available. Skype clinics for RiO running since Oct 2017	G
Second generation mobile workforce	Platform 1 in pilot, 2 in procurement, 3 awaiting supplier	G
Quality Improvement	Completion of initial lean projects	G

Progress in other related programmes

Information Technology Architecture Strategy Implementation Programme
Progress is on target, with the new data network in place and migration to windows 10 complete across 22% of the laptops/desktops running the system as planned.

Connected Care shared record programme
The Berkshire Connected Care Portal went live at the end of January 2016, and has been developed to enable access to GP data and acute hospital admissions, discharge & transfer data.
Berkshire Healthcare staff make extensive use of the Connected Care facility to view information which supports delivery of safe, good quality care, improved patient experience, and effective use of resources.
Training materials and user guidance are provided on our intranet.
EPMA and Connected Care links are in place.
Procedures have been implemented to comply with changes required as part of GDPR.

We have continued to develop our use of **online programmes** as part of our **Talking Therapies** service, enabling us to achieve access targets and expand our offer across major long term physical health conditions. Our partnership with Silvercloud has enabled us to collaborate on the development of programmes for people with long term physical health problems , which is showing encouraging results as identified on page 7.

The application of our **Support Hope and Recovery Online Network** is continuing across our services, from its inception in eating disorder services.

Informatics development remains an important priority – and we are now able to access a wide range of "tableau" dashboards for our mental health services, enabling staff and managers to understand referral, activity and caseload information, at service and team level. We have also aligned ESR and financial information to provide vacancy reports which are crucial to our workforce planning activity.

Measuring our progress and next steps

Berkshire Healthcare NHS
NHS Foundation Trust

Our Mental Health Delivery Plan Submissions identified overall good progress in delivery of FYFVMH targets (please see page 11 for a summary of the key targets from NHS England).
Having secured funding to expand our Individual Placement Support services, areas prioritised as requiring further work are:

- Elimination of out of area placements for people requiring acute care by 2021. As described on page 7 this is linked to our bed optimisation work and requires work on internal as well as system solutions.
- Achievement of CAMHS access targets, given continued growth in demand.

Our Trust Board Vision measures and True North metrics described on page 5 provide a clear focus on our priorities as an organisation. These are at the centre of our Quality Improvement work, which will enable improvements identified by our front line staff.

We have robust arrangements for measuring progress against key mental health targets, and reviewing qualitative and quantitative information through our Executive meetings:

- User safety, people, NHS Improvement, service efficiency and effectiveness and contractual metrics monitored at our Finance Executive
- Patient Safety and Experience issues are reported to our Quality Executive
- Progress of key projects is monitored by our Business and Strategy Executive

These groups support the work undertaken by our Trust Board Committees (Quality Assurance, Finance, Investment & Performance and Audit) in their detailed review of performance and key risks to delivery of Trust Board priorities for our mental health services.

Next Steps

The following activities are currently being prioritised for action :

- Continued focus on our **Quality Improvement** initiatives to reduce restraint and assaults in our inpatient services. Maximising the impact of our Quality Management Improvement System linking front line staff and senor leadership.
- **Progressing mental health initiatives within our ICSs**. This will include work with partners to reduce out of area placements and ensuring mental health is effectively represented in all work streams.
- Implementation of our **Delivery Plans** for the achievement of FYFVMH targets – with a particular focus on those areas we have identified as needing further work.
- Continuing to refine and implement our **Workforce Plan** for mental health – in liaison with ICS partners and Health Education England. This will include addressing specific risks regarding inpatient, IAPT and CAMH Services.
- Working with commissioners to ensure that the **Mental Health Investment Standard** is met, and that Mental Health Investment Strategies reflect funding provided to commissioners to achieve FYFVMH targets.
- **Beginning our forward planning for 2019/20** will ensure that our True North metrics are embedded within our Plan on a Page, which will guide team planning and individual objectives for staff working in our mental health services.

Five Year Forward View for Mental Health. **By 2020:**

70,000 more children will access evidence based mental health care interventions . Community eating disorder teams in place for children & young people

Intensive home treatment will be available in every part of England as an alternative to hospital

No acute hospital is without all age mental health liaison services with at least 50% meeting the "core 24" standard

At least 30,000 more women each year can access evidence-based specialist perinatal mental health care

10% reduction in suicide and all areas to have multi-agency suicide prevention plans in place by 20 17

Increased access to evidence-based psychological therapies will reach 25% of need, helping 600,000 more people

The number of people with SMI who can access evidence-based Individual Placement Support will have doubled

280,000 people with SMI will have access to evidence based physical health checks and interventions

60% of people experiencing a first episode of psychosis will access NICE concordant care within 2 weeks

Inappropriate out of area placements will have been eliminated for adult acute mental health care

New models of care for tertiary MH will deliver care closer to home, reduced inpatient spend and increased community provision

There will be the right number of CAMHS inpatient beds in the right place, reducing the number of inappropriate out of area placements

"Our top three priorities"

By people from groups and communities that are seldom heard, and the charities that support them




A report by Healthwatch Reading

healthwatch Reading
advice • advocacy • action

Home of ReadingVoice
Your local advice & advocacy hub

Reading Refugee Support Group

Reading mencap

Talkback

Reading Community Learning Centre

Launchpad

Summary – themes

People in Reading who are sometimes described as 'seldom heard' have been given a voice through this Healthwatch Reading project. We also talked to charities that support those people.

When we reviewed all of the reports together, we could see these common themes in what people told us, which we think the managers who design, buy and run health and social care services in Reading need to be aware of:

From listening directly to people

1. **Rights** – knowing your individual rights in health and social care and having your rights respected.
2. **Information** – having enough information, at the right time, in a form that is right for the individual
3. **Enough good quality and culturally sensitive care to meet the needs of the individual**

From listening to the charities who support them

1. **Inclusivity matters** – people themselves have valuable information about their needs that can inform how services are designed and provided. Charities that work directly with particular groups can provide valuable additional insights
2. **Mental health services need to be sensitive to cultural issues and individual needs (in services day-to-day & when involving people in service improvement work)**
3. **Unpaid carers have a vital role, and their needs must be addressed** when planning services and thinking about when, where and how service users will have their needs assessed and met.

Introduction

People in Reading who are sometimes described as ‘seldom heard’ have been given a voice through this Healthwatch Reading project.

Our team went out and spoke to people whose experiences, feedback and suggestions might be overlooked or not sought by local services because of various barriers. These might include having a disability, not being able to speak English, or not understanding their right to have their say to help influence the quality of local health and social care services.

We worked in partnership with charities who support these people to arrange listening sessions where people could share their ‘top three priorities’.

We have previously published the five reports in our series of short reports (see summary boxes). In this summary report we are now bringing these priorities together to share with organisations responsible for providing, funding or planning health or social care for these groups of people.

People attending the Reading Community and Learning Centre for language or other classes, said they need:

- access to interpreting services when using the NHS
- culturally aware and timely provision of accurate information about locally available services
- longer appointments, if they do not speak English as their first language, so they can adequately discuss serious health or care concerns and understand their options

"My GP called the [interpreting] phone service. It was good."

People supported by Reading Mencap told us they need:

- health and social care staff who are properly trained about learning disabilities
- to be able to see the same GP each time they visit their surgery
- to get enough, good quality care to help keep them safe and to live as independently as possible

"Sometimes they [care support workers] cancel on the day [and] no-one comes."

People with housing needs, supported by Launchpad Reading told us they need:

- more time for healthcare professionals to listen so that individual needs can be met
- better coordination between healthcare professionals
- to be treated as experts in their own lives, whether in health or in social care

People supported by learning disability charity Talkback said they need:

- services to be sensitive to the needs of carers such as family members, who help them with things like arranging and attending appointments
- easy-read leaflets or other adapted information to help them understand services, their options and their care
- their rights to be known and upheld – such as the right to have reasonable adjustments made to services so they can use them

"They put up on a screen when it's your time to see the doctor, but I need support to read this."

People supported by Reading Refugee Support Group said they need:

- better access to interpreting services
- better and more accessible information, including details about what they can expect in and from healthcare services
- healthcare professionals who make sure that people understand the outcome of appointments – including any diagnosis, what they need to do or what will happen next with their care

One person said a hospital wanted to charge him £240 for a blood test, even though he had papers connected to his asylum application showing he did not need to pay for NHS services. He went back to his GP, who did the blood test at the surgery instead.

Reading Refugee Support Group · Reading mencap · Talkback · Reading Community Learning Centre · Launchpad

The individual project reports are attached at the end of this report.

Themes

Drawing out the themes from the individual reports, what people told us matters was

1. **Rights** – knowing your individual rights in health and social care, and having your rights respected.
2. **Information** – having enough information, at the right time, in a form that is right for the individual
3. **Enough good quality and culturally sensitive care to meet the needs of the individual**

What people told us about their experiences included praise for good practice, but they also told us that services are not always getting things right. Some of the most vulnerable people are not getting the support they need.

We found that people found it more difficult to share experiences on some topics with us in our listening sessions than on other topics. We were guided by the charities we worked with on whether, if at all, it was appropriate to mention mental health in terms of health/illness. We did offer the opportunity for people to speak to us privately, if they wished. In the light of the advice given to us by our partner organisations, we were unsurprised that we heard relatively little about support for mental health issues.

To inform our understanding of additional issues, we also asked staff at the charities supporting those who spoke to us to tell us what they think are the 'top 3 issues in health and social care' affecting their clients. What we understood from what they told us is summarised on the following page. (Please refer to the individual partnership reports for the explanation in wording agreed with us by each partner organisation).

What we heard from Reading Mencap – a charity supporting people with learning disabilities

1. Social care: care and support plans - **getting an assessment that reflects the real needs of the individual matters,** and various current issues and problems with this were highlighted
2. When social care is provided - **the experience of care from Learning Disability Support Workers is affected by high staff turnover, short periods of time allocated for care, and a need for better staff training**
3. **Healthcare - are the needs of people with learning disability understood? are reasonable adjustments made?** We heard that some key aspects of care from GP surgeries can make an important difference (appointments at a time when the person with a learning disability can be accompanied; follow-up by the surgery if a person does not attend an appointment; taking care to obtain proper consent to treatment). Also, that a 'lead' GP in Reading to raise awareness about the needs of patients with learning disabilities in Reading could make a real difference.

What we heard from Talkback – a charity supporting people with learning disabilities

1. The **quality of support,** both personal and social, that people with learning disabilities receive is of vital importance.
2. **How people communicate with people with learning disabilities really matters.** Making appointment letters and information leaflets easy-read may not be the whole answer, but it can make a real difference.
3. **People having meaningful activities** that in some way contribute to the local community are of real importance to people. We can all learn from meeting a diverse range of people in service and activities that are inclusive and welcoming to all.

What we heard from Reading Community Learning Centre (RCLC) – a charity that provides education and support for the most disadvantaged and socially isolated women in Reading, most of whom do not speak English, and many of whom are not literate in their own language

1. Women who are learners at RCLC experience difficulties in **getting access to health and in understanding services,** including social services, generally – barriers including language, interpreter availability, cultural issues of expectation and understanding
2. There is a **lack of enough support for mental health** – not getting timely, appropriate and culturally sensitive treatment for mental health problems
3. **People needing home care need care that is culturally sensitive and appropriate** - RCLC learners as family carers supporting in this situation face extra pressures that may affect their health

What we heard from Reading Refugee Support – a charity supporting refugees and asylum seekers including those in Reading

1. **Difficulties in getting access to health** – barriers including language, interpreter availability, quality and suitability of information resources, and cultural issues of expectation and understanding
2. **Lack of enough support for mental health** – not getting timely, appropriate and culturally sensitive treatment for mental health problems
3. **Additional stress for people who act as carers for family members** – these pressures can affect their health

What we heard from Launchpad Reading - an organisation supporting people with housing needs

1. Mental health services need to be more responsive and accessible to meet the needs of homeless people and people at risk of homelessness.
2. NHS and social care services are very stretched currently due to funding pressures – this makes contacting services and getting the responses that Launchpad clients need difficult
3. There is little evidence that the preventative element of the Care Act is being implemented in practice – many Launchpad clients with eligible needs could benefit from the early and creative intervention to promote wellbeing as the Act requires, and Launchpad Reading has assisted some clients to be aware of their eligibility by using an 'eligibility checker', resulting in positive outcomes.

The themes that Healthwatch Reading concludes these conversations add to what we heard in our listening sessions are:

1. **Inclusivity matters** – people themselves have valuable information about their needs that can inform how services as are designed and provided. Charities that work directly with particular groups can provide valuable additional insights
2. **Mental health services need to be sensitive to cultural issues and individual needs (in services day-to-day & when involving people in service improvement work)**
3. **Unpaid carers have a vital role, and their needs must be addressed** when planning services and thinking about when, where and how service users will have their needs assessed and met.

How can services be designed that are sensitive to individual needs and hear all voices, including people who use services, their families and carers?

Listening to people about their experiences of NHS services, using their views to shape quality improvement work, and involving people in planning of services is a requirement for NHS services. Involvement in service planning and design is often called 'co-design' or 'co-production'.

The NHS Constitution gives people the right to have a say in shaping their own care. They also have the right to be involved, directly or through representatives, in planning and designing services. When planning and carrying out their involvement work, services must have regard to the Equalities Act 2010, which protects individuals from unfair treatment and promotes a fair and more equal society.

Reflecting on this project, Healthwatch Reading has produced a short guide to involving local people in planning and designing NHS services which is attached to this report.

For listening, involvement and co-design/ co-production of services in social care, the Social Care Institute for Excellence, a national charity, has a useful suite of online training materials and resources.

Practically, two things are essential when doing engagement (listening to people and talking to them) and involvement work (people taking part in planning and designing services):

1. **Commitment to the idea**
   Know that engagement and involvement are different – be committed to involvement, so that it is an automatic part of all strategic planning: 'how soon can we involve the public and/or patients/service users and how will we do it?'

2. **Lived Practice**
   Know who to talk to – build relationships of trust locally and in your professional networks. Ask for help early, be open to new ideas. Make real involvement happen.

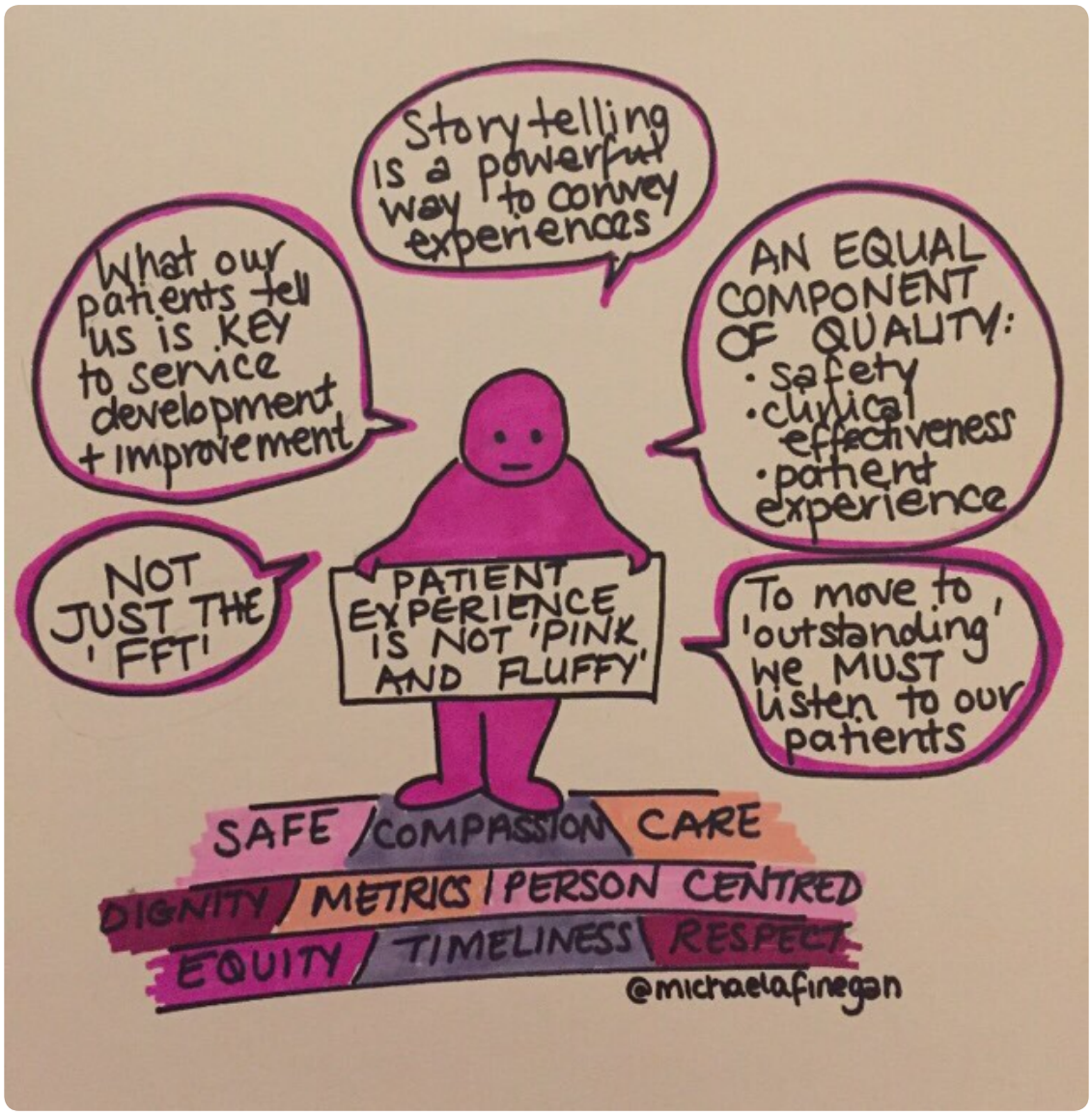
Conclusion

This project has enabled people in Reading who are 'seldom heard' to share their views and priorities. It shows how opportunities to meet with people and listen to them directly can be arranged by working in partnership with the charities that support local people and taking their advice – and we thank our partners for their help and advice in this project. Involvement of local people in service planning and design could be developed further using this approach,

A key principle of such work is to meet people where they are, at a time convenient to them, and shape the occasion to their needs. Expecting people to fit in with a formal meeting or process, and to understand jargon, is often less successful in achieving true inclusivity.

Not everyone will know that they have the right to be involved. Healthwatch Reading can support services to involve local people if commissioners (the managers who buy services), and also NHS and social care services themselves, tell us when services are going to be reviewed or changed. It is important to involve service users and families/carers directly or through their representatives right from the start, when the work is being planned. This doesn't always happen.

'Involvement' in planning & improving health services – a Healthwatch Reading practice guide for NHS organisations



'Innovative organisations also have positive approaches to inclusion and participation, high-quality teamworking and an ethos of optimism, cohesion, co-operation, support and collaboration across boundaries, with a strong commitment to ensuring high-quality care for the communities they serve.'

https://www.kingsfund.org.uk/blog/2017/09/compassion-and-innovation-nhs

Engagement, Consultation, Involvement – is there a difference?

Yes. Engagement is making a connection with people, talking to and listening to them, but not necessarily doing what they suggest. Consultation is a formal process for engaging people – which might have involved them in service design, depending on how you engage them in the process, and how much influence their views can have. Involvement is just what it says – people are working alongside you as equals, helping to improve or redesign services. When people are involved in this way, often the work done is called 'co-design' or 'co-production.'

Why do we need to do it?

Most people working in services recognise that it is the right thing to do – people who use services have expertise to offer about their own lives, experiences, health conditions, wellbeing, disability, culture and characteristics. People in discussion, sharing their stories, can often shed light on real experiences that 'tick the box that applies' data does not. Their experience is different from that of anyone who knows how a service works from the inside, as an employee, whether in they speak in that role or as a service user.

The work also has an important role in ensuring that services are inclusive – helping services to comply with the Equalities Act 2010.

Where national policy directs what will happen in services, the local detail of how it happens, and whether the public feel that this has been 'done to' them or whether they have a sense of ownership, depends on whether involvement happens, or not.

The right to public involvement in planning healthcare service is set out in the NHS constitution:

'You have the right to be involved, directly or through representatives, in the planning of healthcare services commissioned by NHS bodies, the development and consideration of proposals for changes in the way those services are provided, and in decisions to be made affecting the operation of those services.'

https://www.gov.uk/government/publications/the-nhs-constitution-for-england/the-nhs-constitution-for-england#patients-and-the-public-your-rights-and-the-nhs-pledges-to-you

'But we understand the patient experience already'

If this is you, it is worth spending a few minutes listening to breast cancer oncologist and patient Liz O'Riordan:

https://www.nuffieldtrust.org.uk/media/summit-2018-snapshot-liz-o-riordan-a-consultant-plastic-surgeon-on-becoming-a-breast-cancer-patient

and also watching this 20 in minute panel discussion in which Liz and a senior NHS manager with a clinical background explain how they discover how little they understood what it is like to be a patient or service user, how their professional knowledge always gives them a different view. Only a service user who is not a clinician knows what that experience is like – for them:

https://www.nuffieldtrust.org.uk/media/panel-discussion-at-summit-2018-when-nhs-staff-become-patients

The latest guidance for CCGs on refreshing commissioning plans says:

'Public Engagement As systems make shifts towards more integrated care, we expect them to involve and engage with patients and the public, their democratic representatives and other community partners. Engagement plans should reflect the five principles for public engagement identified by Healthwatch and highlighted in the Next Steps on the Five Year Forward View'

https://www.england.nhs.uk/publication/refreshing-nhs-plans-for-2018-19/

These five Healthwatch principles call for organisations to:

- Set out the case for change so people understand the current situation and why things may need to be done differently.
- Involve people from the start in coming up with potential solutions.
- Understand who in your community will be affected by your proposals and find out what they think.
- Give people enough time to consider your plans and provide feedback.
- Explain how you used people's feedback, the difference it made to the plans and how the impact of the changes will be monitored.

https://www.england.nhs.uk/wp-content/uploads/2017/03/NEXT-STEPS-ON-THE-NHS-FIVE-YEAR-FORWARD-VIEW.pdf (See p35)

So what do we need to do?

- People are diverse, so you will need to use different approaches with different groups
- You need to think about people with protected characteristics under the Equality Act and be especially careful to include them
- The general principle is 'go to where people are, and think about them, not any message that you want to communicate – be curious, ask open questions, listen, ask for clarification, listen again'
- Uses language and ways of meeting with, and listening to, that are right for different groups – not Powerpoint, policy jargon, and the language of your meetings
- Going out for coffee or tea, or to join in with a crafting event, or to have an informal question and answer session, might be just the thing
- Always be clear about who you are, how views shared with be used, where any write-up will be published, that views will be kept anonymous if wished etc - agree ground rules at the start, and stick to them
- Voluntary sector organisations and local Healthwatch are key sources of advice for this work – involve them and ask for advice when you are planning what you will do
- Think about whether this is a one-off event or series of events supporting a piece of work, or do you need to build something longer-term and sustainable? How will you fund the work?
- It is not difficult to do this well if you allow enough time to build and develop relationships with community groups - and if you recognise that parachuting in, asking what matters to you in your language, and then leaving, with no commitment to developing a continuing connection, will rarely work
- You need someone – ideally more than one person in a large organisation – as a community liaison person, devoting a significant amount of time, regularly, to this work - someone who becomes known and recognised in the local community, and is a key contact for Healthwatch, the voluntary sector, local councillors and community leaders
- For your community liaison person, time spent out drinking tea and networking is time well-used – people help people – people connect people – people have the answers to the problems that need to be addressed locally in the services you commission or provide

There are many published guides about engagement and involvement. Easy to find, easy to quote. More difficult in a busy and pressured working life to live the practice.

Practically, two things are essential:

1. **Commitment to the idea**
   Know that engagement and involvement are different – be committed to involvement, so that it is an automatic part of all strategic planning: 'how soon can we involve the public and/or patients/service users and how will we do it?'
2. **Lived Practice**
   Know who to talk to – build relationships of trust locally and in your professional networks. Ask for help early, be open to new ideas. Make real involvement happen.

If you need more detail on that statutory background and 'how to', we recommend this excellent suite of guides by Healthwatch Kent:

http://www.healthwatchkent.co.uk/public-consultations

But above all, talk to us at Healthwatch Reading. We are here to help.

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"Our top three priorities"

By people with learning disabilities and the charity that supports them

healthwatch Reading
advice • advocacy • action

Joint report
May 2018

Reading mencap
The local voice of learning disability

"Our top three priorities" Report summary

People supported by Reading Mencap would like:

1. Staff trained on learning disabilities
2. To see the same GP, and time for the GP to listen
3. Enough, good quality, care

Reading Mencap called for:

1. Quality care needs assessments
2. Consistent and adequate care
3. The NHS to adjust for the needs of people with learning disabilities

> "Sometimes they [care support workers] cancel on the day and no-one comes."

This report is based on local listening visits carried out in February 2018. It is one of a series of short reports that Healthwatch Reading is producing in partnership with local charities, to ensure that the views and needs of people and communities who are 'seldom heard', are available to the NHS locally, and Reading Borough Council, to inform planning and funding of health and social care services and quality improvements to services.

Why have we produced this report?

The Quality Statements produced by Healthwatch England for measuring the impact and effectiveness of local Healthwatch include:

Community Voice and Influence – enabling local people to have their views, ideas and concerns represented as part of the commissioning, delivery, re-design and scrutiny of health and social care services;

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> A local Healthwatch needs to formulate views on the standard of health and social care provision and identify where services need to be improved by formally or informally collecting the views and experiences of the members of the public who use them. (Healthwatch England)

Healthwatch Reading is therefore working with other local charities on a series of short 'top three issues' reports to ensure that the views and needs of people and communities who are least often heard are available to the NHS locally and to Reading Borough Council, to inform both commissioning and quality improvement in services

How did we produce this report?

Our first listening meeting was with Leslie Macdonald, Chair of Trustees, Mandi Smith, CEO and Kate Stonehouse, Family Support Team Leader at Reading Mencap.

Our second listening meeting was with Reading people with learning disabilities, at their regular Coffee Club meeting on 26 February, 2018, at Reading Mencap premises.

Part 1: What we heard from Reading Mencap

People with learning disabilities are some of the most vulnerable people in society, and they and their families and carers can often have difficulty in communicating their needs and experiences in health and care services.

These three themes emerged when we listened to Reading Mencap staff talking with us about the experiences of their clients:

1. Social care: care and support plans - getting an assessment that reflects the real needs of the individual

We heard that people with a learning disability need a high-quality assessment so that the social care plan written for them meets their needs.

It is also very important that family carers of people with a learning disability have a carers' assessment, so that their own needs can also be considered. Some people with learning disabilities live with their parents (60% of whom are retired or not working and are often frail themselves according to Reading Borough Council), or other family members, and caring responsibilities are often tiring and stressful, as well as often expensive (e.g. needing to pay for structured activity outings for the cared for person), adding to the stress that carers experience.

Other people live on their own, with some support from paid carers depending on their level of need.

We heard that the way in which social care plans are drawn up and implemented is having a serious impact on the mental health of many people with learning disabilities, who typically will experience high anxiety about forms and processes. People with learning disabilities will have very limited understanding of the process, or how what they say may affect what is put in their plan. This is resulting in social care plans that do not meet their needs.

We heard that:

- a social care assessment is typically carried out by a social worker who has not met the person before and does not necessarily have training in learning disability
- the assessment takes less than half a day, and lack of training in how to ask questions in the right way can mean, that a person's abilities are not correctly recorded

In one case, a person who told the assessor that they 'liked to make curry' meant that they could only make themselves a curry-flavoured instant soup. Heating up microwave meals is also deemed adequate nutrition, rather than being able to cook fresh food.

2. When social care is provided: the experience of care provided by learning disability support workers

We heard that there is a high turnover of care support staff generally, with varying abilities, in agencies that are used to support people with learning disabilities. It is a particular problem that a person with a learning disability may need to visit their GP surgery on more than one occasion to get their needs fully looked at – it can be difficult to get an appointment at a time when the person's support worker can also attend.

Care staff are often kind, but allocated care time is typically very short. This can affect the quality of the care provided.

People with learning disabilities are not able to understand fully how this might affect them, or how to try to change this so that their needs are met.

Mortality rates for people with learning disabilities are 13 years earlier for men and 20 years for women, than for people generally (University of Bristol)

We heard that care support providers may not always be providing training that makes sure that care staff really are alert to health issues for clients and that clients themselves might not be alert to these.

3. Healthcare: are the needs of people with learning disabilities understood and do services make reasonable adjustments?

Reading Mencap suggests that the following would be key reasonable adjustments:

- surgeries ensuring that they offer appointments both for the annual health check for a person with a learning disability and for any non-routine things that are at a time when the person can be supported by someone they know
- if a person with a learning disability does not attend a health appointment, following up with the person to call them in for an appointment can make a difference and ensure that they are seen – but that too often there is a lack of effort beyond what would be done for a person without a disability
- taking care to obtain proper consent to treatment – it takes more time to do this well when a person has a learning disability
- A 'lead' GP in Reading to raise awareness about the needs of patients with learning disabilities – when NHS staff are so busy, having a local 'awareness champion' could make a real difference.

"My support has been reduced because of all the cutbacks."

Part 2: What we heard from people with learning disabilities at a Reading Mencap coffee group

We asked the group to tell us what it is like when they visit their GP or the hospital, and what it is like if someone is helping them with their care at home. Are the people who help with health and care, kind and clear in what they say? What is done well? What could be better?

We spoke with eight people with learning disabilities and one carer. Several Reading Mencap staff and volunteers were present to host the session and contributed when appropriate.

The session was facilitated by Healthwatch Reading and was a mixture of whole group discussion and informal discussion over coffee. (Some contributors use GP services outside the Reading Borough Council area that we cover – where their comments highlighted what is important to people with learning disabilities, we included them in preparing this report).

GP & other primary care services

We heard that the experiences of people with learning disabilities at GP surgeries are varied.

- Some have good experiences with GP surgeries. They like to see the same doctor each time and they like to have enough time to explain things and for the doctor to talk to them. It is also important that the doctor listens to them.
- Some doctors don't seem have a good understanding of learning disabilities.
- One person had moved from Circuit Lane Surgery to another surgery because of "lack of seeing the same doctor and not feeling known".
- One person had found a GP to be unsympathetic about depression – they had moved to another surgery where the doctor was much more helpful.

"I can't get one [a social worker] at all."

"Sometimes they [agency support workers] cancel on the day - no-one comes."

It can be difficult to make an appointment at a time when the person's support worker can go to the appointment with them.

Some people feel that appointments could be given sooner – waiting several weeks to see a named doctor is difficult. Some people have to visit to visit the surgery to make an appointment because it is not easy to be understood by the receptionists on the phone.

We heard that anxiety is a problem for many people with learning disabilities and that it is important to feel known, valued and understood. This can reduce the anxiety that goes with making and going to appointments.

One person talked to us about using dental services and being told that they would have to pay for expensive treatment which they did not take - when in fact they would have been entitled to free NHS treatment.

Hospital

One person told us about an experience at a hospital some years ago. After their surgery they were left in a room opposite the theatre where they could see people walk in and out.

This was because the hospital could not find them a bed. They stayed there until they were discharged. They had to make their own way home on the minibus. This had not been a pleasant experience.

The few people in the group who had used hospital services generally told us they were happy with the treatment they had.

The group also discussed Health Passports (which people themselves hold to show various professionals important information). These can support and empower people, but local NHS funding for these has now stopped and GP records could be used more to hold details.

People with learning disabilities rely on their GPs to make the transition smooth for them when they have to attend hospital appointments, especially if they have no carer or support worker to bring them.

The Healthwatch Reading session at a Reading Mencap coffee group

Social care

The group told us strongly that they are not getting the support they need at home and to support them in going out.

Several have had their care needs reassessed recently, resulting in the allocated number of care hours being reduced. Most people in the group do not have a social worker and if they need to speak to one, they are getting through to a duty officer, who has no background knowledge of their needs.

People told us that things are not so good now as when there was a specialist learning disabilities team of social workers at the council.

Some told us that if care support workers were sick there was no cover for them. We also heard that care is not always provided over Bank Holidays and that this has an impact on people. One participant told us this 'does not make me feel valued'.

Changing care providers means lots of paperwork. This is difficult for people with learning disabilities, the group told us, and reduces their choices. Sometimes they want to change who provides their care, but the process is very difficult.

Several people told us that support workers do a tremendous job. One said that they were happy to tell their care support worker what they were happy with or not.

We heard that a few of the group have their money looked after by the Deputy's Office at Reading Borough Council.

This office does a good job of handling their money but it is very busy and has a long waiting list.

The top three issues raised by the group:
- health & social care staff need to be better trained about learning disabilities
- they need continuity of care at their GP's
- care packages don't always meet full needs

We heard about a positive experience of using IRiS, the alcohol and drug treatment service in Reading. The person told us that the service listened to them and had helped the person with their addiction and now they are doing really well.

Transport to and from health and other appointments can be a significant barrier to getting good access to services. We hear that travelling by public transport can be difficult. For example, staff are not always helpful when a person has physical needs that mean they need to have the access ramp lowered on a bus.

Healthwatch Reading observed in talking with this group that it is not always easy to tell that a person has learning disabilities, so staff in various services might wrongly assume a person does not have additional needs.

Conclusion

In both listening sessions it was clear how important it is for there to be a care plan that reflects and meets a person's real needs, and how important continuity of care is, as well as training for health and care staff specific to working with people with learning disabilities.

Themes from this report, and our recommendations spanning the whole series of reports in this project, will be included in a final report in due course.

Healthwatch Reading thanks Coffee Club members and Reading Mencap staff for giving their time to share their views. Healthwatch Reading is an independent charity with some statutory powers. We can take your feedback in confidence, help you make complaints, and refer serious concerns to other agencies.

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"Our top three priorities"

By people with learning disabilities, supported by the charity Talkback

healthwatch Reading
advice • advocacy • action

Joint report
May 2018

Talkback

"Our top three priorities" Report summary

People with learning disabilities would like:

1. Easy-read leaflets about services, and for use during visits to healthcare professionals
2. To know about their right to ask for reasonable adjustments to make services more accessible
3. More consideration given to the needs of carers, who help support them with daily life

The Talkback charity called for:

1. The right support in place for people with learning disabilities
2. Better communication, tailored for people with learning disabilities
3. People with learning disabilities to have the opportunity to take part in meaningful activities that contribute to the community

> *I don't know when the surgery opens or closes. My support worker does it all on my behalf.*

This report is based on listening visits carried out in March 2018. It is one of a series of short reports that Healthwatch Reading is producing in partnership with local charities, to ensure that the views and needs of people and communities who are 'seldom heard', are available to the NHS locally, and Reading Borough Council, to inform planning, funding and quality improvements to services.

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The Quality Statements produced by Healthwatch England for measuring the impact and effectiveness of local Healthwatch include:

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> **A local Healthwatch needs to formulate views on the standard of health and social care provision and identify where services need to be improved by formally or informally collecting the views and experiences of the members of the public who use them.**
> (Healthwatch England)

Healthwatch Reading is therefore working with other local charities on a series of reports to ensure that the views and needs of people and communities who are least often heard are available to the NHS locally and to Reading Borough Council, to inform both commissioning and quality improvements of services.

How did we produce this report?

Our first listening meeting was with Talkback staff member Sue Pigott on 7th March 2018.

Our second listening meeting was with 28 people with learning disabilities at a Talkback Matters session held at Salvation Army, Anstey Road Reading on 13th March 2018

Part 1: What we heard from Talkback

Talkback is a charity working in the community to amplify the voices of people with a learning disability. It says there are three key issues in health and social care for people they support:

1. **The quality of the support they receive.** Support, both personal and social, are of vital importance to people and many people have a restricted number of support hours which can prove difficult when emergency situations occur, someone gets ill, or relationships at home break down. Sometimes misunderstandings around relationships occur which can impact on people's mental health. Having the right support in place to guide, advise and find ways of supporting these is vital for people to develop their confidence, gain more independence, learn how to sort out these issues (wherever possible) as well as engaging in the local community.
2. **How people communicate with people with learning disabilities.** As more people live independently, receiving long letters, in small print, with no pictures, using jargon words, does not support people to attend appointments. Issuing easy read letters may not be the whole answer- but it may support people with learning disabilities to get some idea of what they 'could' do towards attending an appointment. Easy read leaflets on medical conditions would go a long way too to supporting people in looking after themselves. Having their 'Health Passport' (an easy-to-use record designed specifically for people with learning disabilities, that service users bring to various appointments) read when it's shown is also of great importance to some people - it can lead to a better understanding of the person's support in attending appointments.
3. **People having meaningful activities that contribute to the local community.** Historically, people have simply attended day services, and although some have enjoyed the opportunity to socialise, and take part in activities, they have not always been able to meet people outside of their disability, which would add to everyone's personal development.

Part 2: What we heard from people with learning disabilities

Talkback staff helped us to run the listening session attended by 28 people, and wrote its own report to record what happened in the session and what people said. The session focused on access to GP services.

Introduction

Talkback are a charitable organisation who work in the community to amplify the voices of people with a learning disability.

Through engaging and consulting with people with a learning disability, Talkback capture their thoughts, feelings and opinions about their lives and the issues which affect them, recording these insights in various creative formats and presenting them to professionals. The information gathered is fed into the Learning Disability Partnership Board to ensure that people's voices are heard by service providers in Reading, affecting positive change which is influenced by the lived experience of people with a learning disability.

Talkback Matters

One way of achieving this is through the monthly meetings called TALKBACK MATTERS.

These groups have different topics each month and give people the opportunity to come together in a social way. Individuals are supported by carers who know them and are encouraged to take full active part in the discussions. By using pictures and symbols individuals are supported to speak up about their experiences.

There is always a beginning to every Talkback Matters group. To make sure people feel valued and part of something important we sign in our names. This gives individuals the opportunity to make choices and be seen by everyone else in the room. It also facilitates taking turns.

Individuals have the opportunity to choose who signs in next and this acts as a way of introducing people to each other.

GP Surgeries

Todays topic was around doctors surgeries. Healthwatch Reading are keen to establish a way for people with learning disabilities to access their services and through attendance such as this group we can establish how this can be achieved.

We had some picture set up on a flip chart and so individuals were encouraged to answer the questions, offer their opinion and tell us about their experiences. Support staff were also there to add their contribution as some of the individuals who attend need more support to remember some of the finer details.

Here's what people said to some of the questions asked.

The door of the surgery is not sliding so when I'm in a wheelchair I have to get someone to help me to open the door.

The surgery doesn't have a big car park so my sister has to pay to park her car even when she's only picking up a repeat prescription for me.

I don't know when the surgery opens or closes. My support worker does it all on my behalf.

I have to walk to the surgery as there is no bus route. When you are not feeling well this is hard. I don't get paid support for health appointments

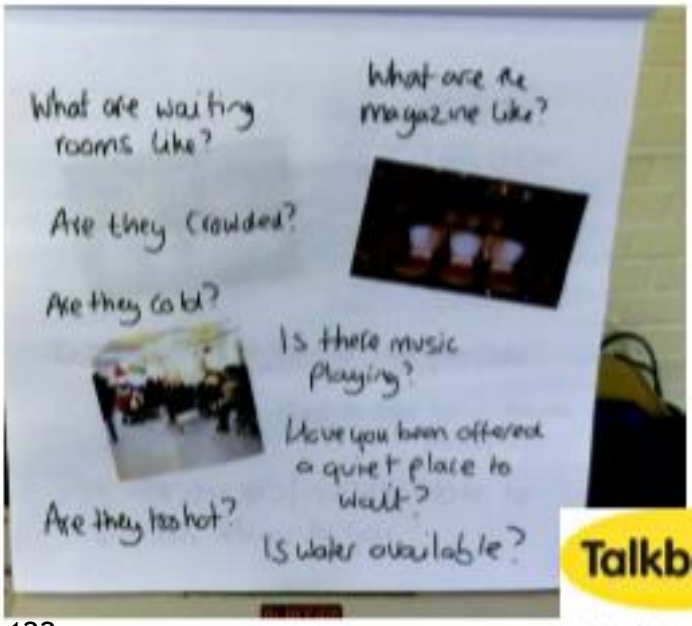
Talkback Reading

Here are a few experiences of people on waiting rooms:

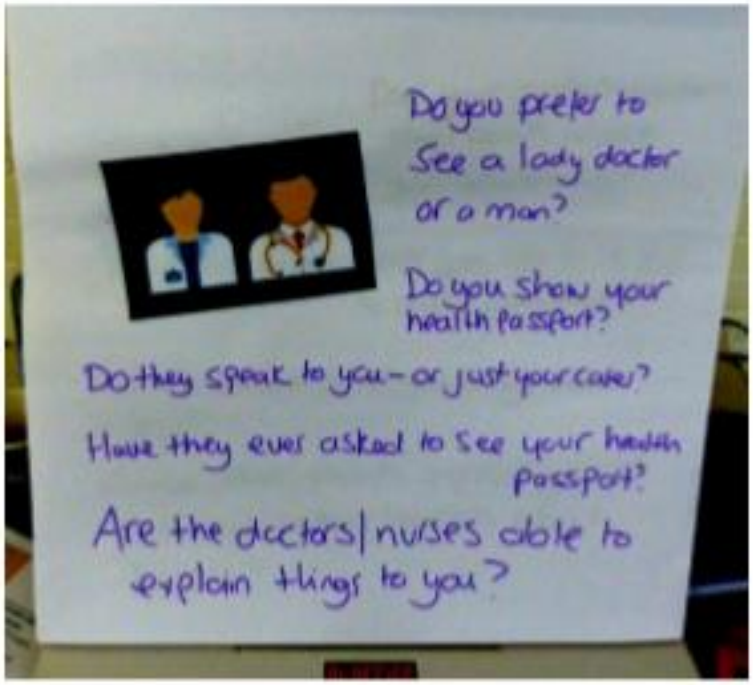
"I didn't know that I could ask for a quiet room to wait in. I have been told that if I ask before my appointment the surgery can provide me with a quieter place to wait as I do find the waiting room a bit noisy"

"The waiting room is big, it can be noisy with kids running about"
"It can get a bit hot really"
" You seem to have to wait for a long time"
" The magazines are ok, but there's no where to get a drink of water"
" The seats aren't very comfortable, they can be a bit hard, especially if you are sitting there a long time"
"They put up on a screen when it's your time to see the doctor, but I need support to read this"

"The receptionist is ok, sometimes I can't see her because the counter is in the way- I'm in a wheelchair and I can't see over the counter"



Talkback Reading



I do feel a bit rushed when I am talking to the doctor. He is very busy.

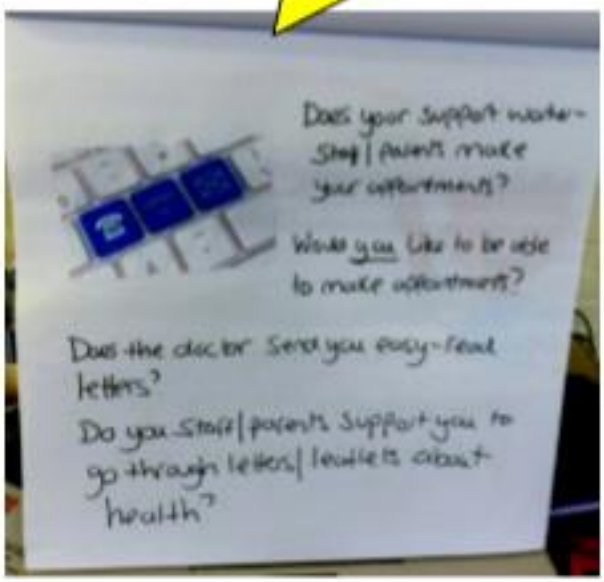
I don't mind if I see a man or a lady doctor.

I've been getting some support from Reading Mencap to go to appointments. My other support time doesn't include time for health.

I have not seen any leaflets/easy read for me to look at. Not in the surgery.

My support worker makes the appointments. I have had a letter about my annual health check but sister has done all that for me.

The doctor does speak to me. He checks things out with my carer.



Talkback have lots of easy read leaflets so it will be good to go through them

I can tell the doctor what I'm feeling like and if I need anything.

Healthwatch Reading would like to know if there are any problems with accessing surgeries. They make sure that everyone has a good service to health care.

Recommendations

1. Talkback will provide people with the contact number of Healthwatch Reading, plus a few other helpful contacts in regards to health.
2. For Healthwatch to raise with GP's that not everyone who lives in the community has support and they may need to rely on family members to take them.
3. When attending an appointment some individuals would like easy read leaflets that they can go through conditions/with support staff.
4. Some people were unaware of the reasonable adjustments that could e provided by the GP surgery. Eg a quiet room to wait, or a double appointment. These need further explanation so that people know how to get these adjustments.
5. For many people with more complex support needs, family members are instrumental in making appointments, explaining the symptoms and caring for their son/daughter. This can put added stress onto the carer as well as have an impact of the amount of care/support as a result of being poorly.

Conclusion

Listening to both people with learning disabilities and people who work with them, these three themes emerged:

1. **Support is key** - people with learning disabilities may have family support, though not all do. Understanding that people with learning disabilities have different situations and different needs, and that being sensitive to the needs of their carers matters, is important

2. **Information is important,** for people with learning disabilities and for their carers. Again, needs and preferences will be individual. Some people with learning disabilities would like easy read leaflets available, for example.

3. **Knowing your rights** – particularly the right to have reasonable adjustments – is important and services need to actively offer adjustments, as not everyone knows that they can ask.

It is important that everyone involved in arranging and providing services understands that these things matter. If they do, then they can help make things work better for everyone by making sure that services are designed to include these important things.

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"Our top three priorities"

By women attending the Reading Community Learning Centre and the charity that supports them

healthwatch Reading
advice • advocacy • action

Joint report
May 2018

Reading Community Learning Centre

"Our top three priorities" Report summary

Women learners would like:

1. Access to interpreting services when using the NHS
2. Culturally aware and timely provision of accurate information about locally available services
3. Longer appointments, if they do not speak English as their first language, to have time to discuss serious health or care concerns

Reading Community Learning Centre called for:

1. People to get access to interpreting services when using NHS and social care services

2. Quicker, better and culturally sensitive support for people with mental health issues
3. Culturally sensitive social care at home - for people with care needs, and family carers

My GP called the [interpreting] phone service. It was good.'

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How did we produce this report?

Our first listening meeting was with staff members Aisha Malik, Shaheen Kausar, Parveen Brar, Premalatha Sudarshan, and Hemamalini Sundararajan at Reading Community Learning Centre (RCLC) on 1 February 2018.

Our second listening meeting was with 14 women at RCLC, at a listening session and lunch held between classes, at the centre on 7th March 2018.

About the Reading Community Learning Centre

RCLC provides education and support for the most disadvantaged and socially isolated women in Reading. Many of the women have had little or no previous educational experience and feel unable to attend mainstream establishments because of the cultural, economic and personal barriers they face. Most do not speak English and often they are not literate in their own language. For some, the centre offers their only contact outside their immediate family.

The service provides social, educational, civic engagement and volunteering opportunities for marginalised women from Black and Minority Ethnic (BME) communities and provides services that address barriers to learning, including child care through a crèche, and supports progression into further education, social and employment opportunities.

BME communities in Reading

Reading has an ethnically diverse population. South Asian groups (Indian, Pakistani and Other Asian) accounted for 12.6% of all residents in the 2011 census. A further 4.9% identified themselves as Black, and those identifying as 'Other White' (including several other nationalities, including Reading's Polish community) accounted for 7.9% of the population.

Local BME communities are in themselves diverse and will have different needs when accessing services. RCLC provides support and opportunities for particularly marginalised women from BME communities.

Part 1: What we heard from RCLC staff

These three themes emerged when we listened to RCLC staff views about women's experiences:

1. Difficulties in getting access to health and in understanding services, including social care.

Barriers include language, interpreter availability, cultural issues of expectation and understanding.

We heard that women know to call the GP when something is wrong, but it is usual then to then have to wait a long time to for an appointment. Language can be a barrier to communication and understanding at all points in the process, as is lack of knowledge of how the system works. Interpreters are not always available for appointments.

We heard that the centre is seeing more women and families affected by domestic abuse…and it is important social workers use interpreters to help women understand both council processes and their rights.

If the woman or a family member needs a hospital referral, women report to RCLC staff that they often cannot understand the referral letter. Women often feel that the wait for the hospital appointment is long, and do not understand why this would be.

We heard that waiting rooms at Royal Berkshire Hospital could be more child friendly, and it was suggested to us that at times priority should be given to those who have younger children instead of parents having long waiting times. Children get restless so sometimes women do not stay for their appointments - they report to RCLC staff that they end up leaving to care for their child in a more appropriate setting.

We also heard that the centre is seeing more and more women and families affected by domestic abuse, who need support and advice about their situation.

The loss of a local service providing counselling in a variety of languages, had reduced opportunities for staff to signpost learners to culturally appropriate support.

They might want support on immigration, or might be on a spousal visa, which then leaves them destitute as they have no access to benefits, any money or social housing once they leave their family home and go into refuge. These women are the most vulnerable of all as they will not know their rights or how to access what they might need.
In many cases of domestic abuse social services are involved, and it is important that social workers work with interpreters to help women understand both the council process and their rights.

2. Lack of enough support for mental health - not getting timely, appropriate and culturally sensitive treatment for mental health problems.

Staff told us that in many cultures there is a stigma attached to mental illness, or it is simply not acknowledged to exist. So it can be very difficult for families to get the help that a person who is unwell needs, and such help needs to be culturally sensitive.
Women who do want support with mental health often lack the knowledge of the NHS and where to access help. They may not understand that a GP is able to talk about mental health, or not have access to a computer, or the skills, to search for information and advice online.

Sometimes cultural issues mean that GPs do not identify an underlying mental health issue, and medication is given for a physical symptom instead.

"Some people would not be comfortable with male care workers. They might also not want care workers to come at prayer time."

The underlying illness remains untreated and may get worse. Staff suggested to us that advertising more about mental health in community languages could raise awareness and signpost sources of help.
We heard that loss of a local service that had provided counselling in a variety of Reading's languages had reduced the opportunity to refer RCLC learners and families to culturally appropriate services – we heard that RCLC learners made very limited use of Talking Therapies, and it did not seem to include easy provision for working with an interpreter.

3. **People needing home care need care that is culturally sensitive and appropriate. RCLC learners as family carers supporting in this situation face extra pressures that may affect their health.**

We heard many workers provided by home care agencies are not trained in and aware of the cultural and religious needs of the families of RCLC learners. Some family members would not be comfortable with male workers and might want a female to do their personal care. They also might not want them to come round when it is prayer time. Many elderly parents want to keep their independence and may not want to move in with a son or daughter but still may need some sort of support at home.

We heard that culturally inappropriate arrangements can cause much unhappiness and distress. Where RCLC learners are supporting family members who receive home care, the impact on them as carers can be considerable – most would not be aware that they are entitled to a Carer's Assessment.

Part 2: What we heard from learners at RCLC

We asked the 14 women to tell us what it is like when they visit a GP or hospital, and what it is like if they have responsibility for caring someone else who they support in accessing services. Are doctors, nurses and others kind, and clear in what they say? Is an interpreter always available? What is done well?

Very limited use was made of Talking Therapies and it did not seem to include easy provision for working with an interpreter.

We also asked, what could be better? Interpreting was provided informally during this session by RCLC staff **and** women who attended. Languages spoken included Arabic, Mandarin Chinese, Pakistani/Urdu, Spanish (Ecuador), Nepali and Punjabi.

Comments about what is done well:

"Yes, [I had access to an interpreter] at hospital - in Arabic'."

"Never [did I have access to an interpreter] at GP. Three times at hospital. It makes me feel comfortable."

"My GP called the phone [interpreting] service. It was good."

"I went to a GP because I wasn't good [at] English. I was shocked that I could speak with her [communicate, be understood]. She spent a long time with me. She explained everything. She was very helpful to me."

"I was asked if I prefer a man or a woman doctor" [at reception at a GP surgery].

"For me the service in my GP is very good - I don't know my doctor but for me any GP is good."

Comments about what could be better:

"With the phone it's difficult to get appointments [at the GP]."

"Having to tell at reception what the appointment is for and it only being possible to ask about that even if you have time and [another] problem is of the same nature."

One woman described a traumatic experience of miscarriage some time ago when she was sent home from A&E to wait one month for a test result and a clinic appointment. No emotional support was given:

> **In my country they would help, give some medication or something. We were told [at A&E], "we don't have a doctor now for a scan".**

The Healthwatch Reading listening and lunch session with learners and staff at the Reading Community Learning Centre.

"I don't know who my GP is - they change whenever they want to."

"They [GPs] need to see the person as a whole [answer questions about more than one thing]."

"Some GP surgeries use locums - you get a quick diagnosis or a prescription in five minutes, [this is worrying]."

"Explaining what the problem is, is [culturally] hard. English…it is hard to be understood - on phone worse."

Once I accompanied a friend, who does not speak very good English, to the Walk-in Centre. I could see that the healthcare professional did not take care to read her record.

Other general feedback:

Dental services

Many told us that they did not understand the dentist and having to pay. They did not feel confident in going to a dentist as they did understand the charges.

Disability support

One of the women explained that she is a carer for her child who has a long-term health condition and disabilities. Her GP surgery has been helpful with her son and has supported her well. Support at the hospital has been good too. However social care support has not been so easy – the parents had to ask for a carer's assessment and also had to make their own enquiries about respite care, as their child's social worker did not know anything about it when asked.

It can also be difficult for family carers to arrange a home visit or telephone call from a GP, although diabetic care is generally good.

The group felt that information about support groups for families with a cared-for person at home was not being passed on to families and information about what statutory services were available was patchy.

GP surgeries

Most people had a good experience, with most having no issues getting appointments and were able to see a GP as soon as they possibly could.

Several found their GP helpful when they went in to see them.

Others reported that they do not get enough time to speak to the GP during appointments and sometime find it difficult to explain more symptoms when they just have an allocated 10 minutes for their appointments. They would like to have more time. The women were mostly unaware of the possibility of being able to request a double appointment.

We heard that it would be good to see the same doctor for continuity, and building that relationship in which repeating the patient's story at every visit is not necessary and it becomes easier to talk about private matters.

There are cultural barriers to asking for help and care for certain conditions and generally, especially for women – it would be better for the GP to offer help.

Interpreting

We heard that Western Elms Surgery offers a translating service for patients who have English as a second language, but not many had that option at other surgeries and they were not offered it when they made an appointment. In contrast, most who used hospital services were offered interpreters for appointments, which made the experience better as they could be understood.

The three key themes that emerged from the session were:

1. Interpreting services are very important in ensuring full and equitable access to NHS services

2. Culturally aware provision of accurate information about services and available support for service users, families and carers, in a timely way, is important in both health and social care services

3. At times, it may be necessary to allocate longer appointments to ensure that serious health and social care matters can be adequately discussed, with interpreting support, with service users and carers who do not speak English as their first language.

Conclusion

It was clear from both meetings that commissioners and health and care providers need to be aware of the need to ensure access to:

+ iinterpreting services
+ culturally aware provision of accurate information, with enough time and support to understand the information, and
+ culturally sensitive services (e.g. awareness that a particularly strong stigma attaches to mental health issues in some cultures).

Themes from this report, and our recommendations spanning the whole series of reports in this project, will be included in a final report in due course.

Healthwatch Reading thanks learners and staff for giving their time to share their views. Healthwatch Reading is an independent charity with some statutory powers. We can take your feedback in confidence, help you make complaints, and refer serious concerns to other agencies.

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"Our top three priorities"

By refugees and asylum seekers in Reading and the charity that supports them

healthwatch Reading
advice • advocacy • action

Joint report
May 2018

Reading Refugee Support Group

"Our top three priorities" Report summary

Refugees and asylum seekers would like:

1. Better access to interpreters
2. Accessible information about what they can expect in and from healthcare services
3. Healthcare staff who make sure people understand things, like their diagnosis and what will happen next with their care

Reading Refugee Support Group called for:

1. Removal of barriers to healthcare e.g. lack of interpreters and information
2. Quicker, better and culturally sensitive support for mental health issues
3. Acknowledgement of the extra stress faced by people who act as carers for family members

One person said a hospital wanted to charge him £240 for a blood test, even though he had papers connected to his asylum application showing he did not need to pay for NHS services. He went back to his GP, who did the blood test instead.

This report is based on local listening visits carried out in April 2018. It is one of a series of short reports that Healthwatch Reading is producing in partnership with local charities, to ensure that the views and needs of people and communities who are 'seldom heard', are available to the NHS locally, and Reading Borough Council, to inform planning, funding and quality improvements to services.

Why have we produced this report?

The Quality Statements produced by Healthwatch England for measuring the impact and effectiveness of local Healthwatch include:

Community Voice and Influence – enabling local people to have their views, ideas and concerns represented as part of the commissioning, delivery, re-design and scrutiny of health and social care services;

Making a difference locally - by identifying where services need to be improved by collecting experiences of local people.

> **A local Healthwatch needs to formulate views on the standard of health and social care provision and identify where services need to be improved by formally or informally collecting the views and experiences of the members of the public who use them.**
> (Healthwatch England)

Healthwatch Reading is therefore working with other local charities on a series of short 'top three issues' reports to ensure that the views and needs of people and communities who are least often heard are available to the NHS locally and to Reading Borough Council, to inform both commissioning and quality improvements of services.

How did we produce this report?

Our first listening meeting was with a manager from Reading Refugee Support Group (RRSG), at the Reading International Solidary Centre (RISC).

Our second listening meeting was with nine men who are refugees or asylum seekers, at a RRSG forum meting held after the regular drop-in meeting at RISC on 9th April, 2018.

Part 1: What we heard from Reading Refugee Support Group

People who are refuges or asylum seekers are some of the most vulnerable people in society, and they and their families and carers can often have difficulty in communicating their needs and experiences in health and care services.

These three themes emerged when we listened to Reading Refugee Support Group (RRSG) staff talking with us about the experiences of their clients. We heard that refugees and asylum seekers in Reading experience:

1. Difficulties in getting access to health. Barriers including language, interpreter availability, quality and suitability of information resources, and cultural issues of expectation and understanding

2. Lack of enough support for mental health – not getting timely, appropriate and culturally sensitive treatment for mental health problems

3. Additional stress for people who act as carers for family members – these pressures can affect their health.

RRSG helps people from many different countries of origin, including people from Syria, Sudan, Afghanistan and Pakistan. Most are fleeing persecution and violence in their own countries. The charity provides caseworker support across an array of issues from asylum and protection to liaising with the Home Office to follow up on applications. They also provide a drop-in service giving advice.

For most people, coming to a new country is a daunting experience - but imagine if you cannot speak the language or everything about the place where you have sought refuge is alien to you. It's not like being on holiday.
We heard that many RRSG clients have seen devastation and violence in their home country. Others have been trafficked to work in poor conditions the UK, which leaves them in a very vulnerable state.

Accessing healthcare is a priority for all of these people as some will suffer from post traumatic stress disorder (PTSD) or other mental illness or physical illness too, often chronic conditions (Syrian refugees living in Reading may have been granted refugee status because of healthcare needs that make them especially vulnerable).

We heard that many men are young and quite fit when they migrate, even if they come from difficult circumstances.

In many cultures, mental illness is not talked about and is not acknowledged.

So the health and social care needs of all these people are diverse, and individual.

Navigating the health system is difficult for many as they come across language barriers; asylum seekers (in contrast to refugees) fear deportation; both groups typically do not know how or where to access healthcare.

We heard that it can take several visits to a GP for a patient and GP to overcome cultural barriers - for the patient to explain what a problem is and to then understand treatment options.

Organising and following through referrals to hospital can be particularly difficult.

Many refugees and asylum seekers, often with their own health problems, are carers for family members and this is an added stress that can affect their health.

Many come from countries where understanding of health and illness, and

Simply understanding what to expect, and what is 'usual' in the UK healthcare system, can be a difficulty.

of what to expect from the health and social care system, is very different from this country – for example, medicines may be prescribed more frequently and for a greater range of conditions, or it may be usual to see a doctor where in the UK a different healthcare professional would be the norm.

Part 2: What we heard from people who are refugees or asylum seekers

We asked people to tell us what it is like when they visit a GP or a hospital, and what it is like if they have responsibility for caring for someone else who they support in accessing services. Are doctors, nurses and others kind, and clear in what they say? Is an interpreter always available? What is done well? What could be better?

During our discussion with people, informal interpreting support was provided by RRSG staff and by people in the RRSG forum, as agreed in advance and following their advice about what would work best for this group.

Here is what we heard about various services:

Dental services

'I was sent to the hospital…with a dental problem – by my dentist. I had to wait two weeks for an appointment [there] and was not offered antibiotics. Pain in my tooth over five days. I was told, 'No appointments – not an emergency'.

"I waited for one hour [for help]. I was in a very bad situation. I did not understand why this happened this way."

I went to [another hospital] and was given painkillers.' This man reported that both 111 and a pharmacist had given advice but not advised how he could access pain relief, despite him being in acute pain.

Hospital services

+ One person reported going to hospital two to three months ago with a fever, because he was very ill. He waited a few hours and when seen by the doctor, was offered antibiotics and painkillers.
  The doctor said he would return with the prescription in two to three minutes but did not return and after one hour the client left with a paper prescription brought to him by a nurse, but with no tablets. He later used tablets he already had at home.
  He said: 'I waited for one hour – I was in a very bad situation. I did not understand why this happened this way.' He said it amounted to 'humanitarian abuse.'
  We heard that he did not know whether he could simply have bought the medicines himself without a prescription, and that he wants to do the proper thing, so needs better information.
+ One person had a first hospital assessment about his health some months ago and asked for an interpreter but he was not provided with one. When he asked the staff 'to explain' things a nurse gave him a leaflet but it was not in English he could understand, and he needed an interpreter. Eventually some medical tests showed that he did not need an operation. Staff explained this to him, and he felt good – he did not want the operation.
+ One person said that a phone interpreter provided for him was not the same nationality as him, and this was difficult. He also said, 'All doctors say something different' so he never knew what was happening or why.

> When one person asked staff to explain things, the nurse 'was rude' and 'frowned' and gave him a leaflet in English he could not understand.

A local interpreter that he had brought along with him was not allowed to be with him during his appointment. During his appointment he was also not asked about medication prescribed by his GP.

- One person with a back problem reported regularly attending the hospital and his GP surgery. He said that there was usually no interpreter available on the phone or in person – he was told to bring one and usually brought a local contact. He explained that on a visit to A&E about an urgent matter he was not told what was wrong with him, even when he left and went home.
- Another person told us that when he went to the phlebotomy clinic at the Royal Berkshire Hospital, staff wanted to charge him £240 for a blood test although he had the papers connected to his asylum application to show that he did not need to pay. RRSG advised him that he did not need to pay. He went back to his GP who did the blood test at the surgery instead.

GP surgeries

One person reported an unsatisfactory sequence of appointments to diagnose a health problem. A GP recommended to him that he drink lots of water for four to five days, but his problem did not settle so he called the surgery again. He was sent to have his blood pressure checked and have a blood test. The blood test was repeated several times after that. The GP said everything was normal but he is still in pain. The client wants to know for sure what is wrong with his health.

> One person told us that finding which online information is correct, is confusing – RRSG staff have to explain to their clients which are the best sites for information and advice.

The Healthwatch Reading session with the Reading Refugee Support Group

The top three issues from the discussion were:

1. Difficulty in accessing interpreting services when needed

2. Needing better and more accessible information, including what to expect in and from healthcare services

3. A need for healthcare professionals to make sure that people understand what is happening - what the diagnosis is, what to do next or what will happen next.

Healthwatch Reading finds it concerning that the NHS tried to charge somebody for a service when they had papers to show they were entitled to free care.

Conclusion

In both listening sessions it was clear that ensuring that services are inclusive and individual – recognising the person's particular needs, including language needs and the fact that they simply might not know about the UK healthcare system – is important.

We noted some reticence in the group in discussing health with us initially. The 90-minute session began with establishing ground rules of confidentiality, anonymity and respect for privacy (we were not asking about details of any health condition), however it was apparent that building trust and understanding takes some time and care.

Themes from this report, and our recommendations spanning the whole series of reports in this project, will be included in a final report in due course.

Government guidance states that GP surgeries are not required to request proof of identity or immigration status from people wishing to register as new patients.

Extra information about migrants

A migrant is anyone who seeks to move overseas. A refugee does so in conditions where they have been forced from their homeland. An asylum seeker is someone who says he or she is a refugee, but whose claim has not yet been definitively evaluated.

If you have refugee status, humanitarian protection, discretionary leave or indefinite leave to remain, you have broadly the same rights and entitlements as other UK residents and citizens. You can work, use health services and apply for housing and welfare benefits.

Asylum seekers cannot claim mainstream benefits. Those who are destitute may be eligible for accommodation and financial support in the form of vouchers from the UK Border Agency.

Some asylum seekers, and those who have been refused asylum, are not entitled to any support and may become destitute and homeless.

Government guidance states:

+ refugees and asylum seekers are entitled to free GP and primary care services; GP surgeries are not required to request proof of identity or immigration status from people wanting to register as new patients
+ people granted refugee status, or who are awaiting asylum decisions, are exempt from any charges for secondary care.

See: https://www.gov.uk/guidance/nhs-entitlements-migrant-health-guide

Healthwatch Reading thanks Reading Refugee Support Group clients and staff for giving their time to share their views. Healthwatch Reading is an independent charity with some statutory powers. We can take your feedback in confidence, help you make complaints, and refer serious concerns to other agencies.

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What are the top three issues in health and social care for Reading people who are homeless or have other housing difficulties?

This is one of a series of short reports on key issues in people's experiences of health and social care in Reading shared with us by local organisations who work with vulnerable groups. These reports will be shared with the Reading Health and Wellbeing Board, bringing together any common themes and our recommendations.

A partnership project with: Launchpad Reading

Where **Launchpad Reading, The Stables, 1A Merchants Place, Reading, RG1 1DT**

Why The Quality Statements produced by Healthwatch England for measuring the impact and effectiveness of local Healthwatch include:

- **Community Voice and Influence** – Local Healthwatch enable local people to have their views, ideas and concerns represented as part of the commissioning, delivery, re-design and scrutiny of health and social care services.
- **Making a difference locally** – A local Healthwatch needs to formulate views on the standard of health and social care provision and identify where services need to be improved by formally or informally collecting the views and experiences of the members of the public who use them.

Healthwatch Reading is therefore working with other local charities on a series of short 'top three issues' reports to ensure that the views and needs of people and communities who are least often heard are available to the NHS locally and to Reading Borough Council, to inform both commissioning and quality improvement in services

How

Our first listening meeting was with: Wendy Webster, Floating Support Officer at Launchpad Reading on 21 February 2018

Our second listening meeting: was on 5 June 2018 with 5 Reading people with housing needs – we met some in person at Launchpad, and spoke to others by telephone

Part 1: What we heard from Launchpad Reading

People with housing needs are some of the most vulnerable people in society, and they and their families and carers can often have difficulty being heard in wider society. Launchpad Reading provides a drop-in service, housing with support, and supports single parents, families, couples and individuals to stay in their own homes by helping with landlord issues _'Floating Support'). The Floating Support service also helps find appropriate housing for people housed in unsuitable accommodation, such as families in B&Bs (support is for three to six months.)

These three themes emerged when we listened to feedback from the Floating Support Team at Launchpad about the experiences of their clients.

1. **Mental health services need to be more responsive and accessible to meet the needs of homeless people and people at risk of homelessness.**

We heard that the Common Point of Entry for mental health service is not always able to respond with an intervention that the client feels is satisfactory. On occasion Launchpad staff have made multiple referrals for the same individual who they feel is in mental health crisis, and the client have not been able to access immediate mental health support. We heard that when people have no phone and/or no fixed abode, it is difficult to arrange mental health assessments and follow up. Launchpad are not always updated with client's progress, needs and risk information and are often required to phone statutory services on multiple occasions to get accurate information.

2. **NHS and social care services are very stretched currently due to funding pressures - this makes contacting services and getting the responses that Launchpad clients need difficult.**

   We hear that the threshold for accepting safeguarding referrals appears to be high. On some occasions, Launchpad staff are not updated with the progress and actions once a Safeguarding referral has been made.

   We heard some people are discharged from hospital with no care package or to poor-quality housing that could be deemed as unsuitable for their health needs. We heard from Launchpad that it is an extremely valuable resource to be able to work alongside the HOLT team who provide a service to homeless people in Reading.

   We heard that a Launchpad client reported not having dental charges explained to them clearly. Launchpad clients often struggle to prioritise health related costs on a low income and do not always appear to be informed about their options in relation to the NHS.

3. **There is little evidence that the preventative element of the Care Act is being implemented in practice - many Launchpad clients with eligible needs could benefit from the early and creative intervention to promote wellbeing the Act requires**

We heard that there are many homeless people who may have eligible needs under the Care Act wellbeing principle. This includes, for example, people who are obese and need adjustments to their homes to support their wellbeing.

We heard that there are homeless people whose needs are such that they would benefit from the support of a social worker.

Launchpad staff use an eligibility checker template to present clients' needs. This has resulted in positive outcomes including a client with mobility issues being accepted for an OT assessment and adaptations being made to their property.

Part 2: What we heard from people who use the services provided by Launchpad Reading

We asked the group to tell us what it is like when they visit their GP or the hospital, and what it is like if someone is helping them with their care at home –are the people who help with health and care clear in what they say and kind? What is done well? What could be better?

We spoke with 5 people – some in a listening session at Launchpad, and some individually by telephone. Unless otherwise indicated, the comments relate to GP surgeries and dental surgeries in Reading, and to the Royal Berkshire Hospital, Reading.

We heard:

'They missed the big bit [of my health problem] until one [day a consultant got it right'

'At a change of shift [at the hospital] it's "needs must" – it's busy'

One person we listened on the phone reported difficulty getting prescriptions sorted by their GP surgery in a timely way, a problem that had persisted over months.

A person in the focus group described visiting their GP surgery over several years describing increasingly worrying symptoms of mood change, and, eventually, disturbances of vision and hearing. They told us that they were never sent for blood tests or any other investigations and were offered advice about relaxation, and a herbal complementary treatment was suggested by the GP. A serious physical illness was eventually diagnosed after a visit to a non-medical healthcare professional, who raised immediate concern and made an urgent and immediate referral to hospital. This person reported not feeling listened to at their GP surgery and disappointed in the service – *'I feel my health has been sabotaged because [making a referral to hospital] will cost GPs money.'.'*

One person told us that their dentist is 'an excellent dentist' and that, 'He listens, and he understands my history – he knows I get anxious and he is good with my son. Getting quick appointments is difficult these days – if not on the phone by 8am, you're doomed.'

Another person also reported having to call their GP surgery at 8am to have any chance of getting an appointment.

One person in the focus group described to us attending hospital for a biopsy after feeling that somethings was stuck in their throat. In all, attended hospital Ear, Nose and Throat Department 10 or 12 times over a period of time complaining of discomfort. Eventually they were sent for a scan and a growth was seen on the scan result, which was then treated. This person felt that this could have been found sooner if they had been taken seriously and sent for a scan.

Anther contributor reported 'good' care and nurse being 'ok' when they experienced a broken leg as a result of a fall. They reported having to insist three days after the accident that their wound was treated to avoid infection – 'This was on my insistence, because the wound was oozing blood'.

One person we spoke to reported that both they and their partner are disabled, and both have significant mobility issues. They reported being disappointed at times with services, including repeat prescriptions not being issued in a timely way, and ambulance and hospital staff being poorly trained and equipped, in their view, to assist with moving a person with a physical disability – not taking advice from the person's carer.

When one person was admitted to hospital there was a six hour wait at the hospital to be given a bed. They felt that they were kept advised, and the reason for the delay was explained – *'I was given good information about why the delay - it was because of prioritisation*

One person said, 'Traditionally we have a lot of trust in the doctor – you tend to believe what they say.' This person feels that doctors 'too easily now suggest a condition with a "special name" which turns to be a fancy name for "it's all in your head" when you look it up'. This person felt that doctors should listen to patients more.

One contributor expressed concern about doctors prescribing the wrong medication and about patients not having a care plan.

One person felt that their GP is '*not particularly good*.' They felt that personnel changes at their GP surgery had changed things – '*I feel that the personal touch I got with my old doctor isn't there. I don't feel they know me – it feels impersonal'* This person has a chronic health condition and visits the surgery several times a year in connection with their long-term condition. They do feel confident in the treatment they receive.

One person has been using the Talking Therapies service for about a year – '*It has all been really good, but difficult to know if it is helping. I do feel recognised as a fellow human being. Very positive.'*

One person reported very good service at Boots pharmacy in Reading – '*It can be very busy, but staff know this person and will bring out the prescription and be friendly – it is a personal service.'*

One person reported having a generally good experience when staying in hospital in connection with a chronic health problem last year. However, they observed that there were lots of staff rushing around (the service was very busy).

One person reported difficulties with obtaining their insulin supply for diabetes treatment and getting into problems communicating with their health team about this because of being depressed and also being reluctant to use their phone because of the cost of calls.: 'When low with depression I find it really difficult to talk to people and message and text is an easier way to talk at this time.' Despite this, they reported being discouraged from using a messaging service in preference to phoning to speak to their care team.

One person we listened to shared concerns about social care administrative arrangements for a close family member – we heard that trying to sort things out can be a source of significant stress for the person who acts as unpaid carer and tries to keep care arrangements stable, and appropriate for their family member.

One person reported the frustration felt by family members at not being given information about someone's health and care for reasons of confidentiality.

What are the top 3 issues? These themes emerged:

1. **Lack of time for healthcare professionals to listen** It is very important that your healthcare professional knows you, knows your story and has time to listen, so they can work out with you what really is the matter - not making wrong assumptions and understand your individual needs.

2. **Poor coordination between health professionals.** 'You need one to oversee all'. We heard that GPs sometimes manage this coordinating role well, and sometimes do not.

3. **Not being treated as an expert in your own life, in health or in social care.** It is very important that your account is listened to – you have information that the other person needs if they are going to help you with your health or care. Also, you may have individual needs, for example in how it is best for you to communicate with your care team, that are important to share and have respected.

Conclusion

In the listening sessions it was clear that ensuring that services are recognising people's particular needs, treating them as individuals, and providing an appropriate level of care is important.

Themes from this report, and our recommendations spanning the whole group of reports in this project, will be included in the final report that will bring all of these short reports together at the end of this

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WORKING WITH SERVICE USERS WITH MENTAL HEALTH NEEDS:

A report of the 2nd Reading Advice Network forum on 30 May 2017

About this report

This report is the outcome of a Reading Advice Network (RAN) forum held on 30 May 2017 which brought together 14 different information, advice or support organisations to share experiences of working with local people with mental health needs.

We also valued the contribution of an invited service user, about their lived experience of mental health needs, and heard findings of a local survey of service users about their perceptions of the availability and quality of support. Professionals from the local NHS community mental health trust, also attended the forum and took an active role in discussions

As the summary table on page 3 of this report illustrates, the forum identified five main themes affecting the voluntary sector's ability to support clients with mental health needs, along with a series of proposed solutions.

We now urge local decision-makers – Reading's NHS clinical commissioning groups, and Reading Borough Council officers responsible for commissioning services from the voluntary sector via the *Narrowing the Gap* framework - to respond to the proposals and state how they will use this report to inform the way they plan, design and fund local services to best meet the needs of people with mental health needs.

Summary of RAN's themed forum on mental health

Issue	Experiences	Proposed solutions	What RBC/CCG could do
Poor interaction between statutory & 3rd sectors.	3rd sector organisations feel undervalued and not respected.	The level, variety and high standards of work undertaken by the 3rd sector, should be promoted more robustly throughout statutory bodies, together with info on accessing the 3rd sector.	Statutory bodies could accept referrals from local charities of clients believed to have urgent needs and include 3rd sector staff in individual client case solving.
Inadequate 3rd sector funding.	Leads to cuts in services, damages sustainability, and does not instil client confidence.	Fund the voluntary sector with realistic amounts that cover true costs of delivering services, including costs of non-frontline work.	Clarify a realistic expectation of how the 3rd sector should evidence outcomes and values, within IT limitations of the 3rd sector.
Perception that some frontline statutory staff do not provide adequate or appropriate support at the client's first point of contact.	Many clients turn to the 3rd sector when their first contact within statutory support has been unsatisfactory and where appropriate support has not been provided.	Ensure that frontline staff in statutory services receive appropriate training in customer services, whether GP receptionists, call-handlers in social services or staff in community mental health teams.	Train/re-train frontline staff. Engage with 3rd sector and share training resources, e.g. the Mental Health First Aid training run from the Reading Community Learning Centre, which has received excellent feedback from attendees.
Clients don't know where to go for help, particularly at times of crisis.	Clients feel they are being passed around – they want to manage their situation but are frustrated by complexities.	Having accurate, up to date information in various formats and languages, available throughout statutory and voluntary service locations, and in public and community spaces.	Develop and maintain an easy-to-find local service map - of both statutory and voluntary sector services – that can be used by individuals or professionals.
Little resource for professional development within 3rd sector.	Many cases are becoming more complex and some 3rd sector staff can face pressure in managing these cases.	3rd sector staff would welcome access to statutory sector resources to bolster their ability to cope with complex cases, plus inclusion in case conferencing, to contribute to 3rd sector continuing professional development.	Include 3rd sector staff in statutory staff training programmes; hold peer support activities between professionals; and provide general advice from mental health clinicians.

Introduction

What is the Reading Advice Network (RAN)?

RAN began in 2013 and exists to bring together all the voluntary organisations that give information and advice to people who live or work in Reading. It aims are to:

- improve the quality of those services, by encouraging them to work towards a quality standard designed for the voluntary sector and that adds value to the current Reading Voluntary Action (RVA) Safe and Sound accreditation
- make it easier for people to use local organisations, and
- be the collective voice for those organisations.

What is Healthwatch Reading?

Healthwatch Reading also was launched four years ago. It has statutory powers to help the patient and public have a greater say over NHS and social care services.

In Reading, Healthwatch also works in partnership with some charities to provide a new type of advocacy for vulnerable people, and more widely, raises issues affecting the voluntary sector via its seat on the Reading Health and Wellbeing Board.

Both organisations are charities in their own right, overseen by local trustees.

Why did we hold a forum focusing on mental health?

The Reading Advice forum is a regular event held for members of RAN, designed to provide information, support and networking opportunities. Members themselves had requested that the second forum on 30 May 2017, take an in-depth look at how to support people experiencing poor mental health.

Healthwatch Reading had also identified the sector's growing concerns about meeting the needs of vulnerable people (including those in mental health crisis) when it held a roundtable of local organisations in February 2017.

The forum aimed to give participants a chance to share and compare their experiences, identify any barriers or constraints on their ability to support this client group, and reach a consensus about possible solutions or changes.

How was the forum run?

RAN chair, Richard Harrison, introduced the forum, held in Reading Borough Council's council chamber. Two short presentations followed, from GRAFT chief executive Hazel Wright, and Rebecca Norris, team manager at Healthwatch Reading. Attendees then split into five facilitated groups to discuss experiences, challenges and solutions. Findings from each group were then shared with all.

Which charities participated?

- Age UK Berkshire
- Age UK Reading
- Citizens Advice Reading
- Communicare
- Dingley's Promise
- GRAFT
- Healthwatch
- Launchpad
- PACT
- Reading & West Berks Carers Hub
- Reading Community Learning Centre
- Reading Community Welfare Rights Unit
- Reading Refugee Support Group
- Reading Voluntary Action
- Red Cross
- Together Your Way

Main findings of the forum

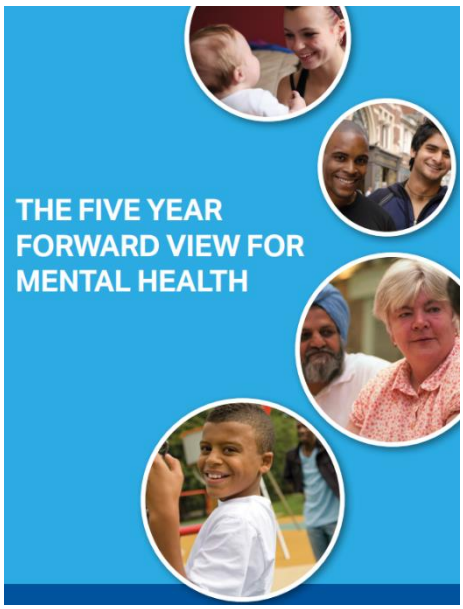
The national picture

Hazel Wright's presentation provided sobering statistics on the national cost of supporting people with mental health needs. Around £19bn is spent by government departments, and a further £15bn by non-governmental organisations, with the voluntary sector believed to be receiving only 3% of the total national costs.

The unemployment rate for adults with mental health problems remains 'unacceptably low', given that a stable job and housing are vital for maintaining good mental health and aiding recovery. (See Appendix 1)

The government's vision

NHS England policy on mental health care is currently driven by the *Five Year Forward View for Mental Health*, published in 2016.



Rebecca Norris from Healthwatch Reading, explained that this policy sets out plans for:

- more child and adolescent mental health services ('CAMHS') to young people
- crisis beds closer to home for young people
- more 'talking therapies' for people with moderate needs
- more help for new and expectant mothers ('perinatal' services)
- more mental health expertise in A&E
- more physical health checks for people who are mentally unwell

Local provision in Reading

Various routes of support are available to people seeking help with mental health needs, compromising a mix of self-referral to voluntary or NHS help, GP referral to specialist services, or teacher or social worker referrals to specialist help. (See appendix 2).

A previous report by Healthwatch Reading has highlighted concerns about gaps in statutory assessments, care or safeguarding procedures, and the voluntary sector's role in taking on more complex cases of vulnerable people needing help. Many organisations are also not aware of the existence of other organisations, and/or the role they can play in supporting people with needs. (See appendix 3)

What do service users feel about current provision?

An informal, random, survey of 10 service users by GRAFT in the week preceding the forum, showed:

Crisis Support:

- The Common Point of Entry can be confusing
- Liaising with professionals is often intimidating
- Don't feel assured that problems can be solved
- Meeting unknown people causes apprehension
- Very often the illness causes suspicion which requires alleviation
- Home support:
  - staff don't arrive on time
  - get impression that staff and teams don't talk to each other
- Pressure on family and friends

Non-Crisis Support:

- Fear of benefit sanctions – being worse off if all information is disclosed
- Don't feel system is there to support them – there to catch them out
- Dread having to re-tell their story
- Hate feeling needy

What is the voluntary sector's experience with this client group?

Participants shared experiences during the facilitated group discussions held at the forum. The following four case studies highlight some of the common themes.

CASE STUDY 1

'We had a client who had been a child soldier and was severely traumatised. He was sectioned in Reading but released straight away. He was not allowed to access services because of his immigration status. He felt he had no support.

He went on to attack someone in the street and was put in prison. He felt he was not taken seriously about his trauma. He fed back that he is getting more support in prison than out in the community. In prison, he is getting regular support from a psychologist.

'We deal mostly with vulnerable migrants who have been seriously traumatised by previous experience. These people feel they do not have enough support because of their immigration status and entitlements to support. What happens to individuals who have no right to stay?''

CASE STUDY 2

'A client – a mother with two small children - came in looking for support to gain employment. She said felt suicidal and staff took this very seriously. Two staff members spent the day on the phone to get her some support. The mental health crisis team suggested that Graft support her to get her to Prospect Park hospital. Graft staff and management are concerned that they are not trained or insured to carry out *this sort of activity but there was no other way to get this client the help she needed. The staff drove her to Prospect Park and she was admitted but released a few days later. Cases like these are very difficult, complex and emotional situations, that require a lot of patience and problem solving.'*

CASE STUDY 3

'A client with mental health needs who had been suffering domestic abuse was being threatened with her benefits being taken away. She had been to the Job Centre and they had not been very helpful. She had found social services to be challenging and they only wanted to offer short term support to her. Social services suggested that if she was not happy with the level of support they were offering that she move out of area to live off the amount of support that she was entitled to.'

CASE STUDY 4

'We had contact from one client over two years. She came to us with many and varied complaints about services that she believed had affected her life, her job, and her physical mobility. But when we tried to help her by drafting letters to services, she began avoiding us. Her contact became sporadic, and on those occasions, she appeared confused, forgetful or accusatory towards us. She then stayed in touch and suddenly disclosed a past trauma. Concerned about her mental health, we tried to signpost her to Talking Therapies and other organisations, but she declined. We continued working with her, based on our principles of avoiding judgements or assumptions and helping people have their say. We arranged a meeting with the service she was unhappy about and went along to support her. It became clear that the professionals were picking up on her needs too, and were gently suggesting other organisations that could help her. But it was like the elephant in the room – no-one would explicitly broach the topic of her mental health. On reflection, we felt that this person had unmet health needs that she was unaware of, or was in denial about. It is upsetting to think that this affects most of her interactions with other people. But unless she wants help, we are unable to breach her confidentiality to take it further.'

Forum participants were unanimous in wanting commissioners to understand:

- the resource implications of supporting people: people in need will often turn to voluntary organisations even if those organisations are not formally funded to support those people's needs
- charities feel they often have to fight to get statutory agencies to take responsibility for supporting people in a crisis or to develop a long-term plan
- people in need, as well as charities, are often unsure who to turn to, for what

Below is a selection of comments captured during the group discussions:

'A single contact with the client can never solve all the issues. You must take it one issue at a time as their issues are so complex. You constantly question yourself and ask, 'have I helped this person?' - mainly because it is so difficult to navigate through all their problems and issues.'

'Simply listening to the client is very important, they always feel like they have been ignored and not listened to.'

'Statutory agencies make referrals out to the voluntary sector, but they do not accept referrals back in.'

'These short-term interventions are not helping society and will cost more in the long-run.'

'What is the cost of refusing services to these clients and sending them around the system?

'Good practice dictates a multidisciplinary meeting to look at the best approach for the individual but this is costly.'

'Isolation is also an issue: the assumption is often made that service users can rely on family support but often there are no support networks available.'

'Frontline staff [at statutory agencies/providers] can have poor communication skills, which can lead to spiralling and further chaos for individuals. Statutory organisations need better customer service.'

'There is a revolving door syndrome with no-one taking ownership. They play 'pass the parcel'.'

'Organisations do not know what others are doing, which mean individuals can be referred to the wrong body. No-one has the time or resources to speak to one another.'

'Staff [at voluntary sector organisations] need support to help them balance the complexities of client.'

'Organisations have to weigh up the cost of not supporting, versus the cost of interventions/long-term support. A cost-benefit analysis needs to be done.'

Proposals for change

It was striking that the discussion groups on the day each reported back the same themes on what could be done to improve support for people with mental health needs. Below are comments from the forum articulating some of the proposed solutions or changes:

'The voluntary and community sector would like the CCGs (NHS clinical commissioning groups) to engage with them.'

'Respect for the VCS: there is a need to bridge the gap between the VCS and statutory services.'

'Trust is an important part of all the relationships.'

'What about social prescribing?'

'Befriending – building trust is important, especially for BME service users.'

'Mental Health First Aid should be completed by all.'

'Receptionists of frontline services need customer services training.'

'What does success look like? Mainly focuses around [for the client] having time, respect, recognition of needs, advocacy support, listening on the day.'

'Reading Your Way have a good model in that they use peer support.'

'Mental health first aid is a fantastic idea for frontline staff [to have training on].'

The service user who took part called for people to be incentivised during recovery: 'There needs to be a new category for those people who are getting better and doing voluntary work – they should receive a higher level of benefits.'

'Specific work in mental health requires trust, safeguarding, signposting, managing expectations. We have to be careful about encouraging over-involvement and dependency. There needs to be a consistent approach and staff [in voluntary sector organisations] need support and guidance.'

'There needs to be a service map, something on YouTube.'

'Technology could be better used – put services that are available on rolling screens in GP surgeries.'

'Knowing where all the services are, what they do, and what is available. The landscape is constantly changing.'

The future local landscape

At the time this report was finalised, Reading Borough Council and Reading's clinical commissioning groups had just published a response to Healthwatch Reading's earlier report on meeting the needs of vulnerable people.

The response (see appendix 3) stated: 'The three commissioning bodies [the council and CCGs] appreciate that Reading needs a sustainable and thriving third sector to help meet the challenges ahead. Clearly the sector is operating under pressure currently, and the report presented by Healthwatch Reading highlights the reasons for needing to work together across statutory and third sector services to pool resources for residents' benefit.'

'The CCG proposes to align its future voluntary sector commissioning with Reading Borough Council's commissioning plans including the 'Narrowing the Gap' framework.'

It adds: 'In order to improve understanding of what community support is available for mental health, the Council has recently developed a resource pack, which is now being used by the CMHT [community mental health team] and other partners. See http://servicesguide.reading.gov.uk/kb5/reading/directory/advice.page?id=n0eWsuf2uVo.'

Another development since RAN's forum was a decision by councillors on 12 July 2017, to keep Focus House – a council-run home for people with serious mental health needs – open, after initially suggesting it be closed. This followed an online petition launched by a resident, and a film produced by Healthwatch Reading, of residents talking about the plans, being shown to the council. This is an encouraging sign that local people are being listened to.

Last but not least, the council has launched a consultation on a Narrowing the Gap 11 framework for 2018-22, with two events planned for August and September 2017. We urge RBC and the CCG to ensure the findings of this forum report are accepted as evidence as part of the consultation.

What happens now? *

Ultimately, we hope this report will provide the basis for an ongoing and mutually supportive working relationship between the statutory and voluntary sector that will result in a model of excellence to benefit our joint service users.

**RAN and Healthwatch Reading will publish summaries of this report on their websites once they receive any official responses from RBC, CCGs or other major stakeholders, for inclusion. Full findings will be shared with all who participated in the forum on 30 May 2017.*

Appendix 1: Graft's presentation to 30 May RAN forum on mental health

ran presentation 30-05-17.pptx

Appendix 2: Example of a mental health service map, Healthwatch Reading

Self-referral: NHS or social services

- **Thames Valley NHS 111 helpline** (new service from Oct 17, to be run by South Central Ambulance Service & partners)
  For: anyone unsure which service they need
  Offers: telephone advice from call-handlers/or access to GP, mental health and other professionals based in a clinical hub
  Contact: Phone 111. Possible online service in future

- **Talking Therapies** (run by Berkshire Healthcare NHS Foundation Trust (BHFT))
  For: depression, anxiety, phobias, panic, stress, obsessive compulsive disorder
  Offers: Online therapy, group sessions or counselling
  Contact: Tel 0300 365 2000 or email talkingtherapies@berkshire.nhs.net

- **Crisis Resolution Home Treatment team** (also BHFT)
  For: first or reoccurring serious episode of psychosis
  Offers: urgent telephone or home response
  Contact: phone 0300 365 9999

- **Early Intervention in Psychosis service** (also BHFT)
  For: first episode of psychosis
  Offers: Assessment within two weeks & range of therapies
  Contact: self-refer or via GP, phone: 0300 365 0300,

- **Own GP** for advice/medication/referral
- **Reading Walk-In Centre** Broad Street Mall, 8am-8pm daily
- **A&E**
- **Adult social services** at Reading Borough Council for info/advice/safeguarding referrals 0118 937 3747

Self-referral: voluntary sector

- **Reading Your Way** (soon to extend in Berkshire)
  For: people seeking drop-in centre/peer support
  Offers: socialising, care planning, advice on work/finances/housing/education, hobbies
  Contact: open door service for new referrals on Mon & Friday, 1pm-4pm, and Weds, 10am-1pm. 1a Rupert Square, Reading, RG1 3HE, phone 0118 9660240 or email: readingyourway@together-uk.org

- **Compass Recovery College**
  For: people who need advice & support for living with (or 'recovery' from) mental health needs
  Offers: a range of short courses on topics such as 'mindfulness' and 'making sense of voices', provided by peer supporters and/or clinicians
  Contact: Prospectus is online http://bit.ly/2rchWwP, or people can visit for information or registration on the first and third Monday of each month at New Directions in South Reading, 330 Northumberland Avenue, Reading, RG2 8DH, phone 0118 9373945

- **Reading Samaritans**
  For: people in mental distress/feeling suicidal
  Offers: Listening by trained volunteers on phone ror sometimes in person or at A&E at Royal Berks
  Contact: Tel local 0118 926 6333, or national freephone 116 123 or national email jo@samaritans.org, or visit: 59a Cholmeley Road, Reading, RG1 3NB 11am-10pm every day except Mon 2-5.30pm

Services via referral

- **Community mental health team** (run by BHFT out of **Prospect Park Hospital)**
  For: people with uncontrolled/enduring symptoms
  Offers: Therapies, anti-psychotic medications, social help or signposting from team including psychiatrists, nurses, occupational therapists, psychologists, psychotherapists, social workers, or care co-ordinators.
  Referral route: Via GP, other healthcare professional or social worker, through a referral hub known as the 'Common Point of Entry' (CPE): phone 0300 365 0300.

- **Eating Disorder Service** (run by BHFT), referral from GP

- **Memory Service:** offering nurse or psychiatrist assessments, diagnosis and referral to dementia nurses, GP must refer, via CPE, 0300 365 0300

- **Traumatic Stress Service** (BHFT) for people such as military veterans or abuse survivors, also GP referral via CPE

- **Older People's Mental Health Liaison Team (BHFT),** for people aged over 65 staying in Royal Berkshire or Wexham Park hospitals, on general wards, who need help with new or existing dementia/delirium/mental health needs or coping with a new physical condition. Referral must be made by hospital staff.

Child and Adolescent Mental Health Services (CAMHS) - also run by BHFT

- Referral must be made by a GP, a teacher (special educational needs coordinator or SENCO), or a social worker, via the 'Children, Young People and Families (CYPF) HealthHub', telephone **0300 365 1234**.

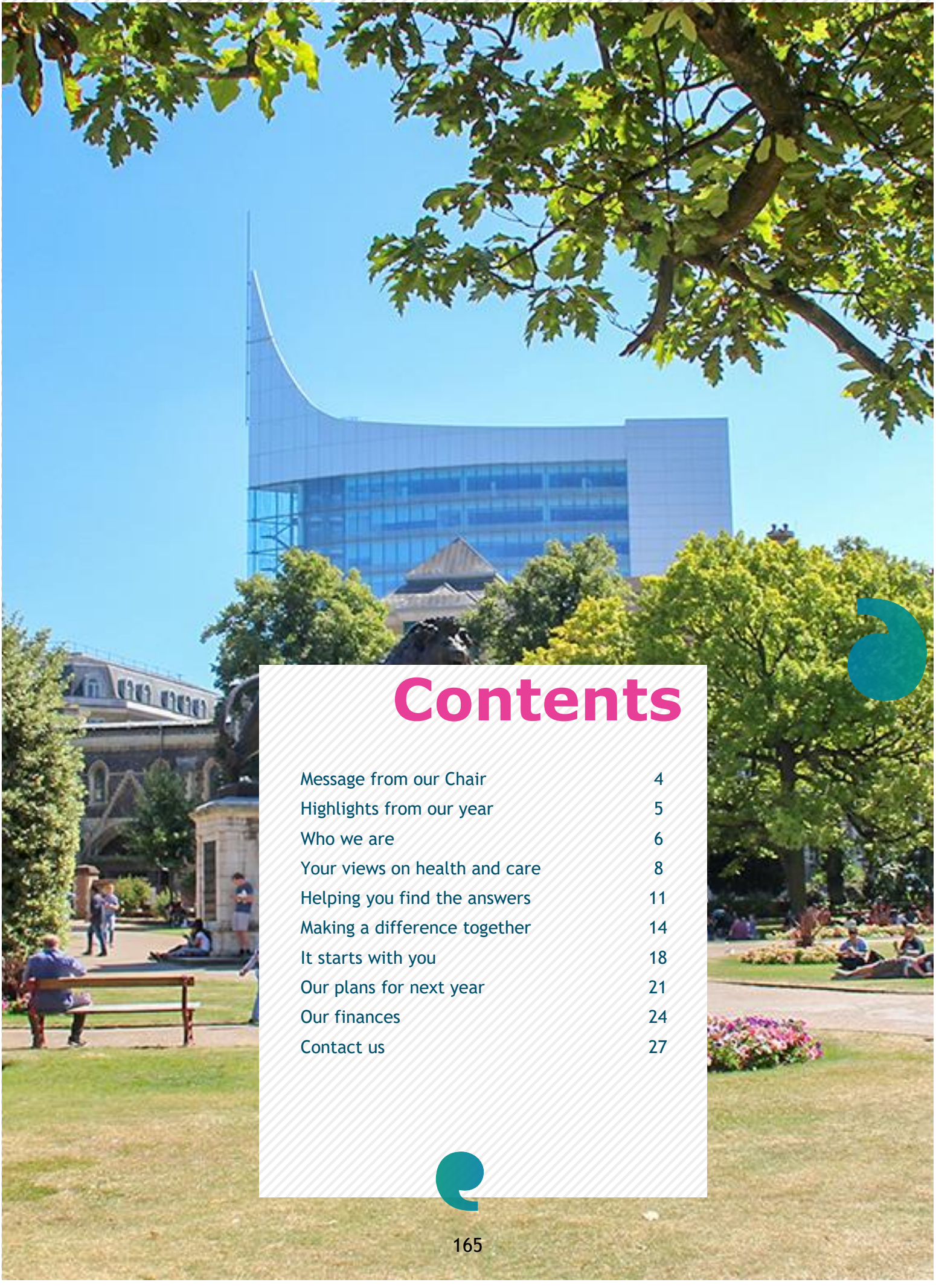
- CAMHS is made up of:
  - Primary CAMHS
  - Specialist Community Team
  - Anxiety and Depression Pathway
  - Attention Deficit Hyperactivity Disorder Pathway
  - Autism Spectrum Disorder Diagnostic Pathway
  - Berkshire Adolescent Unit inpatient/intensive care

Appendix 3: RBC/CCG response to previous Healthwatch Report on voluntary sector

http://www.reading.gov.uk/media/7432/Item07/pdf/Item07.pdf

healthwatch Reading

Annual Report 2017/18



Contents

Message from our Chair

I'm pleased to say that Healthwatch Reading started and ended the 2017-18 year on a high!

Firstly, our chief executive Mandeep Kaur Sira picked up the national 'engagement in service change' award (pictured on the front cover of this report) at Healthwatch England's annual event in July 2017, for our team's project surveying A&E patients. Healthwatch Reading people aren't in the job for any kind of special kudos, but awards like these are important in bringing the experiences of local people to the attention of national decision-makers and influencers.

In another win, shortly before the end of 2017-18, we were named the successful bidder for a new single Reading advocacy service to deliver four types of advocacy for eligible local people. We are delivering this four-year contract as Reading Voice, a complementary service to Healthwatch Reading, with shared resources, under one roof. Key to the success of Reading Voice is our partnership with Age UK Reading and learning disability charity, Talkback, to provide a pool of expert and empathetic advocates who can help both the general public and vulnerable people, get complaints resolved or have their say about their care and wellbeing.

During the year we also helped local people win their fight against the proposed closure of a Reading mental health care home, and we also gave a voice to people sectioned at Prospect Park Hospital, with a TV interview on BBC South Today about a project we carried out jointly with other local Healthwatch across Berkshire.

Like many other local Healthwatch, we faced funding challenges but we will continue to remind commissioners of the value of our work, in championing greater public involvement in the NHS, especially as it celebrates its 70th birthday.

> ***We will continue to remind commissioners who fund us, of the value of our work in championing greater public involvement in the NHS, especially as the health service celebrates its 70th birthday.***

David Shepherd, chair of trustees

Highlights from our year

This year we had more than **14,400** visits to our website

We empowered **20** people to stop the closure of their mental health care home

We've carried out **10** **Enter & View visits**

Our reports have tackled issues from **mental health, TB, care homes & homelessness**

We've engaged with **719** people & Influencers via outreach

We've given **151** people information and advice

Who we are

We deliver our service from Reading Central Library, within an accessible community hub of organisations

You need services that work for you, your friends and family. That's why we want you to share your experiences of using health and care with us – both good and bad. We use your voice to encourage those who run services to act on what matters to you.

Our mission

Healthwatch Reading's mission is to campaign for better care for our community. We do this by:

+ advising people of their rights, giving them information, and signposting them to other services;
+ advocating on behalf of local people to raise concerns, make a complaint, or support them to have their voice heard;
+ taking action to influence decision-makers, by ensuring they hear the experiences of people, especially the most vulnerable, and involve the public in changing and improving health and care services.

As well as championing your views locally, we also share your views with Healthwatch England, which makes sure that the government puts people at the heart of national policies.

We are an independent, local charity - we are not employed by the NHS or social care services. People know they can talk to us confidentially about their personal experiences and they can access us in a variety of ways – over the phone, online, or by dropping in to our town centre base at Reading Central Library.

We use statutory powers granted to local Healthwatch to:

+ carry out planned Enter and View visits to take a 'snapshot' of how local services are meeting the needs of Reading people in order to highlight good practice and any areas for improvement
+ make information requests from organisations
+ use our seat on the Reading Health and Wellbeing Board to speak up and vote on local issues.

Decision making

Our board and trustees are all volunteers and members of the local community. The trustees of Healthwatch Reading, which is a charitable incorporated organisation, are responsible for the strategic vision, governance and finances. The board oversees our work plan and ensures we listen to our local community. We also ask our local community to suggest issues to help decide our annual work plan. We hold regular board meetings in public, so people can see how we work and get the chance to ask questions.

Our people:

Trustees:

+ David Shepherd – chairman
+ Gurmit Dhendsa - financial and strategic development
+ Monica Collings – public health and mental health services

Our Board:

+ Sheila Booth - physical disabilities
+ Francis Brown – North Reading Patient Voice
+ David Cooper – hospital services
+ Douglas Findlay – young people and pharmaceutical services
+ Tony Hall – care for the elderly and GP services
+ James Penn – South Reading Patient Voice
+ Sue Pigott – learning disabilities
+ David Shepherd – commissioning of services
+ Helena Turner – community engagement, young people and mental health

Staff team:

+ Mandeep Kaur Sira – chief executive
+ Carl Borges – advocacy services manager
+ Rebecca Norris – manager (on sabbatical)
+ Pat Bunch – interim projects and engagement manager
+ Phil Healy – digital information officer
+ Shahanaz Uddin – Healthwatch officer
+ Catherine Williams – interim policy and insights manager

Our open meetings are great opportunities for the public and professionals to discuss local NHS & social care services

Your views on health and care

Women at the Reading Community Learning Centre share their experiences with Healthwatch Reading staff member Catherine Williams

People who had been homeless told a Healthwatch Reading focus session how services had treated them

Listening to people's views

Healthwatch Reading is guided by five quality statements set by Healthwatch England, the second of which covers 'community voice and influence'. This means we work hard to enable and support local people to understand how their health and social care system works, express their views and share their experience.
We also have a key role in ensuring the voices of the vulnerable, disadvantaged and people and communities who are ignored or excluded, are listened to.

We did this during 2017-18, by:

+ Interviewing more than **40 voluntary or sectioned mental health inpatients** at Prospect Park Hospital, in a joint project with five other local Healthwatch in Berkshire. They told us nurses and other staff treated them kindly but there was not enough staff to give them time, information and activities.
+ Hearing experiences from **19 people who had been recently homeless** about how they access local health services and attitudes of staff towards them. Access to dental care was the most common and significant problem and we heard evidence of people removing their own teeth.
+ Running a **TB knowledge and attitudes survey answered by 326 people, nearly half of whom were young people aged 16-35, from a wide variety of ethnic backgrounds** including Nepali, Pakistani Indian and Black African. Most people had heard of TB but they held various misconceptions about it and felt that local people needed to know more about it.
+ Helping **20 people living in the community in a mental health care home** to have their say about council proposals to close down their home. All of them opposed the move due to the importance of the home in moving them towards independence as well as preventing readmission into hospital.
+ Speaking with **50 people in the general population, including working age people,** during spot checks at two GP surgeries. They said they were concerned about not being able to see doctors they knew.

We have a key role in ensuring the voices of the vulnerable, disadvantaged and communities who are ignored or excluded, are listened to.

+ Meeting **30, mostly older frail people**, across various Reading care homes (in an ongoing project which will report its findings in 2018-19)
+ Launching a survey to find out how **people who identify as LGBT+**, experience local health and care services (in an ongoing project whose findings will be published in 2018-19)
+ Jointly running a special forum with **representatives of 14 different charities** and other local organisations to hear their views of the mental health needs of their clients. Charities felt people were being 'passed around' without proper support.

We used Enter and View to follow up on concerns raised with us by individuals, to check if services had improved after recent Care Quality Commission inspections, or to offer people help, time and opportunity to have their say.

Overcoming engagement barriers

We successfully gathered views from a wide variety of people because we used engagement methods that acknowledged the barriers people may face in participating. Some of the methods we used included:

+ visiting Prospect Park wards at various times of days, evenings and weekends over a seven-day period, so we could build up a picture of staffing and ward life around the clock;
+ running focus sessions at homeless hostels and offering participants supermarket vouchers to take part;
+ targeting young people from different backgrounds by running stalls at Reading University and college 'Freshers' Fairs' or Open Days, and using eye-catching promotional material showing flags of target countries of origin;
+ carrying out regular visits to a mental care home to build relationships with residents and produce a film of their views;
+ working with the local LGBT charity Support U to inform the way we designed a survey.

Making sure services work for you

We used our statutory Enter and View powers to visit Prospect Park Hospital, Circuit Lane and Priory Avenue GP surgeries and the St Luke's, Northcourt Lodge and River View care homes.

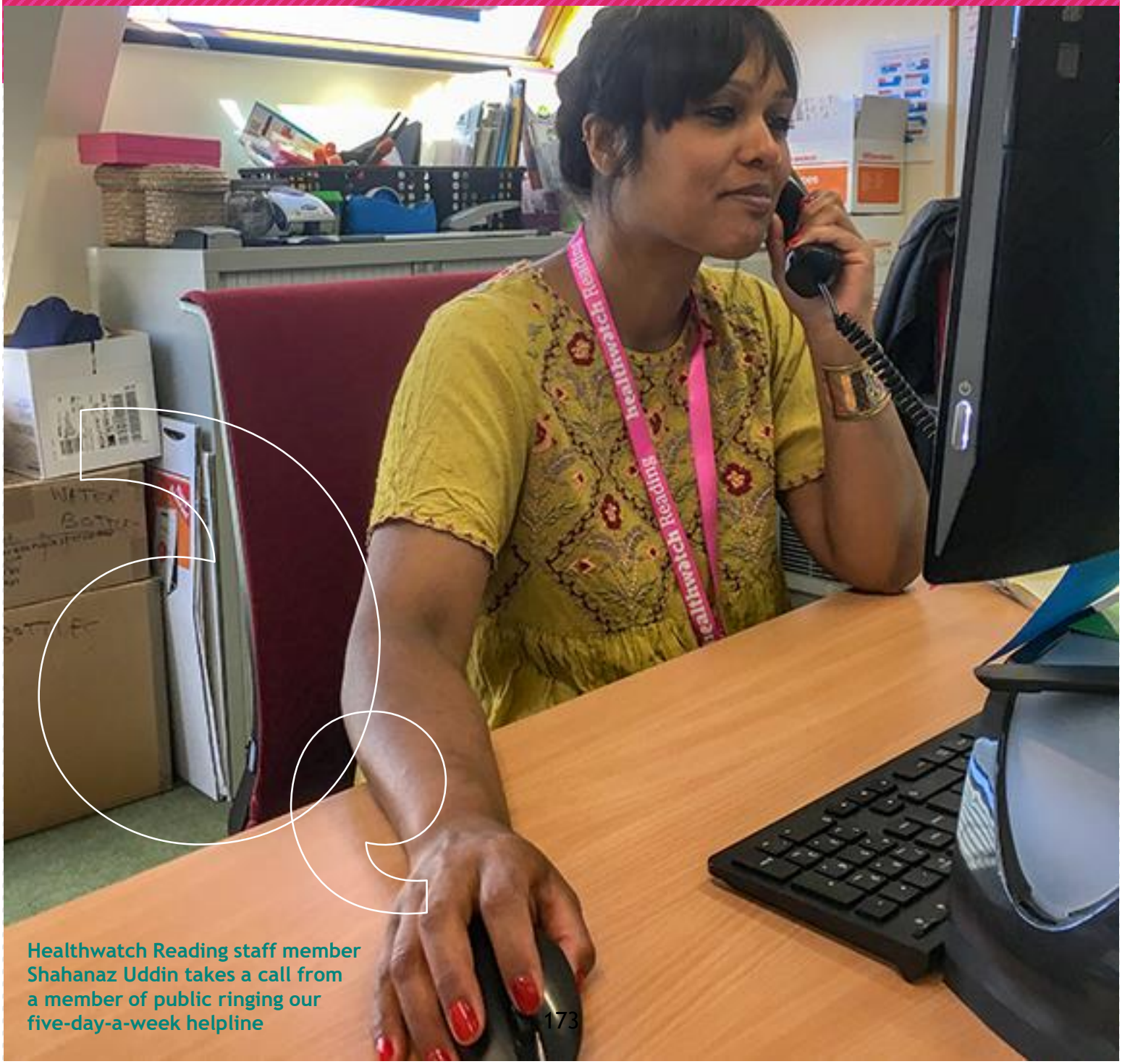
We used Enter and View for a variety of reasons, such as to follow up on concerns shared by individuals; to check if services had improved after recent quality inspections; or to offer people help, time and opportunity to have their say.

Our Info & Advice stand is on wheels, so we can easily get out and about to community events

Our projects prompted services or commissioners to take action such as:

+ exploring what extra activities could be put on for mental heath inpatients
+ deciding against a care home closure
+ ongoing checks on GP surgeries, that eventually led to change of providers
+ a commitment to work with communities to reduce the stigma of TB.

Helping you find the answers



Healthwatch Reading staff member Shahanaz Uddin takes a call from a member of public ringing our five-day-a-week helpline

How we have helped the community get the information they need

One of our key roles is to provide advice and information to the public about how to find services, how to resolve concerns, people's rights when using NHS or social care, and which other organisations might be able to help them.

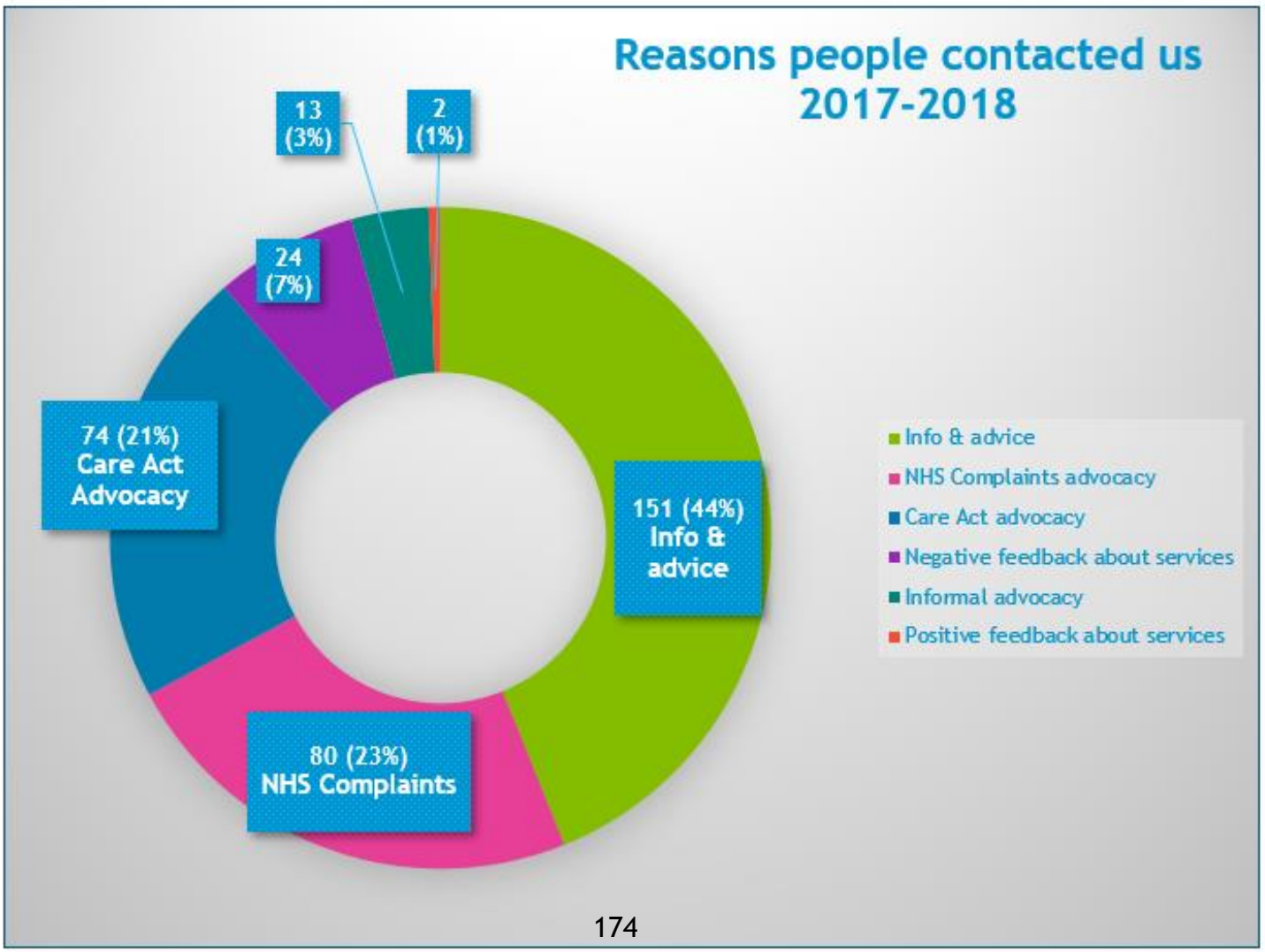
The number of people who contacted Healthwatch Reading with specific issues, totalled 353 in 2017-18. As the chart below shows, most people (151) were seeking information and advice.

We deliver our information and advice service through various methods, including:

+ a telephone helpline, Monday-Friday 9am-5pm
+ online guides on our website, including template complaint letters
+ our drop-in service at our offices in Reading Central Library
+ home visits to people with mobility issues
+ facilitated communication using interpreters or translators
+ talks and Q&As with community groups
+ information stalls at Reading locations
+ leaflets and posters
+ tweets signposting people to information, advice and events.

Our advice might include explaining how to self-refer to health services (such as Talking Therapies or 111), how to get support from a local charity (such as Age UK Reading), or more general advice, like how to find a local NHS dentist.

We deliver information and advice through a telephone helpline, online guides, a drop-in service, community talks, facilitated communication with interpreters and more.



Sometimes people need support if they are unable to resolve concerns on their own. We can support these people through informal advocacy (trying to nip a problem in the bud with a quick, satisfactory solution), or supporting a person to make a formal NHS complaint about serious concerns.

We provided NHS Complaints advocacy to 80 people during 2017-18. The chart below shows that most of these were about the Royal Berkshire Hospital, their GP surgery, or community or mental health care.

Under the NHS Constitution, people have a right to have their complaints investigated and for organisations to provide a response that might include an explanation, an apology, different care for the patient, or general changes of improvements for the whole organisation.

Our NHS Complaints advocacy service is free, independent and confidential and covered issues from administration mistakes to care failings.

Top themes reported by the public to us 2017-18

Poor quality care (67 people)

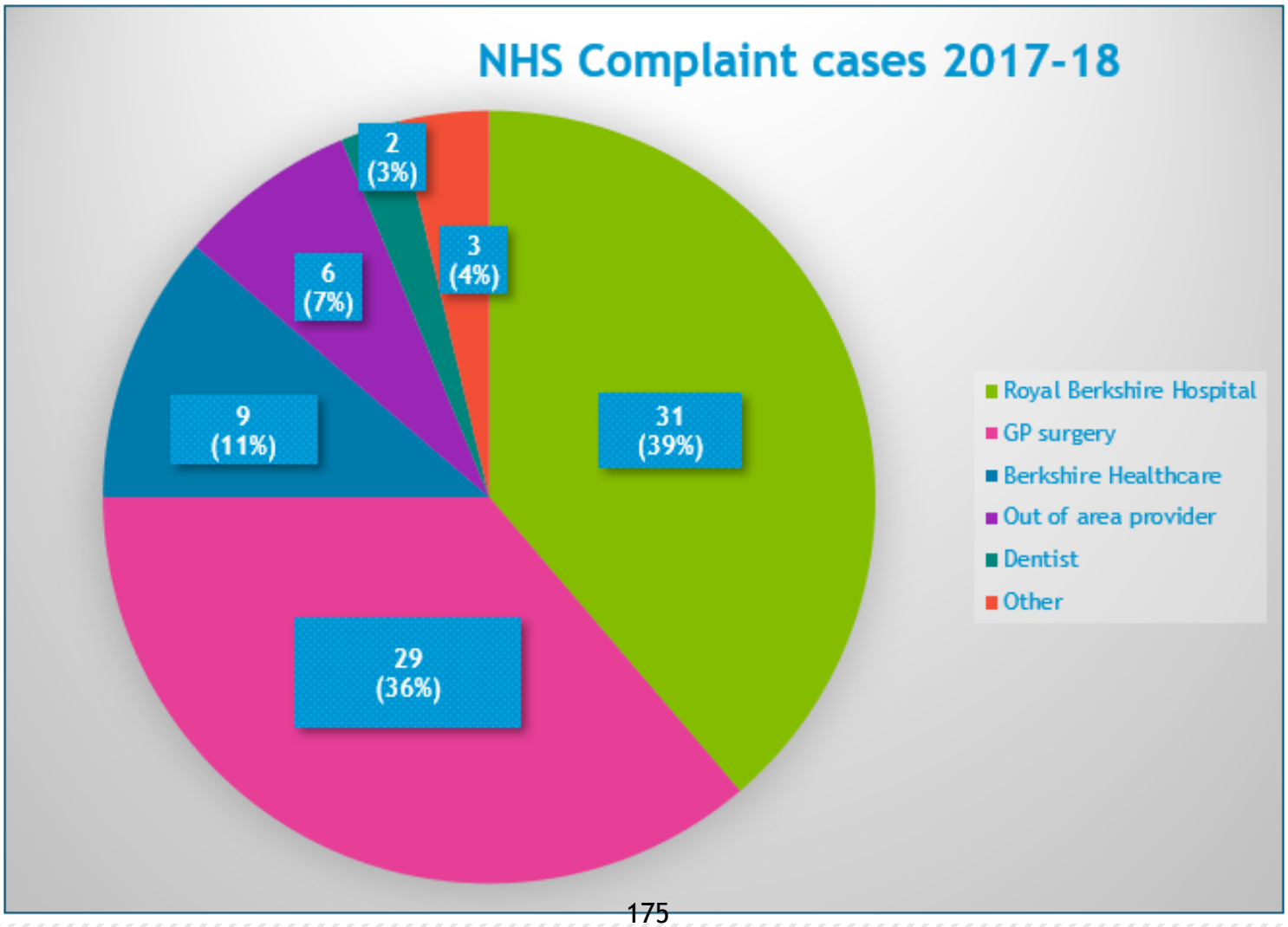
Problems accessing services (37)

Administration/communication issues (23)

Attitude of staff (17)

Referral delays (15)

Medication/prescription problems (13)



Making a difference together

Local advocate Pauline Foy, pictured left, helped us with a project to boost the diversity of volunteer community first responders

Working with other organisations

Healthwatch Reading is committed to a collaborative approach with service providers, commissioners, regulators and other local system leaders to bring about change.

During 2017-18, we demonstrated this approach through a range of projects, including:

Primary care

We worked closely with the Care Quality Commission to share local intelligence we collected at Circuit Lane and Priory Avenue surgeries.

Evidence we collected from people about the quality of care at Circuit Lane and Priory Avenue surgeries, helped the Care Quality Commission and local commissioners understand what improvements were urgently needed.

This helped the CQC to understand if improvements had been made since it had rated both surgeries (run at the time by the same provider) as inadequate.

We also shared our intelligence with the North and West Reading Clinical Commissioning Group. The CCG's GP chairman agreed to a request by the Healthwatch Reading board to come to a meeting held in public to answer questions about why patients had been let down by the practices.

The CCG eventually decided to end its contract with the provider and we were invited to sit on a panel to help choose a local NHS practice to take over Circuit Lane Surgery, and to also advise on communication about changes at Priory Avenue.

Mental health

In a unique project, all six local Healthwatch in Berkshire worked together for the first time to follow up on similar concerns that had been separately reported to us, about Prospect Park Hospital. This enabled us to visit 11 times over a week to capture views of more than 40 people staying as voluntary or sectioned inpatients.

We joined up with the five other local Healthwatch across Berkshire to capture the views of more than 40 people staying as voluntary or sectioned inpatients at Prospect Park Hospital.

The project involved us sharing tasks: one Healthwatch designed posters to tell patients we were coming, another coordinated with Berkshire Healthcare before, during and after the visits, another designed the semi-structured questionnaire, and another supplied a large pool of volunteers to assist staff from all six Healthwatch in collecting feedback.

Healthwatch Reading's main role, aside from speaking to patients, was to write the final report. We also secured media coverage of the findings on BBC South Today, presented the report to a Reading Borough Council committee and shared findings with the CQC.

Urgent care

We were invited to present findings of our A&E report to the committee of Healthwatch England (HWE) in July 2017, shortly after winning the 'engagement in service improvement' category of the HWE annual awards.

Our report had revealed findings of a survey of 10 per cent of people attending A&E over a 7-day period. The award and presentation have meant that HWE can raise the themes in their discussions with national NHS decision-makers.

Voluntary sector

We worked closely with the Reading Advice Network to jointly facilitate a special forum attended by 14 local charities and organisations to discuss the mental health needs of their clients. As well as giving a presentation on the Reading 'map' of available services, we also helped run small group discussions. Many charities felt people were being let down by statutory services, so we presented findings in a jointly written report, to local health and social care commissioners.

Championing public involvement

A key challenge for us during 2017-18 was keeping pace with changes to the structures that plan and fund local services and ensuring the public voice is heard and central to their work. This included the new Berkshire, Oxfordshire and Buckinghamshire Sustainability and Transformation Partnership (STP) and the Berkshire West Integrated Care System (initially known as an accountable care system) which involves Royal Berkshire Hospital, Berkshire Healthcare and commissioners working to get the best out of the local 'NHS pound'.

The Berkshire West Integrated Care System agreed to our proposal for a Healthwatch ICS Officer who will liaise with three local Healthwatch and the ICS, to ensure the public voice is at the heart of NHS transformation.

These organisations sought out regular input from Healthwatch in Reading, Wokingham and West Berkshire, but our small teams had to juggle attending these meetings with our prime function of assisting our own communities to have their say. To remedy this, Healthwatch Reading led a joint proposal with Healthwatch West Berkshire and Healthwatch Wokingham to argue the case for a funded Healthwatch ICS Officer. The ICS agreed, and a full-time postholder will be recruited for 2018-19. Their main role will be to liaise between the three Healthwatch and the ICS, sharing information about the public feedback we each collect and how this can feed in to the work of the ICS to improve local services.

On all the various committees we attend, we point out that having Healthwatch at the table is about facilitating public involvement, rather than acting as a sole representative of all the views of the Reading public. So we will advise, for example, that running an online-only consultation will not be accessible to all and various methods are needed to capture the views of different people.

During 2017-18, we accepted referrals for 56 people who were entitled to Care Act Advocacy, to help them have their say during social care assessments, reviews, or safeguarding enquiries.

Working together to deliver advocacy

We continued our effective partnership with Age UK Reading and the learning disability charities Talkback and Reading Mencap, to jointly deliver the third year of the Care Act Advocacy service. Our advocates help people who are entitled to this statutory advocacy, to express their views about how they want to live their lives and receive care, during social services care assessments, reviews, or safeguarding investigations.

During 2017-18 we received 74 referrals, 56 of which we accepted (14 were outside of the scope of Care Act Advocacy and 2 were out of area).The table below shows the primary need of clients.

The success of our advocacy services has led to an expansion of the type of advocacy we will provide in 2018-19, as outlined in more detail on page 21.

Needs of Care Act Advocacy clients

Brain/head injury:	2 people
Deemed 'vulnerable':	12
Dementia diagnosis:	3
Lacks capacity:	5
Learning disability:	18
Mental health:	8
Physical disability:	8

Involving local people in our work

We involve local people by:

Informing people

We hold special events to help the public understand major changes to local services. This included a special question and answer session we arranged at our annual general meeting held in July 2017, to allow the public to quiz Royal Berkshire Hospital chief executive Steve McManus on everything from a shortage of carparking spaces to the impact of Brexit on staffing.

We continue to send out a monthly newsletter, visit patient participation groups at GP surgeries, attend meetings of North and West and South Reading Patient Voice groups, and regularly take part in discussions on BBC Radio Berkshire about local issues.

Being transparent

We hold Healthwatch Reading board meetings in public, so people can see how we work and make decisions and understand local issues.

We explain and encourage people to exercise their democratic right to have a say and question decision-makers. For example, we helped one person submit a question to the Health and Wellbeing Board on lower male life expectancy in Reading, we worked with care home residents to facilitate a presentation of their petition to Reading Borough Council, and we regularly publicised opportunities for people to attend open meetings of Reading clinical commissioning groups, where decisions were made about local health services.

Championing equality and diversity

We have been chosen by South Central Ambulance to help measure their equality and diversity performance. We do this by facilitating meetings between SCAS and a wide range of people from Reading's community.

We also helped the SCAS Charity recruit 50 new volunteer community first responders, especially women and people from different ethnic backgrounds, by holding special community recruitment events.

Royal Berkshire Hospital chief executive Steve McManus addresses the Healthwatch Reading AGM in July 2017 before taking questions from members of the public who attended.

it starts with YOU

Healthwatch Reading staff member Pat Bunch (pictured right) with Sue, a resident at a local care home.

There's no beds in Prospect Park if anyone had a relapse and then we'd be shifted to London or down south and I can just see a revolving door…"

Claire speaks out against the closure of a Reading mental health care home.

#ItStartsWithYou

Claire brings us into the garden of Focus House, a care home for people with mental health needs, to show us the rabbits she helps look after. Explaining their therapeutic value, she tells Healthwatch Reading: "I have days sometimes, or I have many days in a row, where I wouldn't necessarily go out, but because I've got them, I've got to buy their veg and that gets me into town."

Phil, a keen violin player, explains how he arrived at Focus House after spending 22 years at three different hospitals, which was like being "in the dark ages". On arrival, he said "the feeling was…like it was in a family home, like in the kitchen where we congregate and eat lots of good things".

Sue likes the fact everyone gets together to eat and she praises the staff for getting to know them well and helping her remember to take her medication. The thought of having to leave Focus House makes her so upset she says it could make her self-harm.

Julia, the mother of another resident, says the potential closure of the home is "worrying the life out of me" because her daughter had not coped with a previous move out of a home.

These views were all captured on a short film created by Healthwatch Reading to help empower the residents to have their say about Reading Borough Council's proposal to shut down their home. In a succinct summary at the end of the film, Ray issues a challenge to the council: "You can see the health of a society by the way it treats their poor and vulnerable."

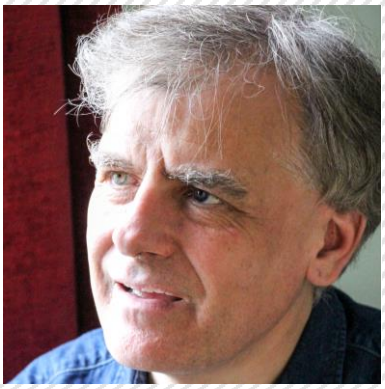
Healthwatch Reading spent months supporting residents through the consultation. We requested from RBC officers, a simple question and answer paper, to help people wade through the formal language of the council consultation documents. We also encouraged people to take part in the consultation in any way they felt best able. Some people told us they felt the consultation questions were leading or they did not always like filling in forms. So we offered them an opportunity to have their say in another way, by filming their views. This was done with their signed consent and showing them the final edited version.

The powerful testimonies of residents won councillors over, and a decision was made to keep Focus House open.

Healthwatch Reading staff member Catherine Williams helps a relative of a Focus House resident understand the council's consultation plans

Spending 22 years in hospital was like the dark ages…here it's like a family home."

Phil describes what Focus House means to him.



The film was shown at the council meeting that decided the fate of Focus House. Claire also presented a petition, signed by hundreds of supporters, telling the meeting that without the home, there was a risk of people relapsing and being readmitted to Prospect Park Hospital.

The powerful testimonies of the residents won councillors over, and a decision was made to keep Focus House open, but to alter its status to supported living accommodation, with familiar staff on hand to support them to live as independently as possible.

We urge Reading people to continue to share their stories and experiences with us, with the confidence that their voice can make a real difference – as the Healthwatch England campaign slogan says: **#ItStartsWithYou!**

You can see the health of a society by how it treats their poor and vulnerable."

Ray's message to the council.

Victory! Smiles after RBC agrees to keep Focus House open

Our plans for next year

Healthwatch Reading advocacy services manager Carl Borges giving a presentation to Reading social workers

What next?

As we enter our sixth year of operation, we are proud to announce we will be running a new one-stop-service advocacy service known as Reading Voice from 1 April 2018. This is due to winning a contract with Reading Borough Council to bring four different types of advocacy provision together. This means we will be providing:

+ Statutory Independent Mental Health Advocacy for Reading people sectioned at Prospect Park Hospital (a service previously provided by another provider, Seap);

We have won a contract to deliver four types of advocacy from 1 April 2018.

+ Social Care Complaints Advocacy, a new non-statutory service to help any Reading adult with a complaint about any social care that has been arranged for them by the council;
+ Statutory NHS Complaints Advocacy, which we have provided in Reading since 2014; and
+ Statutory Care Act Advocacy, which we have coordinated and provided since 2015.

Reading Voice is run in partnership with Age UK Reading, and learning disability charity Talkback, and involves a pool of 11 local advocates with the empathy and expertise to help a wide variety of people. Advocacy helps people know their rights and options, make their own choices and have their say. Advocates don't tell people what to do or work for the NHS or council.

To support the new service we have launched a standalone website at www.readingvoice.org.uk, which includes self-help advice, template complaint letters and referral information. We have also produced leaflets for each type of advocacy, in English, and Polish, Urdu and Nepali (see example, below).

ReadingVoice
Your local advice & advocacy hub

Reading age UK

Talkback

Alongside the expanded advocacy service, we have a full programme of engagement work planned for 2018-19, which aims to help a wide range of people influence the shape of local services.

This includes continuing our aim to visit every care home in Reading to get the views of residents about daily life and how their care and wellbeing needs are met.

Early in 2018-9 we will publish our findings of a survey we ran jointly with the charity Support U, of the LGBT+ community about their experiences of health and social care services.

We plan to talk to university and college students about how their health needs - including mental health issues - are met.

We also hope to go out and listen to people who use drug and alcohol services, in light of Reading Borough Council's new strategy due out for tackling drink and substance misuse.

Another area of focus will be looking at the health of university and college students in our town – an issue of increasing national concern, particularly the mental health needs of young people.

We will also continue to monitor the experience of the general population affected by changes at Circuit Lane Surgery and Priory Avenue Surgery, whose care has been taken over by local NHS GPs after a Leeds-based firm running both surgeries ended its contract at the end of March 2018. Further changes at other GP surgeries in Reading are planned, with the development of larger primary care 'hubs', better access to GPs outside of normal working hours and more care shifted from hospitals into the community, and so we will strive to ensure patients are kept informed, consulted on, and get opportunities to influence the shape of new services.

Another ongoing project is to inform the priorities of the Berkshire West Integrated Care System (ICS) by working with the new Healthwatch ICS Liaison Officer to ensure they understand the experiences and needs of Reading people and how these should fit into wider regional plans to transform care.

Finally, to ensure people can get help at their fingertips, through computers, tablets and smart-phones, we are also working on a refresh of our website, informed by research that Healthwatch England has carried out to improve the way we give information and advice and collect feedback.

Priorities for 2018-19

1. Visiting care homes to find out about the daily lives of residents
2. Understanding the experience of drug and alcohol users
3. Checking the quality of primary care at various GP services
4. Delivering a top-class advocacy service
5. Collecting experiences of university and college students

Our finances

Income	£
Funding received from local authority to deliver local Healthwatch statutory activities	110,000
Additional income	80,442
Total income	190,442
Expenditure	**£**
Total expenditure	171,200
Balance brought forward	19,242

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Our annual report will be publicly available on our website by 30 June 2018. We will also be sharing it with Healthwatch England, CQC, NHS England, Clinical Commissioning Group/s, Overview and Scrutiny Committee/s, and our local authority.

We confirm that we are using the Healthwatch Trademark (which covers the logo and Healthwatch brand) when undertaking work on our statutory activities as covered by the licence agreement.

If you require this report in an alternative format please contact us at the address above.

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TO:	**HEALTH & WELLBEING BOARD**		
DATE:	**13 JULY 2018**	**AGENDA ITEM:**	**11**
TITLE:	**READING HEALTH & WELLBEING ACTION PLAN 2017-20 UPDATE AND DASHBOARD REPORT**		
AUTHOR:	**KIM McCALL / JANETTE SEARLE**	**TEL:**	**0118 837 3245 / 0118 937 3753**
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ORGANISATION:	**READING BOROUGH COUNCIL**		

1. PURPOSE OF REPORT AND EXECUTIVE SUMMARY

1.1 This report presents an update on delivery against the Health and Wellbeing Action Plan (Appendix A), alongside the Health and Wellbeing Dashboard (Appendix B), populated with the latest published data in relation to the Board's agreed strategic priorities. Taken together, these documents provide the Board with an overview of performance and progress towards achieving local goals as set out in the 2017-20 Health and Wellbeing Strategy for Reading.

1.2 The appendixed documents give the Board a context for determining which parts of the Health and Wellbeing Strategy it wishes to review in more depth. Some areas are already the subject of separate reports brought to today's Board. Other issues may be identified for further exploration at subsequent meetings. Identifying priorities from the Health and Wellbeing Strategy to provide themes for Health and Wellbeing Board meetings is in line with the 2016 Peer Review recommendation that the Health and Wellbeing Strategy should be used to drive the agenda of the Health and Wellbeing Board.

1.3 This latest Action Plan represents progress achieved 18m into delivery of a three year strategy. In some priority areas, Actions have already been reviewed and refreshed quite comprehensively. A full refresh across all priority areas in the Action Plan will be presented to the Board in January 2019.

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 as set out at Appendix A.

2.2 That the Health and Wellbeing Board notes the following change to the Health and Wellbeing Dashboard at Appendix B:
- the snapshot of dementia diagnosis rate is now available on a monthly basis, and monthly performance for the last year has now been included.

Public Health England (PHE) publishes most data as part of a quarterly update cycle in August, November, February and May.

2.3 That the Health and Wellbeing Board notes performance indicators in the following areas in particular as these have been updated since the Dashboard was last presented to the Board:

- Health Checks indicators (Priority 1) have been updated with Quarter 4 performance data;
- Smoking prevalence indicators (Priority 1) have been updated with 2017 performance data;
- alcohol treatment completion data (Priority 5) has been updated with Q4 data
- estimated dementia diagnosis rate (aged 65+) (Priority 6) has been updated with monthly snapshot data for May 2017 to May 2018;
- statistics for % of adults physically active (Priority 1) has been updated with 2016-17 data;
- the number of Dementia Friends (local indicator for Priority 5) has been updated with figures to 31st May 2018 supplied by the Alzheimers Society.

2.4 That the Health and Wellbeing Board notes that updated data is expected to be available to populate the Dashboard as presented to the October 2018 meeting of the Board:
- Dementia Friends (Priority 5) – update to number trained to end August 2018
- dementia diagnosis rate – monthly updates expected for June, July and August 2018
- Q1 Healthcheck indicators expected in August 2018
- Q1 alcohol treatment completion rates expected in September 2018

3. POLICY CONTEXT

3.1 The Health and Social Care Act 2012 sets out the requirement on Health and Wellbeing Boards to use a Joint Strategic Needs Assessment (JSNA) and a Joint Health and Wellbeing Strategy (JHWS) to develop plans which:

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

3.2 Reading's 2017-20 Health and Wellbeing Strategy sets out local plans as required under the Health and Social Care Act, and also addresses the local authority's obligations under the Care Act 2014 to promote the wellbeing of individuals and to provide or arrange services that reduce needs for support among people and their (unpaid/family) carers in the local area.

3.3 The current strategy is founded on three 'building blocks' – issues which underpin and are expected to be considered as part of the implementation plans to achieve all of the strategic priorities. These are:

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

3.4 The Strategy then sets out eight priorities:

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

3.5 In July 2016, Reading's Health and Wellbeing Board agreed to introduce a regular Health and Wellbeing Dashboard report to ensure that members of the board are kept informed about the Partnership's performance in its priority areas, compared to the national average and other similar local authority areas.

4. SUMMARY POSITION (JULY 2018)

Priority 1: Supporting people to make healthy lifestyle choices (with a focus on smoking cessation, tooth decay, obesity and physical activity)

4.1 Actions relating to obesity and physical activity are now detailed in the Reading Healthy Weight Action Plan which the Health and Wellbeing Action Plan cross references. The Healthy Weight Action Plan has been modified as a result of needing to operate within a reduced Public Health Grant budget, as reported to the Council's Policy Committee in June 2018.

4.2 The details of how the Healthy Weight Strategy has been impacted are contained in a separate report being brought to this Board today. However, the budget dedicated to delivery of the Healthy Weight Strategy has now been removed, and both the adult and child commissioned weight management programmes are being decommissioned as of September 2018. The Wellbeing Team is working with partners, including those in other Council directorates, to identify opportunities to tackle obesity within other programmes, particularly those supported by Public Health Grant.

4.3 The funding available to commission smoking cessation support has also been reduced. Targets for 2018-19 are under active discussion with the provider in light of this, and a further update will be provided for the next Health and Wellbeing Board.

4.4 The Wellbeing Team is exploring options for developing an integrated hub model for the delivery of public health services in future to address the

forthcoming gaps in provision and so mitigate against these service reductions to reduce lifestyle-related ill health.

4.5 In relation to tooth decay, data published in March 2017 has now been analysed, and it is recommended that an Oral Health Strategy for Reading is developed on the back of this. The details are contained in a separate report being brought to this Board today.

4.6 Per the Dashboard, performance is currently below target for the following Priority 1 indicators.

2.06ii - % 4-5 year olds classified as overweight/obese
A slight increase earlier this year has put Reading slightly above target and above the percentage recorded last year. This follows three years of slight reductions and, statistically, may be the result of chance rather than a 'real' trend. Overweight and obesity has fallen significantly in older primary aged children this year. Performance against both indicators will be monitored to determine whether these represent real trends.

2.22 – Health check indicators.
Reading will not meet local or national targets for proportion of the population who are eligible for a health check (aged 40-74) to be invited for a health check by the end of 2017/18**.** Low performance against this indicator has had implications for the other two health check indicators. Other pressures within local service provision have had an impact on this performance.

Priority 2: reducing loneliness and social isolation

4.7 A cross-sector Loneliness and Social Isolation Steering Group has overseen the development of an in-depth local loneliness analysis. This has now been published as a module within our Joint Strategic Needs Assessment, and draws on national and local research to show how becoming lonely or socially isolated is a complex process affected by a range of interrelated factors. Individuals may be at greater risk if they:

- are single (have no current spouse or life partner;
- have recently experienced a significant life change; or
- face practical barriers to social contact - such as poor health, lack of transport or lack of economic or social resources,

4.8 The Needs Analysis confirms that, although loneliness and social isolation are important issues for people in older age groups, other age groups are also affected. Older people may be at greater risk because they are more likely to be affected by relevant life changes and/or practical constraints than because old age is a risk factor in itself. The Council has commissioned some further research from the University of Reading to explore issues in further detail – such as what the evidence is telling us about effective interventions to support younger people, and how different health conditions may affect the risk of loneliness and social isolation differently.

4.9 The Steering Group has refreshed its Action Plan to focus on some specific practical steps which can be taken to share information about support and services to strengthen social contact, as well as to set out targeted actions to support different at-risk groups. There are some groups, however, for which

this is still being explored and the Group has simply set a marker whilst awaiting the outputs further research.

4.10 Per the Dashboard, performance is currently below target for the following Priority 2 indicators.

1.18 - Adult Social Care users with as much social contact as they would like AND Carers with as much social contact as they would like.
Targets for these indicators were set based on previous performance (for carers) and - where Reading's performance was below national average - previous England averages (Adult Social Care (ASC) users). The proportion of ASC users in Reading reporting enough social contact has improved over the last two years, while the national average has stayed the same. The proportion in Reading is now only very slightly below the national average (45.2 vs 45.4) and the local target (also 45.4). Similarly, for carers in Reading, the proportion reporting enough social contact has remained the same, while the national average has fallen. Consequently, carers in Reading are now more likely to report enough social contact than nationally. Although targets have not yet been met, performance has improved and is in line or better than the national average.

Priority 3: Promoting positive mental health and wellbeing in children and young people

4.11 The (appendixed) Health and Wellbeing Action Plan includes a link to the latest Future in Mind (FiM) Transformation Plan. The local FiM plan was driven by engagement work undertaken across the system in 2014, prior to FiM, echoing national FiM report findings and recommendations. The local plan is refreshed annually to provide a snapshot across the system across the Berkshire West CCG footprint. The last refresh was competed in October 2017 and approved by the Reading Health and Wellbeing Board as well as the Wokingham Health and Wellbeing Board and the West Berkshire Health and Wellbeing Board. Service user feedback, data and service information is gathered throughout the year and this shapes ongoing work.

4.12 Funding for FiM projects increased to £789,271 in 18/19 for the whole of Berkshire West. The CCG reviewed projects funded through FiM during 17/18 in light of national and local care pathway requirements, and all services have been commissioned to support wider emotional health and wellbeing care pathways. The FIM local transformation plan will be refreshed in October 2018 and we will include the projects funded in 18/19.

4.13 Berkshire West CCG requires the support of 2 voluntary sector organisations to add value to the ASD and ADHD care pathways. This funding will provide children and families with support both whilst they are waiting for an assessment to start, as well as once a diagnosis is has been made.

4.14 Funding has been put into new services such as an Anxiety and Depression intervention to be delivered by the University of Reading and recurrent funding of the CAMHs crisis/ urgent care service.

4.15 The CCG has continued to fund Number 5 Youth Counselling at the same level as last year and committed to a 3 year contract- this is in addition to Future In Mind funding. RBC are no longer funding youth counselling in Reading.

4.16 Per the Dashboard, performance is currently on or above target for all Priority 3 indicators.

Priority 4: reducing deaths by suicide

4.17 The updated Health and Wellbeing Action Plan summarises progress to date as overseen by the Berkshire-wide Suicide Prevention Strategy Group and by the Reading Mental Wellbeing Group.

4.18 A range of activities have been co-ordinated to maintain the profile of suicide prevention, including: a Media Summit on responsible suicide reporting; a mini conference to mark the formal launch of the Berkshire-wide Suicide Prevention Strategy; events across Council sites on Time to Talk today in support of RBC's Time to Change pledge to address mental health stigma as an employer; and partnership events to mark Mental Health Awareness Week.

4.19 Ongoing cross Berkshire work includes the preparation of a new four-year Suicide Audit and a review of commissioned support services to inform the refresh of Suicide Prevention Action Plans.

4.20 Per the Dashboard, performance is currently below target for the following Priority 4 indicator.

4.10- Mortality rate from suicide and injury of undetermined intent

The rate in Reading fell from 11 per 100,000 in 2013-15 (44 people) to 9.9 per 100,000 in 2014-16 (40 people). This is in line with the England average and slightly lower than similar LAs but did not meet the local target set by stakeholders.

Priority 5: reducing the amount of alcohol people drink to safe levels

4.21 Actions under Priority 5 are now aligned with the Reading Drug and Alcohol Commissioning Strategy for Young People and Adults 2018-2022, presented to the Board today under cover of a separate report. The strategy has a community-wide focus, including children, young people and adults - whether they are consuming alcohol or drugs themselves or whether they are affected by other people using these substances.

4.22 The strategy provides a framework for realising the vision of reducing the harm, or potential harm, that misusing alcohol and drugs has on the individual, on families and on the wider community. The aim is to enable individuals affected by drug and alcohol misuse to recover and reach their potential in leading a healthier lifestyle with the help of all agencies in Reading.

4.23 The strategy is built around three themes:

- Prevention - reducing the amount of alcohol people drink to safer levels and reducing drug related harm
- Treatment - commissioning and delivering high quality drug and alcohol treatment systems
- Enforcement and Regulation - tackling alcohol and drug related crime and anti-social behaviour.

4.24 Per the Dashboard, performance is currently below target for the following Priority 5 indicator.

2.18 - Admission episodes for alcohol related conditions
Alcohol-related hospital admissions, for many years much better than average, have been increasing gradually and are now in line with the national average.

Priority 6: making Reading a place where people can live well with dementia

4.25 Local action on dementia is overseen by the Reading Dementia Action Alliance (DAA) and the Berkshire West Dementia Steering Group. The DAA co-ordinated a series of Dementia Friends session across Reading during Dementia Action Week (19th May to 26th May 2018) for members of the public, hosted by DAA members at libraries in each community. This took the programme out to new people whereas in the past there has been a focus on linking with existing groups. Although the sessions were small, a media storm was created in Reading to raise the profile of dementia in the period leading up to and including Dementia Action Week. Dementia Friends sessions raise awareness of dementia to reduce the risk of harm to or discrimination against people living with dementia and their carers.

4.26 The DAA also arranged for the Alzheimer's Society to host a stand in Reading town centre (the Oracle) during Dementia Action Week, and this enabled 35 new contacts with support services for people with sensitive and personal issues around living with dementia. This event also facilitated contact with local retail businesses, and DAA members were encouraged by the number of local shops whose staff were already aware of the Dementia Friends campaign, the DAA and the issues around living with dementia. These events highlighted the need to take Dementia Friends sessions to where younger people are (schools, youth clubs etc), and this will be reflected in a refresh of the Action Plan.

4.27 Dementia prevention was the focus of a presentation delivered by the Wellbeing Team at a Health Inequalities event for the BME community in March 2018. The event was well attended by members of the public and community leads, leading to a commitment to future partnership working around health issues and preventative services. Dementia awareness is also now included in the NHS Health Check programme for all patients, but the budget for delivering NHS Healthchecks has been reduced, as report to RBC's Policy Committee in June.

4.28 Per the Dashboard, performance is currently below target for the following Priority 6 indicator.

4.16/2.6i - **Estimated diagnosis rate for people with dementia**
The estimated rate of diagnosis fell slightly below target in May 2018, after being above target for almost every month in the preceding year.

Priority 7: increasing the take-up of breast and bowel screening and prevention services

4.29 The local authority (Wellbeing Team) and CCGs are continuing to work in partnership to raise awareness of cancer risks, signs and symptoms, and support available. This has included: supporting PHE's Be Clear on Cancer campaign; sharing messages on breast cancer in women over 70 via local authority webpages, digital media and during community events; and promoting bowel screening at the Southcote Over 50s group.

4.30 A Macmillan Cancer Educator has been appointed to raise awareness of the signs and symptoms of cancer among hard to reach groups in South Reading. Macmillan Cancer Champion training has been organised for volunteers, and these champions will now organise cancer awareness sessions for their community groups. Over 30 people from the community have signed up to become cancer champions.

4.31 Per the Dashboard, performance is currently on or above target for all Priority 7 indicators.

Priority 8: reducing the number of people with tuberculosis (TB)

4.32 A wide range of partners is being engaged in raising awareness of TB and signposting people to appropriate services. This work is being driven by the outputs of a Berkshire-wide workshop in December 2017 including clinical representation from Slough and Reading, along with local stakeholders and representatives from NHS England and Public Health England. The groups worked through how to reduce the DNA rate, how to improve community engagement and data reporting.

4.33 Similarly, work to develop campaign materials was initially co-ordinated by a cross Berkshire working group. Responsibility for further communication and engagement is now with the local Operational Group, with oversight from the Berkshire TB Strategy Group. Key information on active and latent TB and a map of high risk countries has been made available on the Reading Services Guide and JSNA profile to facilitate public access to TB information.

4.34 Per the Dashboard, performance is currently on or above target for all Priority 8 indicators.

5. CONTRIBUTION TO STRATEGIC AIMS

5.1 The 2017-20 Health and Wellbeing Strategy and accompanying Action Plan draw on the findings of the Joint Strategic Needs Assessment (JSNA) for Reading to identify priorities. The Strategy complements plans for health and social care integration, and supports the drive towards co-commissioning across the Health and Wellbeing Board's membership. The 2017-20 strategy also incorporates wellbeing responsibilities towards residents with current or emerging care and support needs so as to be comprehensive and Care Act compliant.

6. COMMUNITY & STAKEHOLDER ENGAGEMENT

6.1 Delivery of the Health and Wellbeing Action Plan is through a range of multi agency forums which bring together representatives of the Health and Wellbeing Board with other local partners. These are referred to in the appendixed update.

7. LEGAL IMPLICATIONS

7.1 The Health and Social Care Act (2012) gives duties to local authorities and clinical commissioning groups (CCGs) to develop a Health and Wellbeing Strategy and to take account of the findings of the JSNA in the development of commissioning plans. In addition, the Council has a duty under the Care Act (2014) to develop a clear framework for ensuring it is meeting its wellbeing and prevention obligations under the Care Act.

8. EQUALITY IMPACT ASSESSMENT

8.1 The Health and Wellbeing Strategy and Action Plan are vehicles for addressing health inequalities, and accordingly delivery is expected to have a differential impact across groups, included those with protected characteristics. This differential impact should be positive, and so delivery of the Action Plan supports the discharge of Health and Wellbeing Board members' Equality Act duties.

9. FINANCIAL IMPLICATIONS

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

10. APPENDICES

Appendix A – Reading Health and Wellbeing Strategy 2017-20 – Action Plan updated July 2018

Appendix B – Health and Wellbeing Dashboard – July 2018

11. BACKGROUND PAPERS

Reading Health and Wellbeing Strategy 2017-20
Healthy Weight Strategy
Oral Health report

Appendix A: Reading Health and Wellbeing Strategy 2017-20 - Action Plan - updated July 2018

PRIORITY No 1	Supporting people to make healthy lifestyle choices – dental care, reducing obesity, increasing physical activity, reducing smoking *The original Health and Wellbeing Strategy Action Plan contained a number of actions within this priority area which are now set out in the updated Action Plan for the Healthy Weight Strategy – see separate report submitted to the Health and Wellbeing Board 13.07.2018.*				
What will be done – the task	**Who will do it**	**By when**	**Outcome – the difference it will make**	**Supporting national indicators**	**Progress Update - July 2018**
To Prevent Uptake of Smoking - Education in schools - Health promotion - Quit services targeting pregnant women/families - Underage sales	**Wellbeing Team; Trading Standards; CS; S4H; Youth Services; Schools;**	**From April 2017**	**Maintain/reduce the number of people >18 years who are estimated to smoke in Reading** **Improve awareness of impact of smoking on children** **Reduce the illegal sale of tobacco to >18 years**	**PHOF 2.03 - Smoking status at the time of delivery** **PHOF 2.09i – Smoking prevalence at age 15- current smokers (WAY survey)** **PHOF 2.09ii – Smoking prevalence at age 15 –**	**Prevention in Schools is delivered by PHSE Leads but is supported by local Tobacco Control Alliance.** **Whole 9 Yards campaign regarding Smoke-free Homes with Routine and Manual workers recommenced – this targeted local depot and**

			Increase uptake of smoking cessation >18 years	**regular smokers (WAY survey)** **PHOF 2.09iii – Smoking prevalence at age 15 – occasional smokers (WAY survey)** **PHOF 2.09iv – Smoking prevalence at age 15 – regular smokers (SDD survey)** **PHOF 2.09v – Smoking prevalence at age 15 – occasional smokers (SDD survey)**	**warehouse workers.** **Work with target groups on illegal tobacco, involves presentations and Trading Standards contact details for reporting –report and awareness campaign.**
To provide support to smokers to quit - **Health promotion** - **Referrals into service** - **VBA training to staff** - **Workplace and community smoking policies**	**S4H; RBC; CCGs;**	**From April 2017**	**Achieve minimum number of4 week quits - 722** **Achieve minimum number of 12 week quits** **Supporting national campaigns – 463** **Achieve minimum of 50% quitters to be from a priority group**	**PHOF 2.03 - Smoking status at the time of delivery** **PHOF 2.14 – Smoking prevalence in adults – current smokers (APS)** **PHOF 2.14 – Smoking prevalence in adults in routine and manual occupations – current**	**Quarter 4 2017/18 Quit Performance is as follows:** **4 week successful quits – 179** **12 week successful quits – 56** **Of which 28 were routine and manual workers and 2 were pregnant women.**

			Increase referrals to S4H by GPs; **Increase self-referrals to S4H**	**smokers (APS)** **NHS OF 2.4 - Health related quality of life for carers**	**2018/19 targets are under negotiation. Budget decision set by Policy Committee 2018 resulted in discussions with the provider. Further update will be given at the next HWB.**
To take action to tackle illegal tobacco and prevent sales to <18 - **Health promotion** - **Act on local intelligence** - **Retailer training – challenge 25** - **Test purchasing**	**Tobacco Control Co0rdinator, Trading Standards; S4H**	**From April 2017**	**Increase awareness of impact of illicit/illegal sales have on community** **Improve the no of successful completions of Retail Trainer Training (challenge 25)** **Reduce the number of retailers failing test purchasing**		**Sniffer Dog was used by Trading Standards to raise awareness of illegal tobacco sales.**
Local Smoking Policy – workplace, communities - **Update workplace smoking policy (wellbeing policy)** - **Smoking ban in community (RBC**	**Wellbeing Team; Health & Safety; Trading Standards; Environmental health;**	**From April 2017**	**Increase referrals to S4H smoking cessation services** **Prevent harm to community through restriction of exposure to second hand smoke.**		**Ongoing Wellbeing Team input into local development plans**

sites, school grounds; RSL; Broad Street)					
To collect dental epidemiology data for Reading	**Wellbeing Team**	**From January 2017**	**Reading Borough Council will have access to dental epidemiological data in order to be able to monitor progress in relation to Public Health Outcomes Framework indicators on oral health**	**PHOF 4.2: tooth decay in 5 year old children**	**Data published in March 2017 has now been analysed, and it is recommended that an Oral Health strategy for Reading is developed on the back of this.**

PRIORITY No 2	**Reducing Loneliness and Social Isolation**				
What will be done – the task	**Who will do it**	**By when**	**Outcome – the difference it will make**	**Supporting national indicators**	**Progress Update - July 2018**
Establish a Reducing Loneliness Steering Group	**Health & Wellbeing Board**	**February 2017**	**A cross-sector partnership is in place to oversee an all-age approach – covering prenatal, children and young people, working age adults and later life**		**COMPLETED - Steering Group now meeting bi monthly representing a range of interests.**

Develop a reducing loneliness and social isolation module as part of the Reading Joint Strategic Needs Assessment	**Wellbeing Team, RBC**	**April 2017**	**We will understand the local loneliness issue, in particular which groups of Reading residents are at greatest risk of experiencing health inequalities as a result of loneliness**	**PHOF 1.18i / ASCOF 1.i - % of adult social care users who have as much social contact as they would like** **PHOF 1.18ii / ASCOF 1.1 - % of adult carers who have as much social contact as they would like** **PHOF 2.23 i-iv – self-reported wellbeing**	**COMPLETED - The Loneliness and Social Isolation Steering Group has overseen the development of an in-depth local loneliness analysis, which has now been published as JSNA module.**
Refresh the Loneliness and Social Isolation JSNA module annually	**Wellbeing Team, RBC**	**June 2019** **June 2020**	**We will understand the local loneliness issue, in particular which groups of Reading residents are at greatest risk of experiencing health inequalities as a result of loneliness**	**PHOF 1.18i / ASCOF 1.i - % of adult social care users who have as much social contact as they would like** **PHOF 1.18ii / ASCOF 1.1 - % of adult carers who have as much social contact as they would like**	**A student has been recruited via the University of Reading to carry out a further literature analysis plus interviews and focus groups over the months of summer 2018.**

				PHOF 2.23 i-iv – self-reported wellbeing	
Map out community notice boards, including owners and access criteria	**Ebony George (Neighbourhood Intiatives), Matt Taylor (AUKR), Steph Francis (CCGs)**	**November 2018**	**Partners will be enabled to share information about services and resources to reduce loneliness and social isolation.**		
Start to map local Facebook pages	**Sarah del Tufo (RCLC)**	**September 2018**	**Partners will be enabled to share information about services and resources to reduce loneliness and social isolation.**		
Reinstate lunchtime learning sessions for Adult Social Care staff to raise awareness of services to reduce loneliness and social isolation	**Sarah Hunneman (Wellbeing Team, RBC)**	**September 2018**	**Adult Social Care staff will have up to date knowledge of local services so as to signpost or refer people at risk of social isolation.**		
Develop a plan for regular awareness raising with local NHS staff about services to reduce loneliness and social	**Steph Francis (CCGs)** **Sarah Morland**		**NHS staff will have up to date knowledge of local services so as to signpost or refer people at risk of**		**Members of the LSI Steering Group are able to disseminate information via the weekly GP practice newsletter from the**

isolation.	**(RVA)**		**social isolation.**		**CCGs.** **The weekly RVA e-newsletter is promoted to NHS staff.**
Link the Loneliness and Social Isolation Steering Group into plans to co-ordinate the maintenance of online directories of service for Reading	**Kirsty Wilson (Connect Reading)**	**Ongoing**	**People will be enabled to access groups and services to reduce loneliness and social isolation.**		
Collate and share partner experiences of supporting peer support / social groups to develop and become self sufficient	**Sarah Morland (RVA)**	**January 2019**	**Tools are available to promote sustainable solutions**		
Develop and raise the profile of community transport solutions	**Reducing Loneliness Steering Group**	**Ongoing**	**At-risk individuals know how to access transport as needed to join in social networks**		**All members of the Steering Group to promote the accessibility of general public transport in Reading, and consideration of travel companions as part of service provision** **All to promote Readibus's volunteer driver training scheme**

					Maintain good links with Readibus (a LSISG member) and Reading Buses to raise and resolve issues
Review and promote tools to assess and evaluate services' impact on social connectivity	**Reducing Loneliness Steering Group**	**August 2017**	**Local commissioners and providers will be able to measure the contribution of a range of services to reducing loneliness, and ensure provision is sensitive to local need**	**PHOF 1.18i / ASCOF 1.i - % of adult social care users who have as much social contact as they would like** **PHOF 1.18ii / ASCOF 1.1 - % of adult carers who have as much social contact as they would like** **PHOF 2.23 i-iv – self-reported wellbeing**	**Ongoing - the Loneliness Steering Group is being used as a vehicle to share ideas and best practice on evaluation.**
Support the neighbourhood Over 50s groups to grow and be self-sustaining	**Michelle Berry & Sarah Hunneman (Wellbeing Team, RBC)**	**Ongoing**	**Older residents are able to be part of developing opportunities for neighbours to know one another better**	**PHOF 1.18i / ASCOF 1.i - % of adult social care users who have as much social contact as they would like** **PHOF 1.18ii / ASCOF 1.1 - % of adult carers who have as much social contact as they would**	**There are now four thriving Over 50s clubs – in Caversham, Southcote, Whitley and Coley.**

				like **PHOF 2.23 i-iv – self-reported wellbeing**	
Support access to employment as a way of addressing loneliness and social isolation	**Marc Murphy (Oracle)**	**Ongoing**			**Ongoing confidence building, interview skills and work experience programme at the Oracle for single parents** **Ongoing work shadowing programme for people who face challenges to work / integration** **Retail Business Manager from the Oracle spoke at 'Make Reading Friendlier' conference to encourage businesses to do more to support people who are lonely or isolated**
Develop volunteering and employment opportunities for adults with care and support needs	**Sarah Hunneman (Wellbeing Team, RBC) / Sarah Morland (RVA) / Kirsty Wilson (Connect**	**Ongoing**	**There will be more opportunities for adults with care and support needs to enjoy supportive and enabling social connections through work**	**PHOF 1.18i / ASCOF 1.i - % of adult social care users who have as much social contact as they would like** **PHOF 1.18ii / ASCOF 1.1 - % of adult carers who**	**New volunteering and employment opportunities have been created as part of:** **- The relocation and reshape of The Maples Day Service** **- The development of the**

	Reading)			**have as much social contact as they would like**	**Recovery College** **- The development of the Over 50s clubs** **RVA has an officer who specialises in volunteering opportunities for people with additional needs.** **Berkshire West Your Way commenced delivery under a new contract 01.06.2018 which includes supporting people with mental health needs into employment** **RBC has made a 'Time to Change' pledge to end mental health discrimination – this campaign to be promoted to other Reading employers** **Connect Reading is promoting Mental Health First Aid as workplace training with Reading businesses**
Raise awareness of services to reduce loneliness and	**Sarah del Tufo (RCLC)**	**ongoing**	**People who are not literate or who speak little**		**RCLC, Reading Refugee Support and Communicare commenced**

social isolation with people who are not literate or who speak little or no English			**or no English will be enabled to access groups and services to reduce loneliness and social isolation.**		**delivery 01.06.2018 on a new contract for people facing language or cultural barriers to social contact.** **Independent report into the needs of ethnic minority women in Reading and how RCLC meets those needs to be published 19.07.2018.**
Raise awareness of services to reduce loneliness and social isolation with people who are not literate or whose first language is BSL	**To be discussed following further analysis**				**Deaf people to be a priority group for further analysis within ongoing research**
Raise awareness of services to reduce loneliness and social isolation with people who aren't literate because of cognitive limitations	**To be discussed following further analysis**				**Further research which has been commissioned includes considering how different long terms conditions or disabilities affect people's ability to form social connections differently**
Raise awareness of loneliness and social isolation amongst and services to support children and young people	**To be discussed following further analysis**	**ongoing**			**Children and young people to be a priority group for further analysis within ongoing research**

PRIORITY No 3	**Promoting positive mental health and wellbeing in children and young people**

Actions to support delivery of this priority are set out in the Reading Future In Mind Transformation Plan that covers the key issues. This has been published at:
https://www.berkshirewestccg.nhs.uk/media/1742/october-2017-refreshed-transformation-plan-final-for-submission.pdf

Building on the October 2016 refresh of plans, the latest Future in Mind plan contains the following sections.

1. Our journey so far- A snap shot of how services are delivered now compared to 2014 pp 7- 8
2. An overview in the local paradigm shift from a traditional tiered system to a THRIVE framework pp 9-11
3. A review of progress and achievements since October 2016 through a THRIVE lens

- **Thriving pp12-15**
- **Getting advice pp 15-19 include Emotional Health Academy**
- **Getting help pp 19- 25**
- **Getting more help pp25- 26**
- **Getting risk support -risk management and crisis response pp 26-30**

4. A summary of progress against Five Year Forward View for Mental Health, key planning guidance p 31-39
5. Further work which needs to be undertaken over coming years. This is our action plan which picks up on issues identified earlier in the document pp 40- 56
6. Current challenges in achieving this pp 57- 60
7. A summary of workforce concerns and plans pp 61-63
8. An overview of financial investment pp 64- 68
9. An update on data submissions to the national Mental Health Services Data Set (MHSDS) p 69
10. Governance p 72- 73
11. Need and activity pp 74- 81
Appendix 1 workforce data pp 81-85

PRIORITY 4	Reducing Deaths by Suicide				
What will be done – the task	**Who will do it**	**By when**	**Outcome – the difference it will make**	**Supporting national indicators**	**Progress Update - July 2018**
Identify local sponsors to oversee Reading's Suicide Prevention Action Plan	**Health & Wellbeing Board (Berkshire West Mental Health Strategy Group / Reading Mental Health Strategy Group)**	**February 2017**	**Reading actions to reduce deaths by suicide will be co-ordinated across agencies / There will be consistent local representation on the Berkshire Suicide Prevention Planning Group**		**Terms of Reference for Reading Mental Wellbeing Group includes oversight of Reading's Suicide Prevention Action Plan**
Develop a communication plan to raise awareness of Reading's Suicide Prevention Action Plan, including: **- the formal launch of the Berkshire Suicide Prevention Strategy** **- contributions to the**	**RBC Communications Team**	**April 2017**	**Individuals will have increased awareness of support available /** **Partners will know how to engage with and support the Reading Suicide Prevention Action Plan**		**Media Summit on responsible suicide reported held on 11.09.2017 to mark Suicide Prevention Day** **RBC signed Time to Change pledge on 06.10.2017.** **Berkshire Suicide Strategy formally launched on**

'Brighter Berkshire' Year of Mental Health 2017 **- marking World Suicide Prevention Day (10 September)**					**17.10.2017.** **Events were organised at five different Council sites to mark 'Time To Talk Day 2018' on 01.02.2018.** **25 members of staff across RBC teams and directorates have now signed up as Time to Change employee champions, and 10 champions received formal training from the Time To Change National Team on 27.04.2018.** **The Wellbeing Team in partnership with the Recovery College and Meadway Sports Centre organised multiple events to mark Mental Health Awareness Week (14-20 May 2018), including a dog friendly mental health walk, free yoga, bake off competition, fundraising for MIND and talks from an anorexia recovery speaker**

Target initiatives on groups at higher risk of death by suicide: **- Support the review of CALMzone and development of future commissioning plans for support services which target men** **- Review local DAAT contracts to ensure suicide prevention objectives are included** **- Develop post discharge support for people who have used mental health services via the Reading Recovery College**	**Wellbeing Team, RBC**	**October 2017** **April 2017** **Ongoing**	**Suicide risk will be mitigated for higher risk groups: men, people who abuse drugs or alcohol, people who have been in contact with mental health services**	**PHOF 4.10 – suicide rates**	**PHE has now been commissioned by Wokingham BC to progress this work** **Completed** **There were a total of 686 attendances on formal tuition sessions offered by the Reading Recovery College sessions in 2017-18 (a 23% increase on the 2016-17 figure). There were a further 1,188 attendances at informal sports, leisure ad social groups**

					linked to the College.
Tailor approaches to improve mental health in specific groups: - **Support delivery of the local 'Future in Mind' programme to improve mental health in children and young people** - **Recognise the mental health needs of survivors and links to suicide prevention in the implementation of the Reading Domestic Abuse Strategy** - **Raise awareness of support available to survivors of sexual abuse through Trust House Reading** - **Contribute to a Berkshire wide**	**Reading Mental Wellbeing Group as local sponsors (see above)**	**Ongoing** **ongoing** **ongoing**	**Mental health will be improved for some specific groups (children and young people, survivors of domestic or sexual abuse) through tailored approaches** **Future commissioning of community based**	**See Action Plan for Priority 3 for details in relation to children and young people.**	**- See Priority 3 update in relation to 'Future in Mind'** **- links established** **- Survivors Trust hosted a workshop at the Berkshire Suicide Strategy launch in October** **- A evaluation report is being**

review of targeted community based interventions, including suicide prevention and mental health first aid training			**interventions will be informed by a review of impact**		**prepared by a PHE Practitioner which will be shared with Berkshire suicide prevention group** **- Reading DAAT providers are aware of the Suicide Prevention Strategy and objectives. They attended a workshop delivered by BHFT in February 2018 with substance misuse professionals from Wokingham and Newbury.**
Analyse local data gathered from the suicide audit and/or real-time surveillance to identify trends and clusters and recommend appropriate action(s)	**Public Health Team, Wokingham**	**ongoing**	**Access to the means of suicide will be reduced where possible**		**Next audit deferred until after April 2018 so as to encompass a four year data period (based on date of inquest rather than date of death)**

Review pages on the Reading Services Guide to include national resources (e.g. 'Help is at Hand' and National Suicide Prevention Alliance resources) and signposting to local services **Map local bereavement support and access to specific support for bereavement through suicide**	**Wellbeing Team, RBC**	**June 2017**	**Those bereaved or affected by suicide will have access to better information and support**		**Reading Services Guide has been developed to include these additional resources.**
Ensure local media and communications staff are aware of Samaritans guidance on responsible suicide reporting **Support a Berkshire-wide Summit on journalism and reporting standards with local press and media organisations, to develop and agree standards for reporting.**	**Wellbeing Team, RBC**	**February 2017** **July 2017**	**Local media will be supported to report on suicide and suicidal behaviour in a sensitive manner**		**Media summit held on 11.09.2017, with information cascaded to those who were unable to attend**
Update Reading JSNA module on suicide and self-harm	**Wellbeing Team, RBC**	**tbc**	**Local and county-wide Suicide Prevention Action**		**A refreshed Suicide and Self Harm module of the Reading**

Refresh Reading Mental Health Needs Analysis	**Adults Commissioning Team, RBC**	**May 2016**	**will be informed by up to date research, data collection and monitoring**		**JSNA was published in March 2017. An update is due to be published by September 2018.** **Am updated Mental Health Needs Analysis is due to be published by September 2018.**

PRIORITY No 5	**Reducing the amount of alcohol people drink to safer levels**				
What will be done – the task	**Who will do it**	**By when**	**Outcome – the difference it will make**	**Supporting national indicators**	**Progress Update - July 2018**
Treatment					
Increase the number of people receiving support at the appropriate level to address risky, harmful and dependent use of alcohol. **Review current alcohol pathways to enable the specialist service to gain capacity to work with more risky, harmful and dependent drinkers.**	**All Partners required to support an alcohol pathway** **DAAT Contract Manager, CCG Leads, IRIS Reading Borough Manager, GP Lead**	**Ongoing**	**Lower level drinkers understand the risks to their drinking and prevent become more harmful/ hazardous drinkers.** **Other Stakeholders become a part of the alcohol pathway and understand their role in preventing people becoming harmful/ hazardous drinkers.**	**PHOF 2.15iii – Successful completion of alcohol treatment** **PHOF 2.18 – Admission episodes for alcohol-related conditions (narrow) (Persons, M and F)**	**Alcohol Pathway under review.**
Promote knowledge and	**All partners**	**Ongoing**		**PHOF 2.15iii –**	**NHS Health Check provides**

change behaviour by promoting understanding of the risks of using alcohol and by embedding screening and brief intervention in primary care, social care and criminal justice settings, housing and environmental health contacts.				**Successful completion of alcohol treatment** **PHOF 2.18 – Admission episodes for alcohol-related conditions (narrow) (Persons, M and F)**	**opportunistic conversation around alcohol use as Audit C is part of a check. Number of invites and health checks completed by GPs (providers) have declined from 2015/17 to 2016/17.** **Alcohol brief intervention training programme being drafted for the Summer**
Deliver IBA Training across all sectors – Need to encourage uptake of more Alcohol Champions	**CAP Lead and Source Team Manager**	**Ongoing**	**More individuals trained to deliver an intervention – Making every contact count approach to managing alcohol issues/ signposting**		**Ongoing**
CCG and Public Health to present a business case for an Alcohol Liaison Nurse to help reduce alcohol related admissions to hospital.	**Alcohol Mapping Group**	**April 2018**		**PHOF 2.18 – Admission episodes for alcohol-related conditions (narrow) (Persons, M and F)**	**A Business Case for Berkshire West has been prepared for presentation to the BW10 Delivery Group**
Need to gain authority for Peer Mentors to be on the (selective) Wards at RBH **Alcohol Peer mentors – to visit clients on hospital wards and assist in transition into community (including following detox).**	**IRIS Reading Borough Manager/ Peer mentors**	**April 2018**	**Peer mentors can advise patients on specialist community services and alcohol service available locally.** **To prevent re-admissions to hospital.**	**PHOF 2.18 – Admission episodes for alcohol-related conditions (narrow) (Persons, M and F)**	**Peer mentors are supporting patients on Sidmouth Ward at RBH from Qtr 1 2018/19**

GP Lead to promote IBA training in primary care. **Promotion of IBA training in secondary care**	**Dr. H George** **DAAT contract Manager**	**Ongoing**	**Primary and secondary care professionals have the skills to deliver IBA and knowledge to make appropriate referrals on discharge**	**PHOF 2.15iii – Successful completion of alcohol treatment** **PHOF 2.18 – Admission episodes for alcohol-related conditions (narrow) (Persons, M and F)**	**Ongoing – this has been to the South Reading GP council and a list of resources provided, and also included in GP newsletter.** **RBC Trading Standards has also run a course for local stakeholders.**
Monitor and review existing interventions and develop a robust multi agency model to reduce alcohol-related hospital admissions.	**All**	**Ongoing**		**PHOF 2.18 – Admission episodes for alcohol-related conditions (narrow) (Persons, M and F)**	**South Reading CCG has reviewed the alcohol pathway with IRIS, Reading Borough Council DAAT, BHFT, RBH inpatients and A&E. Service improvements from other CCGs have also been reviewed. A proposed model for a community alcohol nurse, initially developed and piloted by Brighton and Hove CCG, has been developed into a business case for funding.**
Alcohol CQUIN - preventing ill health caused by alcohol. RBH to identify and support inpatients who are increasing or higher risk drinkers	**RBH/ Public Health/ IRiS Reading/ CAP**	**June – Sept 2018**	**Reduction in alcohol admissions to hospital.**	**PHOF 2.18 – Admission episodes for alcohol-related conditions (narrow) (Persons, M and F)**	**Specialist drug and alcohol services and CAP lead to support RBH in training Trust staff in IBA and ensuring referral pathway into specialist treatment services is robust.**
Licensing					
A community free of alcohol related violence in homes and in public places,	**CAP Lead**	**Ongoing**	**Reduction in alcohol admissions to hospital.**	**PHOF 2.18 – Admission episodes for alcohol-related conditions**	**Street drinking initiative underway**

especially the town centre. **Create responsible markets for alcohol by using existing licensing powers to limit impact of alcohol use on problem areas and by promoting industry responsibility.** **Address alcohol-related anti-social behaviour in the town centre and manage the evening economy** **Address alcohol-related anti-social Neighbourhoods**			**Responsible drinking in public spaces.**	**(narrow) (Persons, M and F)**	
Review all extended new applications under the Licensing Act – Public Health review and consider all new applications. Make representations for anything that is of concern and attend Licensing Hearings, Performance review or Licence reviews. **Reading Festival - work with Festival Republic, the organisers of Reading Festival, in preparation for**	**Public Health/ Licensing** **CAP/ Licensing Team/ Public Health**	**Ongoing** **July- Aug 18**	**Control of licensed outlets and review of Reading's late night economy.**		**Ongoing** **Send out Newsletter before Reading Festival to all Retailer's in the area to remind them of their 4 Licensing objectives and laws around**

this year's event and consider how best to tackle the issue of alcohol (and illegal drug use)					**Underage drinking and proxy purchases.** **Test Purchasing on site at Reading Festival**
Licencing to promote responsible retailing, 4 Licensing objectives. **CAP to increase Test Purchasing – Challenge 25, Under 18.** **Training Log to be rolled out to all retailers.** **Retailer Training to commence.** **Encourage retailers to restrict**	**CAP / Licensing**	**Ongoing**	**Stricter licensing restrictions will be in place.** **There is a minimum price for a unit of alcohol as a mandatory condition of a License.**		**Commenced – CAP arranged joint retailer visits with licensing to complete the licensing surveys, licensing checks and Training log.** **Qtrly test purchasing of Challenge 25. CAP to do a 6 month trial of monthly test purchasing with PCSO in all hotspot area.** **Ongoing - Updated Retailer training offered after Test Purchasing. These will run more frequently with the increased of TP C25 being monthly. If this is popular will offer regular free quarterly training for all retailers.** **Map out those retailers that have agreed to this initiative**

the sale of higher ABV % cans					**and cross reference against ASB intelligence in those areas.**
Promotion of better marketing of soft/ mixer-diluted drinks in Bars and Pubs.	**CAP/ licensing**	**Ongoing**	**Promote healthier non-alcoholic options to customers**		**Competiton being launched as part of a Diversionary activity to design a Manga CAP Hero Character, across all schools in Reading. Once character designed, used this to promote the Soft drink messages in Universities/young people's bars.** **Attend Pubwatch to discuss ideas for future projects.**
Encourage neighbourhoods to report street drinking to the Police via NAG meetings	**All**	**Ongoing**	**Reduce street drinking and ASB**		**Ongoing. RSG to include a link for reporting alcohol issues.** **Promote CAP Role within the community to build relationships and encourage reporting.** **CAP work in Whitley within the WDCA Café -training members of staff re Proxy purchased, Challenge 25 and IBA training.** **Attending WDCA every other Monday morning to have a presence in the Café and speak to the community about**

					Alcohol awareness.
Education					
Parent education – **2018 Parents Survey 'Howmuchis enough' trialled with 250 parents to empower parents when making decisions about allowing their children to drink alcohol.**	**CAP lead**	**completed.**			**Collation of figures to inform future educational activities**
Education if for all ages. **Alcohol awareness sessions for all.** **Mini Police Project - a fun and interactive volunteering project for children in Years 5**	**CAP Lead**	**Ongoing**	**Educating everyone on the risks of alcohol and promote drinking responsibly.**		**Developed a Needs assessment and sent out to all Secondary schools with the CAP Young Peoples survey.; to be able to give Alcohol awareness sessions that fit the schools and pupils needs.** **CAP to offer joint IBA training sessions to Reading Services with Prospect Park Misuse Nurse.** **SCHOOL children at Katesgrove Primary School benefitted from alcohol awareness sessions (**

and 6. The aim is for children to work with neighbourhood police teams on local issues. The pupils will also spread the word among their school friends about the work they are involved in and gain awareness of a variety of issues. **CAP to expand on this and set up new project 'Young CAP Champions' to encourage YP to promote important messages about alcohol amongst their peers (Primary schools in Reading).** **MANGA Comic Project to encourage alcohol awareness.**					**age appropriate awareness of alcohol, including risks, health impacts and associated laws), as part of a 'Mini Police' project. Primary Schools being encouraged to sign up to this initiative.** **Summer weekly drop in at Library – arty activities for young people, in a bid to raise awareness of the dangers of alcohol consumption. It will enable young people to create their own manga style comic strip/story based around the theme of alcohol awareness. Drop in sessions will be held at Reading libraries over the summer – days and times to be confirmed**

Commence a Youth Health Champion role – encourage youngsters to be active in tackling alcohol and understanding the risks of drinking alcohol. **Work in partnership with Colleges and University to promote alcohol awareness to students** **Volunteers from the Specialist Treatment Service to visit school age children to educate them about the risks of alcohol and how their lives have been affected.**					**Ongoing – 2 qualified Youth Health Champions. 12 children are signed up and involved in the programme. Workshops to continue – Looking at a Wellbeing initiative. Further funding for 2018 being secured to roll out this programme.** **PSHE presentations are taking place. Peer Mentors are willing to visit schools and this is co-ordinated when required. Film being produced by CAP and IRiS Reading Peer mentors on risks of alcohol – to be shown in schools.**
Promote diversionary activities to all – via schools, colleges, website	**CAP Lead**	**Ongoing**	**Promote social activities and exercise as alternatives to drinking alcohol.** **Resolve the "boredom" and social issues associated with alcohol.**		**Ongoing** **Work with CAP and specialist drug and alcohol service to produce a flm on the risks of drugs and alcohol (see above).**
Prevention					
Promotion of Dry January campaign.	**CAP Lead, DAAT Contract & Project**	**December 2017 and January 2018**	**Encourage awareness of effects of alcohol on staff, clients and local**		**10th Jan 2018 – Massage session for RBC staff.**

Promotion of January alcohol detox via IRIS Reading as part of the Dry January campaign	**Manager, IRIS Reading IRIS Reading Borough Manager & RBC Press team**		**community.** **Promote drinking responsibly.**		**18th Jan – RBH staff welfare day (alcohol session)** **Campaign planning to commence Autumn 2018**
Explore with the street care team whether we can promote drinking responsibly at recycling depots.	**DAAT / Street Care Team**		**Encourage drinking responsibly and increase public awareness of the risks of alcohol**		**Action still needed.** **In light of Reading Festival, CAP to organise for Streetcare team to install Recycling bins at the Mothercare/Aldi site to reduce alcohol cans and bottles being discarded on the streets in this area.**
Work in partnership with RVA to promote Public Health messages through their newsletter	**Public Health Lead/ RVA**	**Ongoing**	**Encourage healthier lifestyles.**		**Ongoing**

PRIORITY NO 6	**Making Reading a place where people can live well with dementia**				
What will be done – the task	**Who will do it**	**By when**	**Outcome – the difference it will make**	**Supporting national indicators**	**Progress Update - July 2018**

Establish a Berkshire West Dementia Steering Group to implement the Prime Ministers Dementia 2020 challenge and ensure up-to-date local information about dementia can be reflected into dementia care services and that there is an opportunity to influence and inform local practice			**The Berkshire West Dementia Steering Group will report to the three Berkshire West Health and Wellbeing Boards as required from time to time, contributing updates and commentary on performance in relation to local dementia priorities and issues identified by those Boards. The Berkshire West Dementia Steering Group will also report to the Berkshire West Long Term Conditions Programme Board and will in addition keep the Thames Valley Commissioning Forum updated**		**The Berkshire West Dementia Steering Group is representative of local partners involved in dementia awareness and care. Quarterly meetings provide the opportunity to influence and inform local practice.**
Raise awareness on reducing the risk of onset and progression of dementia through building on and promoting the evidence base for dementia risk reduction	**Public Health (LAs), GPs, Schools**	**May 2017**	**By 2020 people at risk of dementia and their families/ carers will have a clear idea about why they are at risk, how they can best reduce their risk**	**PHOF 4.16 and NHS 2.6i– Estimated diagnosis rate for people with dementia** **PHOF 4.13 – Health**	**Reading DAA delivered 20 awareness raising sessions throughout 2017, including presentations at Older People's Day.**

(including education from early years/school age about the benefits of healthy lifestyle choices and their benefits in reducing the risk of vascular dementia) and health inequalities and enhancing the dementia component of the NHS Health Check.			**of dementia and have the knowledge and know-how to get the support they need.** **This will contribute towards the national ambition of reduced prevalence and incidence of dementia amongst 65-74 year olds, along with delaying the progression of dementia amongst those that have been diagnosed.**	**related quality of life for older people** **ASCOF 2F and NHS Outcomes Framework 2.6ii – effectiveness of post-diagnosis care in sustaining independence and improving quality of life for people with dementia.** **ASCOF 1B – People who use services who have control over their daily life** **NHS OF 2.1 - Proportion of people feeling supported to manage their condition**	**Dementia awareness is now included in the NHS Health Check programme for all patients. However, the number of NHS Health Checks completed in Reading for 2018/19 will potentially be impacteded by budgets set by RBC's Policy Committee in April 2018.**
Identify patients early including those from Black, Asian and Minority Ethnic origin and other seldom heard groups enabled	**Primary care, Social Care (LAs), Memory Clinics, Care homes**	**March 2018**	**More people diagnosed with dementia are supported to live well and manage their health**	**ASCOF 2F - a measure of the effectiveness of post-diagnosis care in sustaining independence and**	**'Top Ten Tips' pack launched to assist non-medical staff recognise dementia signs** **Care home assessments use**

through greater use by health professionals of diagnostic tools that are linguistically or culturally appropriate; encourage self-referral by reducing stigma, dispelling myths and educating about benefits of obtaining a timely diagnosis				**improving quality of life** **NHS OF 2.6ii - effectiveness of post-diagnosis care in sustaining independence for people with dementia**	**the Diagnosis of Advanced Dementia[1] [DiADeM] and General Practitioner Assessment of Cognition[2] [GPCOG] tools to identify missed cases of memory impairment.** **Ongoing community engagement, including work led by Alliance for Cohesion and Racial Equality** **Annual reports from the Memory Clinics enable the monitoring of progress.**
Play a leading role in the development and implementation of personalised care plans including specific support working in partnership with memory assessment services and care plan design and implementation.	**Primary Care/BWCCGs/BHFT**	**March, 2018**	**GPs ensuring everyone diagnosed with dementia has a personalised care plan that covers both health and care and includes their carer. This will enable people to say "I know that services are designed around me and my needs", and "I have personal choice and control or influence over**	**PHOF 4.13 - Health related quality of life for older people** **ASCOF 2F- a measure of the effectiveness of post-diagnosis care in sustaining independence and improving quality of life**	**Care Plans uploaded on DXS, easily accessed by GPs and practice staff.** **DCAs who are commissioned through the CCG's at the Alzheimer's Society complete a support plan for every service user. These are not yet directly accessible in primary care pending interoperability**

[1] DiADeM is a protocol developed by the Yorkshire and Humber Dementia Strategic Clinical Network aimed at supporting Gps to diagnose dementia for people living advanced dementia in a care home setting. See https://dementiapartnerships.com/resource/diadem-diagnosis-of-advanced-dementia-mandate-in-care-homes/ for further information.
[2] GPCOG is an instrument to screen for dementia specifically in primary care settings. For more information about CPCOG please visit http://gpcog.com.au/index/more-about-the-gpcog

			decisions about me"	**NHS OF 2.6ii - effectiveness of post-diagnosis care in sustaining independence for people with dementia** **ASCOF 1B - People who use services who have control over their daily life** **NHS OF 2.1 - Proportion of people feeling supported to manage their condition**	**solution.** **Personalised care plans for use in GP practices are being developed by TVSCN.**
Ensure coordination and continuity of care for people with dementia, as part of the existing commitment that everyone will have access to a named GP with overall responsibility and oversight for their care.	**BWCCGs**	**March, 2018**	**Everyone diagnosed with dementia has a named GP as well as a personalised care plan that covers both health and care and includes their carer.**	**PHOF 4.13- Health related quality of life for older people** **ASCOF 2F- a measure of the effectiveness of post-diagnosis care in sustaining independence and improving quality of**	**Every diagnosed dementia patient has a named GP – now a requirement.** **DCA service support in this with a robust referral route from GP.**

				life **NHS OF 2.6ii - effectiveness of post-diagnosis care in sustaining independence and improving quality of life for people with dementia.** **ASCOF 1B - People who use services who have control over their daily life** **NHS OF 2.1- Proportion of people feeling supported to manage their condition**	
Provide high quality post-diagnosis care and support, which covers other co-morbidities and increasing frailty.	**Primary care/ Memory Clinics/ Social Care (LAs),**	**Ongoing**	**Reduced: unplanned hospital admission, unnecessary prolonged length of stay, long-term residential care**	**ASCOF 1B - People who use services who have control over their daily life** **NHS OF 2.1- Proportion of people feeling supported to**	**Initial referrals are to the Memory Clinic, accredited with MSNAP.** **Dementia Care Advisors employed by the Alzheimers Society are commissioned to provide support to a Pathway**

				manage their condition	**devised by the Thames Valley Clincal Strategic Network.** **BHFT, RBH and GP practices all have programmes to increase staff awareness of and responsiveness to dementia.** **RBC commissioned care services are required to meet minimum training standards.**
Target and promote support and training to all GP practices, with the aim of achieving 80% Dementia Friendly practice access to our population	**BW CCGs project Lead/ DAA co-ordinators**	**March, 2018**	**80% of practices in Berkshire West will have adopted the iSPACE and sign up to the Dementia Action Alliance to become dementia-friendly.**	**PHOF 4.16 - Estimated diagnosis rate for people with dementia** **NHS 2.6ii- effectiveness of post-diagnosis care in sustaining independence and improving quality of life for people with dementia** **PHOF 4.13 – Health related quality of life for older people**	**Tier 1 training has been offered to all Practice staff across South Reading and North & West Reading CCGs. All practices in Reading have put plans in place to become dementia friendly.** **Training is under development specifically focused on GP practices which will encourage participation. All practices are encouraged to have a Dementia Champion to facilitate. This will be further assessed using the iSPACE**

					model and supported by the Dementia Action Alliance.
Work with local organisations, care homes and hospitals to support more providers to achieve Dementia Friendly status	**DAA/ LAs/ Alzheimers society/BHFT**	**Ongoing - reviewed in December 2017, 2018 and 2019**	**More services will be staffed or managed by people with an understanding of dementia and the skills to make practical changes to make their service more accessible to those with dementia**	**PHOF 4.16 - Estimated diagnosis rate for people with dementia** **NHS 2.6ii - effectiveness of post-diagnosis care in sustaining independence and improving quality of life for people with dementia** **PHOF 4.13 – Health related quality of life for older people**	**7 new members have joined the Reading DAA and completed local action plans, including John Lewis Partnership, Launchpad, Reading libraries, Get Berkshire Active, Salvation Army.** **Up until 31st May 2018:** **- 1,148 people in the Reading have completed online Dementia Friends training.** **- 272 Dementia Friends sessions have been delivered in Reading.** **- 5,530 people in the Reading area have become a Dementia Friend following a session** **All of these figures are in excess of targets.**

Maximise the use of Dementia Care Advisors & training opportunities & roll out a training package/train the trainer model for NHS & Social Care staff and other frontline workers	**BWCCGs/Alzheimers Society/ HEE/BHFT**	**March, 2018**	**People with dementia and their carers will be supported by health and care staff in all types of service that will have the appropriate level of dementia awareness and training.**	**NHS OF 2.1- Proportion of people feeling supported to manage their condition**	**All DCAs are trained in Tier 1 dementia training.** **Plans for Tier 2 are underway through the TVSCN, and need identified for a rolling Tier 1 programme led by champions who have undertaken Train the Trainer.** **RBH has a Dementia Champions programme.** **BHFT have achieved their target of training 80% of staff in dementia awareness**
Ensure commissioned services contractually specify the minimum standards of training required for providers who care for people with dementia including residential, nursing and domiciliary care settings.	**Local authority and NHS commissioning teams**	**March, 2018**	**People with dementia and their carers will be supported by health and care staff in all types of service that will have the appropriate level of dementia awareness and training.**	**NHS OF 2.1- Proportion of people feeling supported to manage their condition**	**RBC commissioned services contractually specify minimum standards of training required for providers who care for people with dementia in residential, nursing and domiciliary care settings. Providers are expected to have in place a learning and development framework for staff to ensure a skilled workforce is available to meet the diverse needs of**

					the individuals who access their service. Dementia awareness is currently desirable training for support staff. All providers carrying out registered activities in Reading are inspected by the Care Quality Commission. Reading Borough Council's Quality and Performance Monitoring Team in Adult Care and Health Services also monitor local services.
Review benchmarking data, local JSNA , variation, & other models of Dementia Care to propose a new pathway for Dementia Diagnosis/Management.	**BWCCGs/ Public Health/BHFT – not clear who leads on what here**	**March, 2017**	**National dementia diagnosis rate maintained at two-thirds prevalence, and reduced local variation between CCGs following agreement and implementation of an appropriate and affordable plan to bring services into line within the national framework for treatment and care.**	**PHOF 4.16 - Estimated diagnosis rate for people with dementia** **NHS 2.6ii - effectiveness of post-diagnosis care in sustaining independence and improving quality of life for people with dementia**	**ACS Outpatient workstream is currently reviewing the memory service pathway against vanguard/best practice examples and this will be used to inform the JSNA. Ethical pathway will be linked to a national MCI pathway currently being developed through the TVSCN.**

Identify & map opportunities, learning from similar and neighbouring CCGs, Providers and Local Authorities, for future service delivery to meet the 2020 Challenge. e.g. annual assessment, shared care, carer identification & support	**BWCCGs/ BHFT**	**April, 2017**	**Diagnosis rate maintained at two-thirds prevalence, and reduced local variation between CCGs following agreement and implementation of an appropriate and affordable plan to bring services into line within the national framework for treatment and care**	**PHOF 4.16 - Estimated diagnosis rate for people with dementia** **NHS 2.6ii - effectiveness of post-diagnosis care in sustaining independence and improving quality of life for people with dementia**	**The Berkshire West Steering Group meets quarterly and brings together key health, social care, community and voluntary sector partners to share progress and identify opportunities for learning.** **A webinar and checklist is under development specifically focused on GP practices to improve identification, coding and raising awareness of dementia in primary care.**
Raise awareness of and ensure that at least 80% of people with dementia and their carers have a right to a social care assessment.	**LAs/ Memory Clinics/ Primary Care/ CMHT/ DCAs**	**March, 2018**	**At least, 80% of people with dementia and their carers are able to access quality dementia care and support.**	**PHOF 4.13– Health related quality of life for older people** **ASCOF 2F- a measure of the effectiveness of post-diagnosis care in sustaining independence and improving quality of life**	**Action update:** **Anyone with the appearance of care or support needs is entitled to a social care assessment. The local priority is to raise awareness of this statutory right and the national eligibility criteria.**

				NHS OF 2.6ii - effectiveness of post-diagnosis care in sustaining independence and improving quality of life for people with dementia **ASCOF 1B- People who use services who have control over their daily life** **NHS OF 2.1- Proportion of people feeling supported to manage their condition**	
Provide opportunities for people with dementia and their carers to get involved in research through signposting them to register with joint dementia research (JDR)	**BHFT/Alzheimers Society /LA/BWCCGs/ University of Reading**	**March, 2018**	**More people being offered and taking up the opportunity to participate in research and to support the target that 10% of people diagnosed with dementia are registered on JDR by**		**Several Memory Clinics are installing Joint Dementia Research (JDR) kiosks which enable people with dementia and/or their carers to register.** **BHFT Research Team also provide information about**

			2020. Future treatment and services to be based on and informed by the experiences of people living with dementia		**JDR and how to join.** **In addition to JDR, patients and carers attending memory clinics are routinely asked about participation in research.**
Enable people to have access to high quality, relevant and appropriate information and advice, and access to independent financial advice and advocacy, which will enable access to high quality services at an early stage to aid independence for as long as possible.	**BHFT/LAs**	**March, 2018**	**People with dementia and their carers are able to access quality dementia care and support, enabling them to say "I have support that helps me live my life", "I know that services are designed around me and my needs", and "I have personal choice and control or influence over decisions about me"**		**DAA partners include local information and advice hubs and solicitors who specifically provide independent advice and advocacy. These partners support the larger community events to raise awareness of this information. This has also been fed into the local Dementia Friends sessions.** **The Berkshire Dementia handbook for Carers is offered to the main carer of all who are newly diagnosed. Carers are also offered a place on the 6 session Understanding Dementia Course for Carers.** **PWD and Carers are all**

					advised that they can contact the Memory Clinic for advice/information.
Evaluate the content and effectiveness of dementia friends and dementia friendly communities' programme.	**AS/DAA/UoR**	**March, 2018**	**More research outputs on care and services.**		**This is led by the Alzheimers Society nationally.**

PRIORITY NO 7	**Increasing take up of breast and bowel screening and prevention services**				
What will be done – the task	**Who will do it**	**By when**	**Outcome – the difference it will make**	**Supporting national indicators**	**Progress Update July 2018**
Identify Practices where screening uptake is low and target initiatives and practice support visits to increase uptake.	**NHSE/PHE Screening Team** **Cancer Research UK Facilitator**		**Improved Screening Coverage and detection of cancers in early stages.**	**PHOF 2.19 Cancer Diagnosed at early stage** **2.20iii Cancer Screening coverage-bowel cancer** **2.20i Cancer screening**	**Teachable moment pilot project for South Reading rolled out from August 2017 (see below). Pilot ended in January after implementation by only two practices. Lack of time, workload constraints and**

				coverage- breast cancer **4.05i Under 75 mortality rate from cancer (persons)** **4.05ii Under 75 mortality rate from cancer considered preventable (persons)**	**capacity of the team to support the implementation were seen as barriers.** **Tailored GP Surgery bowel screening letters are now sent to patients from the Hub.** **The Cancer Research UK Facilitator has offered to visit all South Reading practices to improve cancer screening uptake**
To work in partnership with key stakeholders to increase public /patient awareness of signs and symptoms and screening programmes	**Public Health Berkshire** **Macmillan**		**Patients seek advice and support early from their GP** **Increase uptake of screening programmes**		**Local authority is supporting the promotion and engagement of Macmillan Cancer Education Project, led by Rushmoor Healthy Living with funding from Macmillan Cancer Support.** **Macmillan Cancer Educator has been appointed to raise awareness of the signs and symptoms of cancer among hard to reach groups in South Reading,**

					Over 30 people from the community have signed up to become cancer champions. A number of community events and meetings have been held. **Macmillan Cancer Champion training have been organised for volunteers from different community groups. These champions will now organise cancer awareness sessions for their community groups** **CRUK bowel screening promotional video has been shared through local authority web pages.** **Wellbeing team has been promoting various cancer awareness campaigns including PHE's Be Clear on cancer: Breast Cancer in women over 70 by sharing key messages via local authority webpages digital media and during community events** **Wellbeing team in partnership**

					with CCG promoted bowel screening among Southcote over 50s group. Participants completed questionnaires around bowel cancer screening and they were provided information on using the test kit
To plan and implement a pilot project that provides motivational behaviour change interventions to patients who have had a 2WW referral and a negative result ("teachable moments")	**Public Health Berkshire** **Cancer Research UK Facilitator**		**Patients motivated to make significant changes to lifestyle behaviours that will help to reduce their risk of developing cancer**		**See above – take up too low for a formal evaluation**

PRIORITY NO 8	**Reducing the number of people with tuberculosis**				
What will be done – the task	**Who will do it**	**By when**	**Outcome – the difference it will make**	**Supporting national indicators**	**Progress Update - July 2018**

Offer training in Reading for health professionals , community leaders and other professionals who come in contact with at risk population	**FHFT & RBH TB service /South Reading CCG**	**Jan-17**	**Increase awareness about TB amongst local health and social care professionals as well as third sector organisations**	**PHOF 3.05ii - Incidence of TB (three year average)**	**Workshops were held for health professionals and for RBC staff during March 2017. Sessions have also been delivered to other groups by the New Entrant Screening Nurse / TB nurse team from RBH.** **A dedicated TB project manager has been appointed to South Reading CCG using with funding from NHS England to work with clinicians and the TB operational group to support delivery of the LTBI New Entrant Screening Service, this includes scoping a suitable training programme.**
Develop resources / training materials for wide range of LA staff to enable them to discuss TB and signpost to local services	**Berkshire shared PH team / TB Alert**		**Increase awareness about TB amongst local authority staff working with those at increased risk of TB**	**PHOF 3.05ii - Incidence of TB (three year average)**	**A workshop was held on 05.12.2017 with clinical representation from Slough and Reading along with local stakeholders and representatives from NHS England and Public Health England. The groups worked through how to reduce the DNA rate, how to improve community engagement and data reporting. The outputs of this will form an action plan for**

					the next 12 months.
Develop and run a joint public-facing communications / social marketing campaign to raise awareness of TB, latent TB and the local New Entrant Screening Service in order to reduce stigma and encourage those invited for LTBI screening to attend	**Berkshire shared PH team / CCG comms / NESS nurses**	**March 2017**	**Address social and economic risk factors related to TB**	**PHOF 3.05ii - Incidence of TB (three year average)**	**Work to develop campaign materials was initially co-ordinated by a cross Berkshire working group. Responsibility for further communication and engagement is now with the LTBI Operational Group, with oversight from Berkshire TB Strategy Group.** **Reading Wellbeing team organised 2 TB awareness sessions for the Nepalese & Pakistani community in partnership with Healthwatch Reading and SRCCG** **- 40 participants and 32 surveys filled in total including both sessions** **TB information stands organised during four local events to raise awareness on LTBI screening services** **– Health & Wellbeing Week targeting staffs at RBH (**

					08.09.2017 Sep); **- Compass Recovery College Prospectus Launch event (16.08.2017);** **- New Directions event (16.09.2017)** **- Older People's Day event (09.10.2017)**
Include TB data and service information in JSNA	**Reading Wellbeing team**	**February 2017**	**Address social and economic risk factors related to TB**	**PHOF 3.05ii - Incidence of TB (three year average)**	**Key information on active and latent TB and a map of high risk countries has been made available on the Reading Services Guide and JSNA profile to facilitate public access to TB information.** **TB data will be refreshed in 2018 as part of the JNSA rolling update schedule.**
Provide service users with a means to feed into service design discussions	**PH / TB Teams**	**Ongoing**	**Future treatment and services are based on and informed by the experiences of people living with TB** **Repeat service user survey annually**	**PHOF 3.05ii - Incidence of TB (three year average)**	**The TB team utilises the Friends and Family test**

Continue to work closely with PHE health protection colleagues to ensure robust and effective contact tracing takes place as standard	**TB Nurses / Berkshire TB Strategy Group**		**Contract tracing is monitored through the Thames Valley TB Cohort Review**	**PHOF 3.05ii - Incidence of TB (three year average)**	**Public Health England is routinely notified of cases of Tuberculosis (TB) and implements public health actions to prevent and control onward transmission, including identification of close contacts of active TB cases and offer of appropriate TB testing. Eight cases of TB infection that were notified to the Thames Valley Health Protection Team over the previous two years have been found to be linked by genetic testing. Further genetic testing of all cases is being undertaken using an alternative technique that can provide higher discriminatory power. Investigation is ongoing to further explore any links.**
Maintain robust systems for providers to record and report BCG uptake	**NHS England**		**Monitor provision and uptake of BCG vaccination as new policies are implemented**	**PHOF 3.05ii - Incidence of TB (three year average)** **Local indicator on BCG update could be developed in**	**A risk-based strategy to offer BCG to infants at increased risks of TB (based on National Guidance) has been adopted by RBH Maternity Services and is supported by the Berkshire TB Strategy Group**

				partnership with NHSE	
Develop / maintain robust systems for providers to record and report uptake and to re-call parents	Midwifery teams in FHFT and RBH	January 2017	Ensure registers of eligible infants who have missed vaccination due to shortages are kept to up to date and a mechanism exists to re-call when vaccine is available	PHOF 3.05ii - Incidence of TB (three year average)	Catch up campaign was successful. BCG vaccine is no longer in short supply.
Continue to communicate clearly on BCG shortage and ordering arrangements to allow planning	NHS England	Ongoing	Vaccinating teams have timely information on which to base decisions	PHOF 3.05ii - Incidence of TB (three year average)	BCG vaccine is no longer in short supply. See above
Ensure processes are in place to identify eligible babies, even in low-incidence areas	Midwifery teams in FHFT and RBH	Ongoing	Midwifery Teams use agreed service specification to identify eligible babies	PHOF 3.05ii - Incidence of TB (three year average)	A risk-based strategy to offer BCG to infants at increased risks of TB (based on National Guidance) has been adopted by RBH Maternity Services and is supported by the Berkshire TB Strategy Group.
Tackle the clinical and social risk factors associated with development of drug resistance in under-served populations by maintaining	Reading Wellbeing Team / Reading Reading Housing Team /	Jan-17	Work to develop the provision of appropriate and accessible information and support to under-served and high-risk	PHOF 3.05ii - Incidence of TB (three year average)	Reading Healthwatch has conducted a Knowledge and Behaviours Survey. Over 300 people have taken part indicating their views and knowledge towards TB. The

high treatment completion rates and ensuring thorough contact tracing around MDR cases	**NESS nurses/CCGs**		**populations.**		**results of this will provide a baseline to measure impact of communication and engagement work.** **This information will also be used to further shape engagement with under-served and other at-risk groups** **Resources shared with providers including IRIS**
Ensure patients on TB treatment have suitable accommodation	**Reading Wellbeing Team / Reading** **Reading Housing Team / NESS nurses/CCGs**		**Development of robust discharge protocol**	**PHOF 3.05ii – Treatment completion for TB**	**PHE have developed Thames Valley guidance to inform the process for assessment and discharge of homeless TB patients - both with and without recourse to public funds.** **This guidance has been used to inform process across the Berkshire LAs during 2017, demonstrating it is fit for purpose.** **Work is in progress to develop an MOU between the CCGs and local authorities across Berkshire West to ensure provision of accommodation to**

					homeless TB patients with no recourse to public funds
Develop and promote referral pathways from non-NHS providers	**LA public health / NESS nurses/CCGs**		**Align local service provision to these groups as per NICE recommendations**	**PHOF 3.05ii - Incidence of TB (three year average)**	**Work with under-served groups is a priority for CCG LTBI Project Manager and LA PH team in 2018** **LA public health team co-ordinated this year's Reading event to mark the 'Light up the World for TB ' awareness-raising on 24.03.2018. Christchurch Pedestrian Bridge was lit up in Red to highlight the issue of TB in Reading and raise awareness in the fight against TB and the event was attended by Cllr Graeme Hoskin , Reading's Lead Councillor for Health, Wellbeing Team, representatives from the CCGs and TB teams from RBH** **TB information stands were organised at Central and Battle library where members of the public were given TB related information and information on New Entrant screening services.**

					World TB Day was promoted by the local authority via web pages and digital media. **A TB awareness session was organised for the Nepalese community in partnership with the charity Communicare** **Wellbeing Team has developed links with different community groups to identify TB Champions who could raise awareness of TB and NESS within their groups**
Engagement with SE TB Control Board to share best practice	**DPH / PHE CCDC**		**Work to decrease the incidence of TB in Berkshire through investigating how co-ordinated, local latent TB screening processes can be improved**	**PHOF 3.05ii - Incidence of TB (three year average)**	**The SE TB Control Board held a workshop in Reading in November 2017 to review its objectives for 2018.** **There are 2 face to face board meetings a year, and 2 TB network lead meetings to share work streams.** **There is a public facing website with links to general information, and a TB nurse forum**

Fully implement EMIS and Vision templates in all practices in South Reading	**South Reading CCG**	**Ongoing**	**Ensure that new entrants are referred routinely to local services for screening through addressing issues with local pathways**	**PHOF 3.05ii - Incidence of TB (three year average)**	**Templates installed in all practices. Majority of 16 South Reading practices are returning monthly lists to NESS. 199 patients were screened from April-November 2017 compared with 55 in the previous year.** **DNA rates are still higher than ideal, work is ongoing to identify and address barriers.**

Priority	Indicator	Target Met/Not Met	Direction of Travel
1. Supporting people to make healthy lifestyle choices	2.12 Excess weight in adults	Met	Better
	2.13i % of adults physically active	Met	Better
	2.06i % 4-5 year olds classified as overweight/obese	Not Met	Worse
	2.06ii % 10-11 year olds classified as overweight/obese	Met	Better
	2.03 Smoking status at the time of delivery	Met	Better
	2.14 Smoking prevalence - all adults - current smokers	Met	Better
	2.14 Smoking prevalance - routine and manual - current smokers	Met	Better
	2.22iii Cumulative % of those aged 40-74 offered a healthcheck 2013-2018	Not Met	No change
	2.22 iv Cumulative % of those offered a healthcheck who received a healthcheck 2013-2018	Not Met	No change
	2.22 v Cumulative % of those aged 40-74 who received a healthcheck 2013-2018	Not Met	No change
2. Reducing loneliness and social isolation	1.18i/1l % of adult social care users with as much social contact as they would like	Not Met	Better
	1.18ii/1l % of adult carers with as much social contact as they would like	Not Met	No change
	Placeholder - Loneliness and Social Isolation	*NA*	*NA*
3.Reducing the amount of alcohol people drink to safer levels	2.15iii Successful treatment of alcohol treatment	Not Met	Worse
	2.18 Admission episodes for alcohol related conditions (DSR per 100,000)	Not Met	Worse
4.Promoting positive mental health and wellbeing in children and young people	Pupils with social, emotional and mental health needs (primary school age)	Met	No change
	Pupils with social, emotional and mental health needs (secondary school age)	Met	Worse
	Pupils with social, emotional and mental health needs (all school age)	Met	No change
5.Living well with dementia	4.16/2.6i Estimated diagnosis rate for people with dementia	Not Met	No change
	No. Dementia Friends (Local Indicator)	Met	Better
	Placeholder - ASCOF measure of post-diagnosis care	*NA*	*NA*
6.Increasing take up of breast and bowel screening and prevention services	2.20iii Cancer screening coverage - bowel cancer	Met	No change
	2.20i Cancer screening coverage - breast cancer	Met	No change
7.Reducing the number of people with tuberculosis	3.05ii Incidence of TB (three year average)	Met	Better
8. Reducing deaths by suicide	4.10 Age-standardised mortality rate from suicide and injury of undetermined intent	Not met	Better

PRIORITY 1: Supporting people to make healthy lifestyle choices

Indicator Title	Framework	Source	Frequency updated	Good performance low/high	Most recent reporting period	Most recent performance	Target	Met/Not Met	DOT	England Average	2015 Deprivation Decile Average
2.12 Excess weight in adults	Public Health Outcomes Framework	Active People Survey	Annual	Low	2015-16	59.2	63.4	Met	Better	61.3	61.8
2.13i % of adults physically active	Public Health Outcomes Framework	Active Lives Survey	Annual	High	2016-17	68.7	64	Met	Better	66.0	67.2
2.06i % 4-5 year olds classified as overweight/obese	Public Health Outcomes Framework	National Child Measurement Programme	Annual	Low	2016-17	22.9	22.0	Not Met	Worse	22.6	22.6
2.06ii % 10-11 year olds classified as overweight/obese	Public Health Outcomes Framework	National Child Measurement Programme	Annual	Low	2016-17	32.9	36	Met	Better	34.2	32.6
2.03 Smoking status at the time of delivery	Public Health Outcomes Framework	Smoking Status At Time of Delivery (SSATOD) HSCIC	Annual	Low	2016-17	6.8	8.0	Met	Better	10.7	12.0
2.14 Smoking prevalence all adults	Public Health Outcomes Framework	Annual Population Survey	Annual	Low	2016	13.6	14.8	Met	Better	14.9	13.2
2.14 Smoking prevalance - routine and manual - current smokers	Public Health Outcomes Framework	Annual Population Survey	Annual	Low	2016	27.6	28.9	Met	Better	25.7	23.7
2.22iii Cumulative % of those aged 40-74 offered a healthcheck 2013-2018	Public Health Outcomes Framework	www.healthcheck.nhs.uk	Annual	High	2013-2018 Q4	72.4	100%	Not Met	No change	90.9	Not available
2.22 iv Cumulative % of those offered a healthcheck who received a healthcheck 2013-2018	Public Health Outcomes Framework	www.healthcheck.nhs.uk	Annual	High	2013-2018 Q4	48.1	50%	Not Met	No change	44.3	Not available
2.22 v Cumulative % of those aged 40-74 who received a healthcheck 2013-2018	Public Health Outcomes Framework	www.healthcheck.nhs.uk	Annual	High	2013-2018 Q4	34.8	50%	Not Met	No change	48.7	Not available

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PRIORITY 2: Supporting people to make healthy lifestyle choices

Indicator Title	Framework	Source	Frequency updated	Good performance low/high	Most recent reporting period	Most recent performance	Target	Met/Not Met	DOT	England Average	2015 Deprivation Decile Average
1.18i/1I % of adult social care users with as much social contact as they would like	Public Health Outcomes Framework/Adult Social Care Outcomes Framework	Adult Social Care Survey - England	Annual	High	2016-17	45.2	45.4	Not Met	Better	45.4	NA
1.18ii/1I % of adult carers with as much social contact as they would like	Public Health Outcomes Framework/Adult Social Care Outcomes Framework	Carers Survey	Bi-Annual	High	2016-17	36.2	38.5	Not Met	No change	35.5	32.4
Placeholder - Loneliness and Social Isolation	NA	TBC	Annual							NA	NA

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

Indicator Title	Framework	Source	Frequency updated	Good performance low/high	Most recent reporting period	Most recent performance	Target	Met/Not Met	DOT	England Average	2015 Deprivation Decile Average
2.15iii Successful treatment of alcohol treatment	Public Health Outcomes Framework	National Drug Treatment Monitoring System	Quarterly	High	Q4 2017/18	37.8%	38.3%	Not Met	Worse	38.6%	Not available
2.18 Admission episodes for alcohol related conditions (DSR per 100,000)	Public Health Outcomes Framework	Local Alcohol Profiles for England (based on HSCIC HES)	Annual	Low	2016/17	602	599	Not Met	Worse	636	602

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

Indicator Title	Framework	Source and frequency updated	Good performance low/high	Most recent reporting period	Most recent performance	Target	Met/Not Met	DOT	England Average	2015 Deprivation Decile Average
Pupils with social, emotional and mental health needs (primary school age)	Children and Young People's Mental Health and Wellbeing	DFE Special Needs Education Statistics	Low	2017	2.3%	2.3%	Met	No change	2.1%	2.0%
Pupils with social, emotional and mental health needs (secondary school age)	Children and Young People's Mental Health and Wellbeing	DFE Special Needs Education Statistics	Low	2017	3.3%	3.3%	Met	Worse	2.4%	2.0%
Pupils with social, emotional and mental health needs (all school age)	Children and Young People's Mental Health and Wellbeing	DFE Special Needs Education Statistics	Low	2017	3.0%	3.0%	Met	No change	2.3%	2.1%

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Priority 5: Living well with dementia

Indicator Title	Framework	Source	Frequency updated	Good performance low/high	Most recent reporting period	Most recent performance	Target	Met/Not Met	DOT	England Average	2015 Deprivation Decile Average
4.16/2.6i Estimated diagnosis rate for people with dementia	Public Health Outcomes Framework/NHS Outcomes Framework	NHS Digital	Annual	High	2017	67.5	67.7	Not Met	No change	67.3	66.2
No. of Dementia friends	NA (Local only)	Local Report	Quarterly	High	Reported locally	5800	4500	Met	Better	Not available	Not available

PLACEHOLDER - Post diagnosis care

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

Indicator Title	Framework	Source	Frequency updated	Good performance low/high	Most recent reporting period	Most recent performance	Target	Met/Not Met	DOT	England Average	2015 Deprivation Decile Average
2.20iii Cancer screening coverage - bowel cancer	Public Health Outcomes Framework	Health and Social Care Inform	Annual	High	2017	56.5	52%	Met	No change	58.8	60.6
2.20i Cancer screening coverage - breast cancer	Public Health Outcomes Framework	Health and Social Care Information Centre (HSCIC)	Annual	High	2017	72.9	70%	Met	No change	75.4	77.6

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Priority 7: Reducing the number of people with tuberculosis

Indicator Title	Framework	Source	Frequency updated	Good performance low/high	Most recent reporting period	Most recent performance	Target	Met/Not Met	DOT	England Average	2015 Deprivation Decile Average
3.05ii Incidence of TB (three year average)	Public Health Outcomes Framework	Public Health	Annual	Low	2014-2016	26.4	30	Met	Better	10.9	7.1

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Priority 8: Reducing deaths by suicide

Indicator Title	Framework	Source	Frequency updated	Good performance low/high	Most recent reporting period	Most recent performance	Target	Met/Not Met	DOT	England Average	2015 Deprivation Decile Average
4.10 Age-standardised mortality rate from suicide and injury of undetermined intent	Public Health Outcomes Framework	Health England (based on	Annual	Low	2014-16	9.9	8.25	Not met	Better	9.9	10.2

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Indicator number	**2.12**
Outcomes Framework	**Public Health Outcomes Framework**
Indicator full name	**Excess weight in adults**
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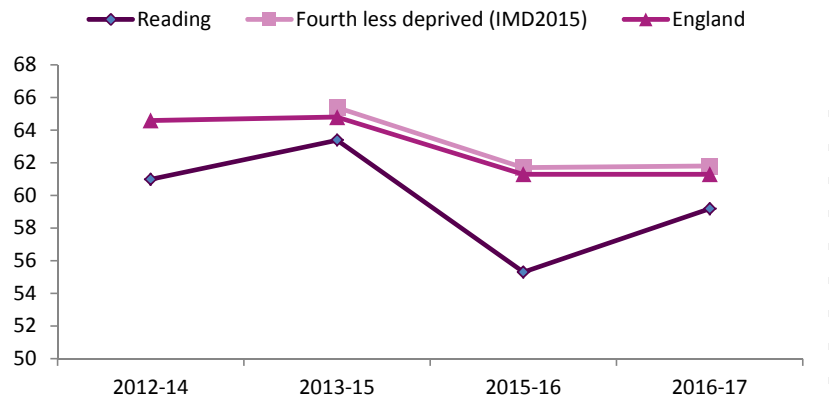
Data source	Active Lives Survey (previously Active People Survey) Sport England
	* Note change in methodology in 2015-16
Denominator	Number of adults with valid height and weight recorded. Active lives Survey. Historical (before 2015-16) Number of adults with valid height and weight recorded. Data are from APS year 1, quarter 2 to APS year 3, quarter 1
Numerator	Number of adults with a BMI classified as overweight (including obese), calculated from the adjusted height and weight variables. Active Lives Survey. Previously (before 2015-16) from Active People survey. Adults are defined as overweight (including obese) if their body mass index (BMI) is greater than or equal to 25kg/m2.

Period	Reading	Fourth less deprived (IMD2015)	England
2012-14	61		64.6
2013-15	63.4	*65.4*	64.8
2015-16	55.3	*61.7*	61.3
2016-17	59.2	*61.8*	61.3



Indicator number	**2.13**
Outcomes Framework	**Public Health Outcomes Framework**
Indicator full name	**% Physically Active Adults**
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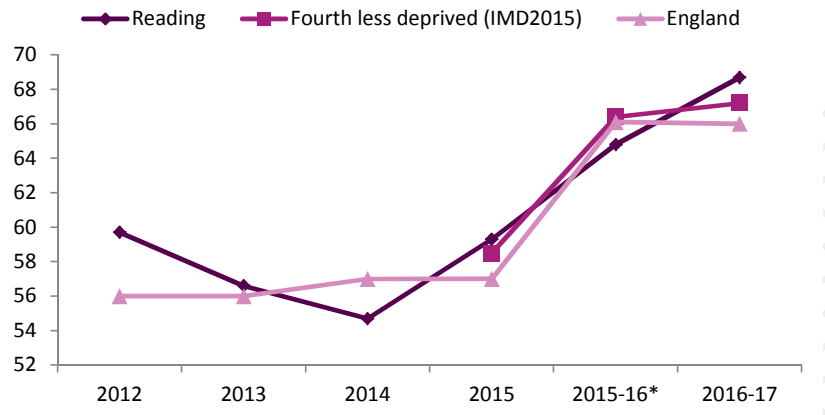
Data source	Until 2015 - Active People Survey, Sport England
	2015-16 onwards - Active Lives, Sport England
	* Note change in methodology in 2015-16
Denominator	Weighted number of respondents aged 19 and older with valid responses to questions on physical activity
Numerator	Weighted number of respondents aged 19 and over, with valid responses to questions on physical activity, doing at least 150 MIE minutes physical activity per week in bouts of 10 minutes or more in the previous 28 days.

Period	Reading	Lower CI	Upper CI	Fourth less deprived (IMD2015)	England
2012	59.7	55.3	64.2		56
2013	56.6	52.3	60.8		56
2014	54.7	50.4	58.9		57
2015	59.3	55	63.6	*58.5*	57
2015-16*	64.8	61.7	67.7	*66.4*	66.1
2016-17	68.7	65.8	71.5	*67.2*	66



Indicator number	**2.06i**
Outcomes Framework	**Public Health Outcomes Framework**
Indicator full name	**Child excess weight in 4-5 year olds**

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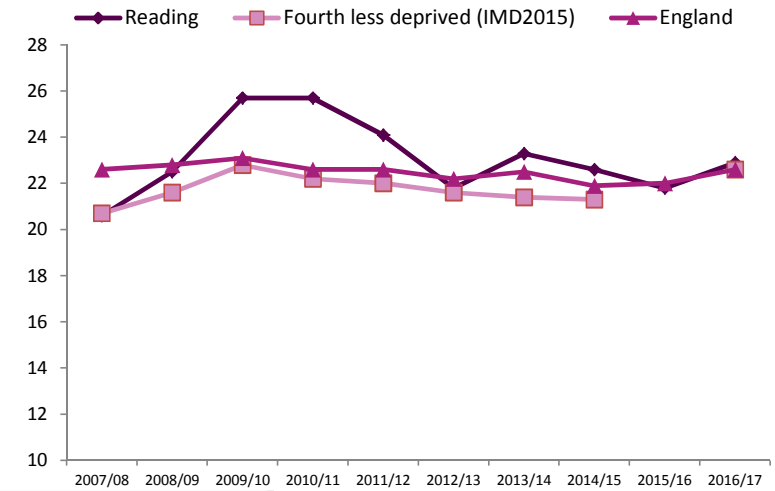
Data source	National Child Measurement Programme
Denominator	Number of children in Reception (aged 4-5 years) measured in the National Child Measurement Programme (NCMP) attending participating state maintained schools in England.
Numerator	Number of children in Reception (aged 4-5 years) classified as overweight or obese in the academic year. Children are classified as overweight (including obese) if their BMI is on or above the 85th centile of the British 1990 growth reference (UK90) according to age and sex.



Period	Reading	Lower CI	Upper CI	Fourth less deprived (IMD2015)	England
2007/08	20.6	18.5	22.9	*20.7*	22.6
2008/09	22.5	20.5	24.6	*21.6*	22.8
2009/10	25.7	23.7	27.9	*22.8*	23.1
2010/11	25.7	23.7	27.8	*22.2*	22.6
2011/12	24.1	22.1	26.1	*22*	22.6
2012/13	21.8	20	23.9	*21.6*	22.2
2013/14	23.3	21.3	25.5	*21.4*	22.5
2014/15	22.6	20.9	24.5	*21.3*	21.9
2015/16	21.8	20.1	23.6	-	22
2016/17	22.9	21.1	24.7	*22.6*	22.6

Indicator number	**2.06i**
Outcomes Framework	**Public Health Outcomes Framework**
Indicator full name	**Child excess weight in 10-11 year olds**

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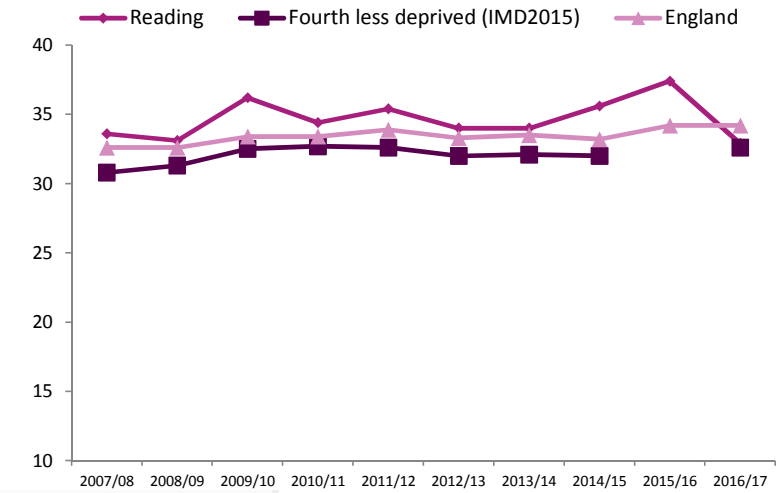
Data source	National Child Measurement Programme
Denominator	Number of children in Year 6 (aged 10-11 years) measured in the National Child Measurement Programme (NCMP) attending participating state maintained schools in England.
Numerator	Number of children in Year 6 (aged 10-11 years) classified as overweight or obese in the academic year. Children are classified as overweight (including obese) if their BMI is on or above the 85th centile of the British 1990 growth reference (UK90) according to age and sex.



Period	Reading	Lower CI	Upper CI	Fourth less deprived (IMD2015)	England
2007/08	33.6	31	36.2	*30.8*	32.6
2008/09	33.1	30	35.7	*31.3*	32.6
2009/10	36.2	33.6	38.8	*32.5*	33.4
2010/11	34.4	32	36.9	*32.7*	33.4
2011/12	35.4	32.9	37.9	*32.6*	33.9
2012/13	34	31.6	36.5	*32*	33.3
2013/14	34	32.2	37.1	*32.1*	33.5
2014/15	35.6	33.2	38	*32*	33.2
2015/16	37.4	35.1	39.7	-	34.2
2016/17	32.9	30.7	35.2	*32.6*	34.2

Indicator number	**2.14**
Outcomes Framework	**Public Health Outcomes Framework**
Indicator full name	**Smoking Prevalence in Adults - Current Smokers**

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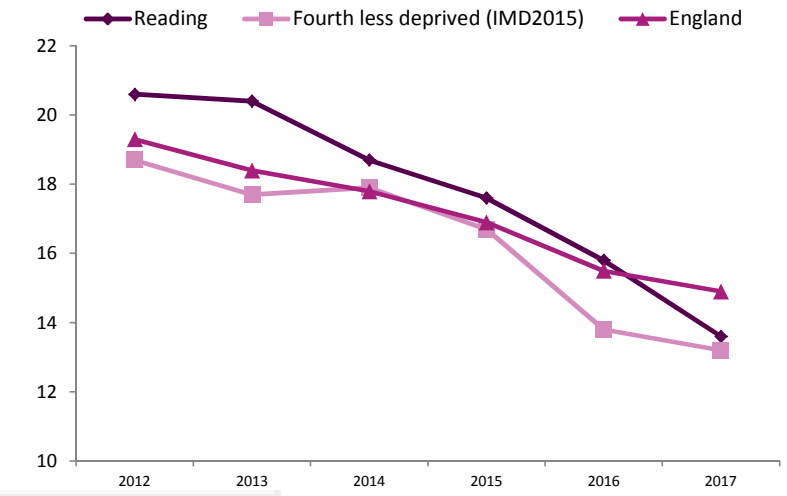
Data source	Annual Population Survey
Denominator	Total number of respondents (with valid recorded smoking status) aged 18+ from the Annual Population Survey. The number of respondents has been weighted in order to improve representativeness of the sample. The weights take into account survey design and non-response.
Numerator	The number of persons aged 18 + who are self-reported smokers in the Annual Population Survey. The number of respondents has been weighted in order to improve representativeness of the sample. The weights take into account survey design and non-response.

Period	Reading	Lower CI	Upper CI	Fourth less deprived (IMD2015)	England
2012	20.6	18.4	22.8	*18.7*	19.3
2013	20.4	18.2	22.6	*17.7*	18.4
2014	18.7	16.7	20.7	*17.9*	17.8
2015	17.6	15.5	19.8	*16.7*	16.9
2016	15.8	13.5	18.1	*13.8*	15.5
2017	13.6	10.9	16.3	*13.2*	14.9



Indicator number	**2.03**
Outcomes Framework	**Public Health Outcomes Framework**
Indicator full name	**% of women who smoke at the time of delivery**

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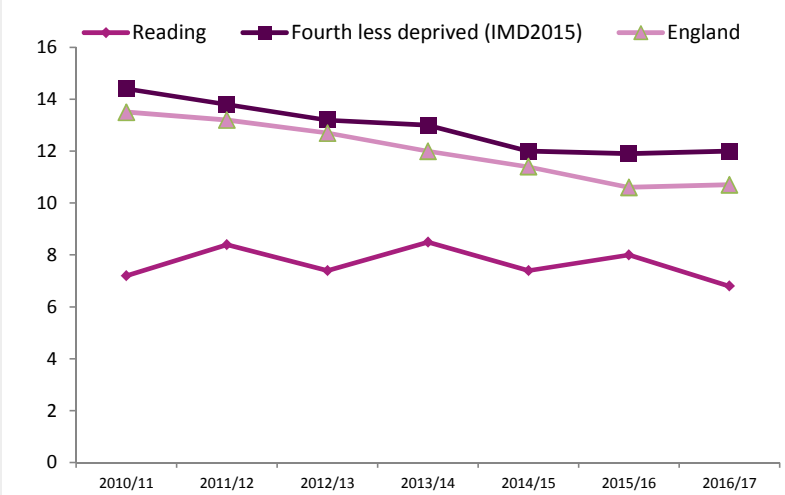
Data source	Calculated by KIT East from the Health and Social Care Information Centre's return on Smoking Status At Time of delivery (SSATOD)
Denominator	Number of maternities (estimated based on counts for CCGs)
Numerator	Number of women known to smoke at time of delivery (estimated based on counts for CCGs)

Period	Reading	Lower CI	Upper CI	Fourth less deprived (IMD2015)	England
2010/11	7.2	6.1	8.2	*14.4*	13.5
2011/12	8.4	7.4	9.6	*13.8*	13.2
2012/13	7.4	6.3	8.2	*13.2*	12.7
2013/14	8.5	7.4	9.6	*13*	12
2014/15	7.4	6.4	8.5	*12*	11.4
2015/16	8	7	9.1	*11.9*	10.6
2016/17	6.8	5.9	7.9	*12*	10.7



Indicator number	**NA**
Outcomes Framework	**Local Tobacco Control Profiles**
Indicator full name	**Smoking prevalence in routine and manual occupations - Current smokers**

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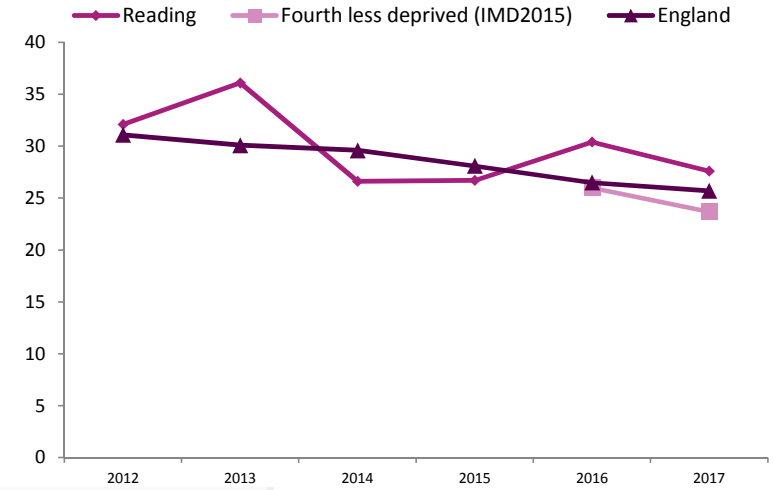
Period	Reading	Lower CI	Upper CI	Fourth less deprived (IMD2015)	England
2012	32.1	26.4	37.8	*NO DATA*	31.1
2013	36.1	30.1	42.1	*NO DATA*	30.1
2014	26.6	21.2	32	*NO DATA*	29.6
2015	26.7	20.6	32.7	*NO DATA*	28.1
2016	30.4	23	37.9	*26*	26.5
2017	27.6	19.4	35.8	*23.7*	25.7

Data source	Annual Population Survey
Denominator	Total respondents with a self-reported smoking status aged 18-64 in the R&M group. Weighted to improve representativeness.
Numerator	Respondents who are self-reported smokers in the R&M group. Weighted to improve representativeness



Indicator number	**2.22ii**
Outcomes Framework	**Public Health Outcomes Framework**
Indicator full name	**Cumulative percentage of the eligible population aged 40-74 offered an NHS Health Check**

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Data source	Public Health England - www.healthcheck.nhs.uk
Denominator	Number of people aged 40-74 eligible for an NHS Health Check in the five year period
Numerator	Number of people aged 40-74 eligible for an NHS Health Check who were offered an NHS Health Check in the five year period

Period	Reading	Lower CI	Upper CI	Fourth less deprived (IMD2015)	England
2013/14-16/17	65.2	64.8	65.7	75.7	74.1
2013-2018 Q2	68.72				82.54
2013-2018 Q3	70.33				86.36
2013-2018 Q4	72.44				90.91

Indicator number	**2.22iii**
Outcomes Framework	**Public Health Outcomes Framework**
Indicator full name	**Cumulative percentage of the eligible population aged 40-74 offered an NHS Health Check who received a Health Check**

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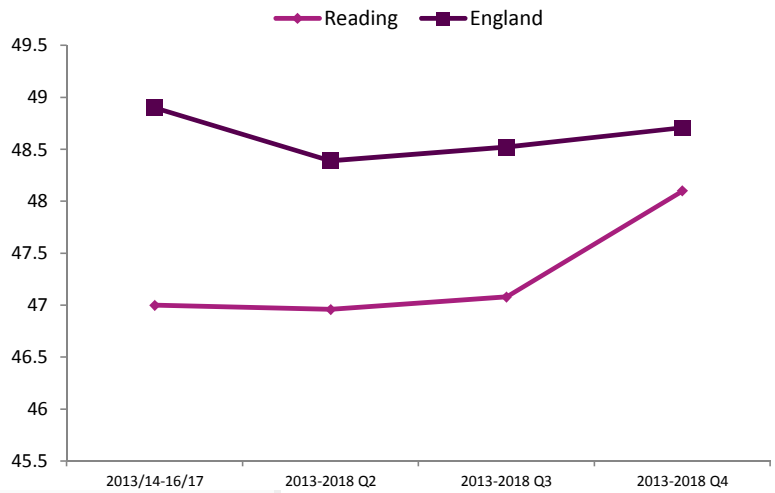
Data source	Public Health England - www.healthcheck.nhs.uk
Denominator	Number of people aged 40-74 offered an NHS Health Check in the five year period
Numerator	Number of people aged 40-74 eligible for an NHS Health Check received an NHS Health Check in the five year period

Period	Reading	Lower CI	Upper CI	Fourth less deprived (IMD2015)	England
2013/14-16/17	47	46.1	47.8	*50.7*	48.9
2013-2018 Q2	46.96				48.39
2013-2018 Q3	47.08				48.52
2013-2018 Q4	48.1				48.71



Indicator number	**2.22iii**
Outcomes Framework	**Public Health Outcomes Framework**
Indicator full name	**Cumulative percentage of the eligible population aged 40-74 who received a Health Check**

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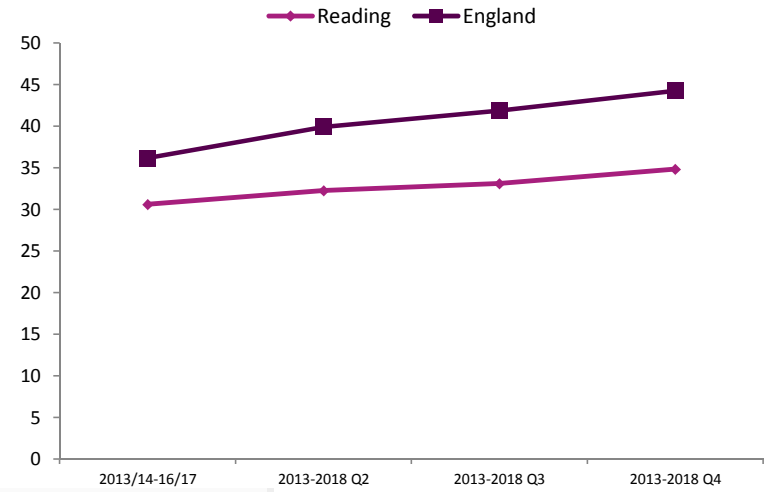
Data source	Public Health England - www.healthcheck.nhs.uk
Denominator	Number of people aged 40-74 eligible for an NHS Health Check in the five year period
Numerator	Number of people aged 40-74 eligible for an NHS Health Check who received an NHS Health Check in the five year period

Period	Reading	Lower CI	Upper CI	Fourth less deprived (IMD2015)	England
2013/14-16/17	30.6	30.2	31.1	*38.4*	36.2
2013-2018 Q2	32.27				39.94
2013-2018 Q3	33.11				41.91
2013-2018 Q4	34.84				44.28



Indicator number	**1.18i/1l**
Outcomes Framework	**Public Health Outcomes Framework/Adult Social Care Outcome Framework**
Indicator full name	**% of adult social care users who have as much social contact as they would like according to the Adult Social Care Users Survey**

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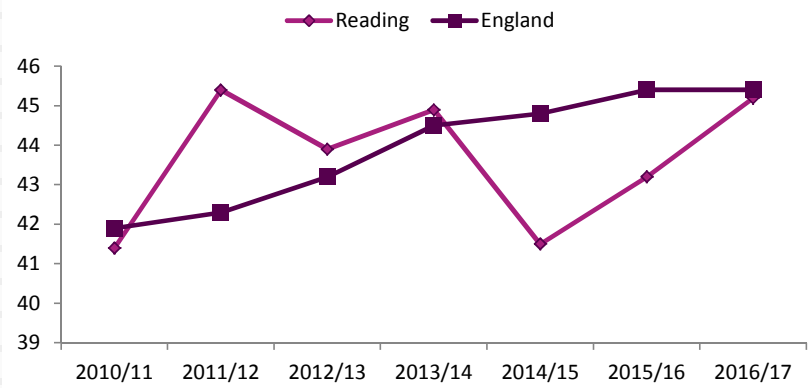
Data source	Adult Social Care Survey - England
	http://content.digital.nhs.uk/catalogue/PUB21630 - Annex Tables
Denominator	The number of people responding to the question "Thinking about how much contact you've had with people you like, which of the following statements best describes your social situation?"
Numerator	All survey respondents who responded to the question (adult social care users identified by LA) NHS Digital - Personal Social Services Adult Social Care Survey England



Period	Reading	Fourth less deprived (IMD2015)	England
2010/11	41.4	-	41.9
2011/12	45.4	-	42.3
2012/13	43.9	-	43.2
2013/14	44.9	-	44.5
2014/15	41.5	-	44.8
2015/16	43.2	-	45.4
2016/17	45.2	-	45.4

Indicator number	**1.18ii/1l**
Outcomes Framework	**Public Health Outcomes Framework/Adult Social Care Outcome Framework**
Indicator full name	**% of adult carers who have as much social contact as they would like according to the Adult Social Care Users Survey**

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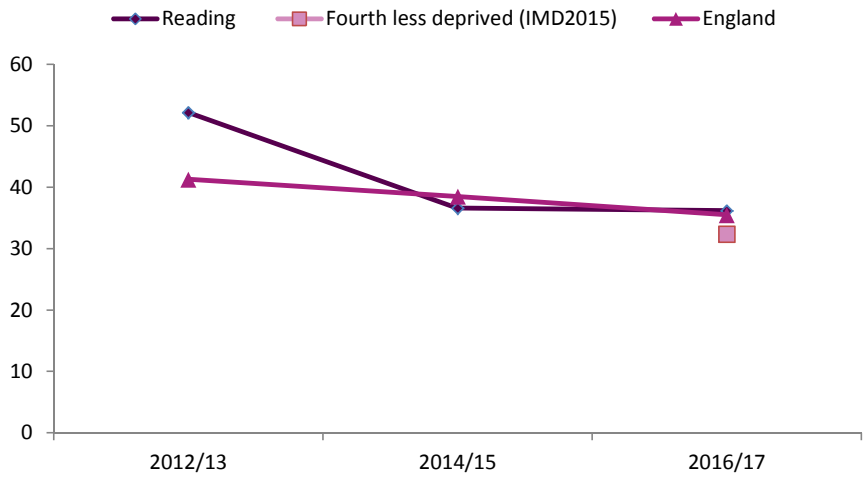
Data source	Carers Survey
Denominator	The number of people responding to the question "Thinking about how much contact you've had with people that you like, which of the following statements best describes your social situation?", with the answer "I have as much social contact as I want with people I like" divided by the total number of responses to the same question.
Numerator	All survey respondents who responded to the question (adult social care users identified by LA) NHS Digital - Personal Social Services Adult Social Care Survey England

Period	Reading	Lower CI	Upper CI	Fourth less deprived (IMD2015)	England
2012/13	52.2	48.1	56.3		41.3
2014/15	36.6	31.8	41.4		38.5
2016/17	36.2	30.4	42.4	*32.4*	35.5



Indicator number	**2.15iii**
Outcomes Framework	**Public Health Outcomes Framework**
Indicator full name	**Successful completion of alcohol treatment**
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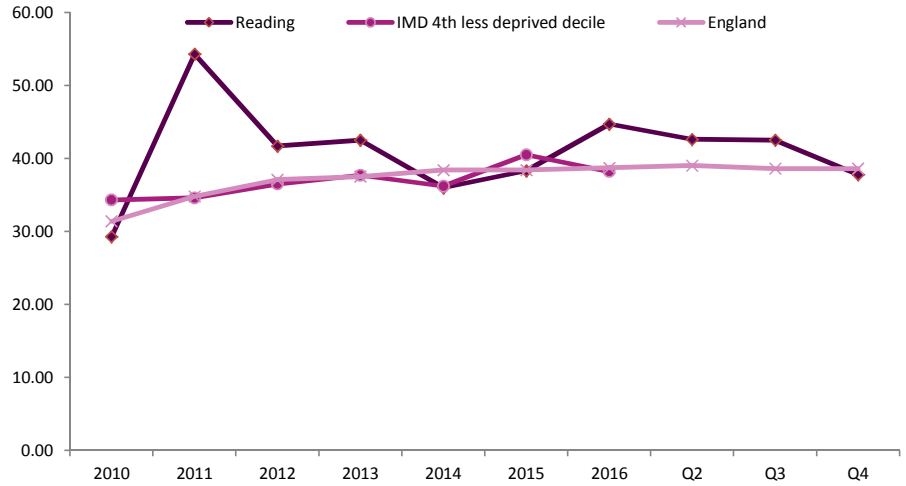
Data Source	National Drug Treatment Monitoring System
Denominator	Total number of adults in structured alcohol treatment in a one year period
Numerator	Adults that complete treatment for alcohol dependence who do not re-present to treatment within six months

Period	Reading	IMD 4th less deprived decile	England
2010	29.30	34.30	31.40
2011	54.30	34.60	34.80
2012	41.70	36.50	37.10
2013	42.50	37.70	37.50
2014	36.00	36.20	38.40
2015	38.30	40.50	38.40
2016	44.70	38.20	38.70
Q2	42.60		39.00
Q3	42.50		38.60
Q4	37.80		38.60



Indicator number	**2.18**
Outcomes Framework	**Public Health Outcomes Framework**
Indicator full name	**Admission episodes for alcohol-related conditions per 100,000 people**

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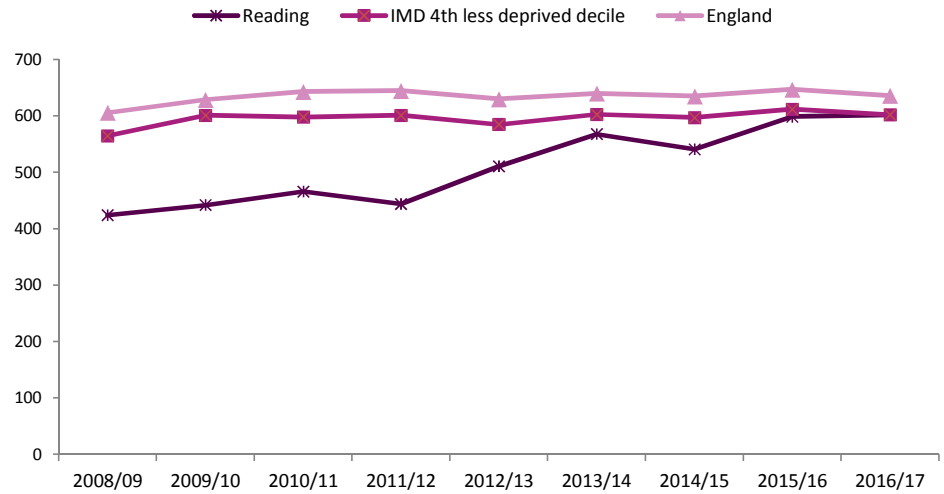
Data Source	Health and Social Care information Centre - Hospital Episode Statistics. Via Local Alcohol Profiles for England
Denominator	Mid-Year Population Estimates (ONS)
Numerator	Admissions to hospital where primary diagnosis is an alcohol-related condition or a seconday diagnosis is an alcohol-related external cause. Uses attributable fractions to estimate.

Period	Reading	IMD 4th less deprived decile	England
2008/09	424	565	606
2009/10	442	601	629
2010/11	466	598	643
2011/12	444	601	645
2012/13	511	585	630
2013/14	568	603	640
2014/15	541	597	635
2015/16	599	612	647
2016/17	602	602	636



Indicator number	**NA**
Outcomes Framework	**Children and Young People's Mental Health and Wellbeing**
Indicator full name	**Pupils with social, emotional and mental health needs (primary school age)**

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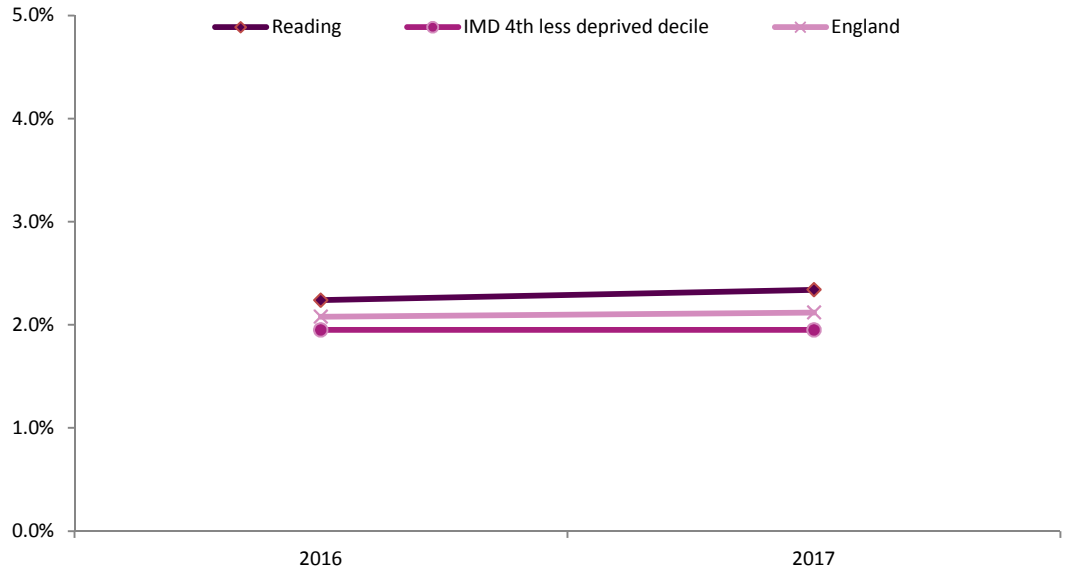
Data Source	DFE Special Needs Education Statistics
Denominator	Total pupils (LA tabulations) https://www.gov.uk/government/collections/statistics-special-educational-needs-sen
Numerator	Number of pupils with statements of SEN where primary need is social, emotional and mental health

Period	Reading	IMD 4th less deprived decile	England
2016	2.2%	2.0%	2.1%
2017	2.3%	2.0%	2.1%



Indicator number	**NA**
Outcomes Framework	**Children and Young People's Mental Health and Wellbeing**
Indicator full name	**Pupils with social, emotional and mental health needs (secondary school age)**

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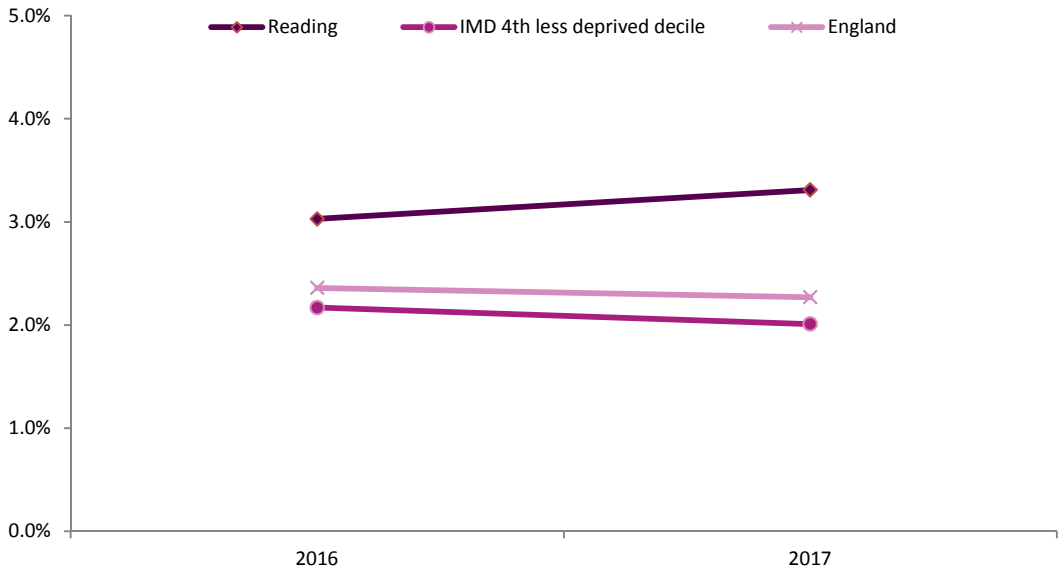
Data Source	DFE Special Needs Education Statistics
Denominator	Total pupils (LA tabulations) https://www.gov.uk/government/collections/statistics-special-educational-needs-sen
Numerator	Number of pupils with statements of SEN where primary need is social, emotional and mental health

Period	Reading	IMD 4th less deprived decile	England
2016	3.0%	2.2%	2.4%
2017	3.3%	2.0%	2.3%



Indicator number	**NA**
Outcomes Framework	**Children and Young People's Mental Health and Wellbeing**
Indicator full name	**Pupils with social, emotional and mental health needs (all school age)**

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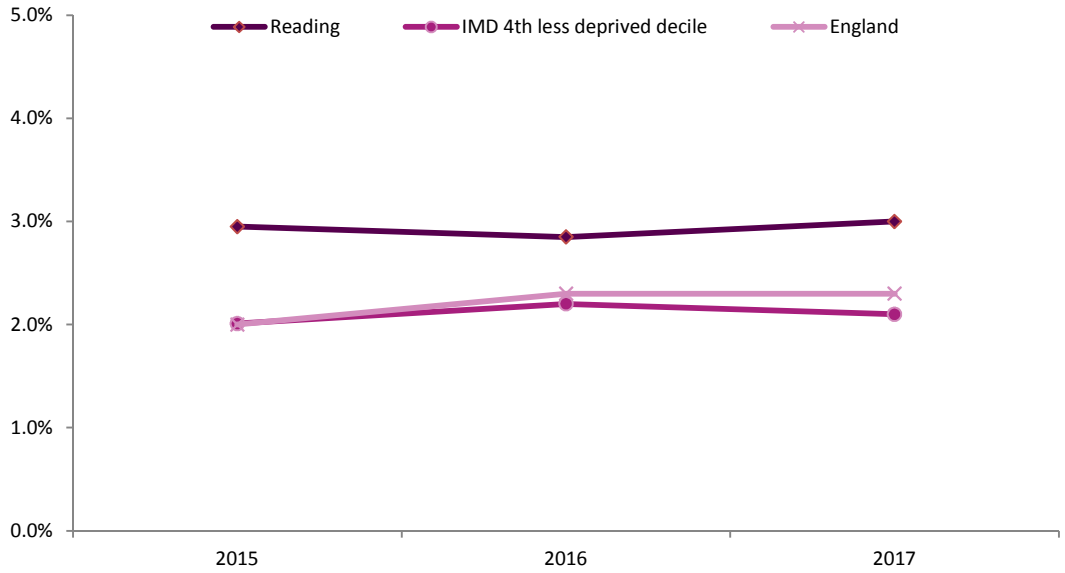
Period	Reading	IMD 4th less deprived decile	England
2015	3.0%	2.0%	2.0%
2016	2.9%	2.2%	2.3%
2017	3.0%	2.1%	2.3%

Data Source	DFE Special Needs Education Statistics
Denominator	Total pupils (LA tabulations)
Numerator	Number of pupils with statements of SEN where primary need is social, emotional and mental health https://www.gov.uk/government/collections/statistics-special-educational-needs-sen



Indicator number	**4.16 / 2.6i**
Outcomes Framework	**Public Health Outcomes Framework / NHS Outcomes Framework**
Indicator full name	**Estimated diagnosis rate for people with dementia**

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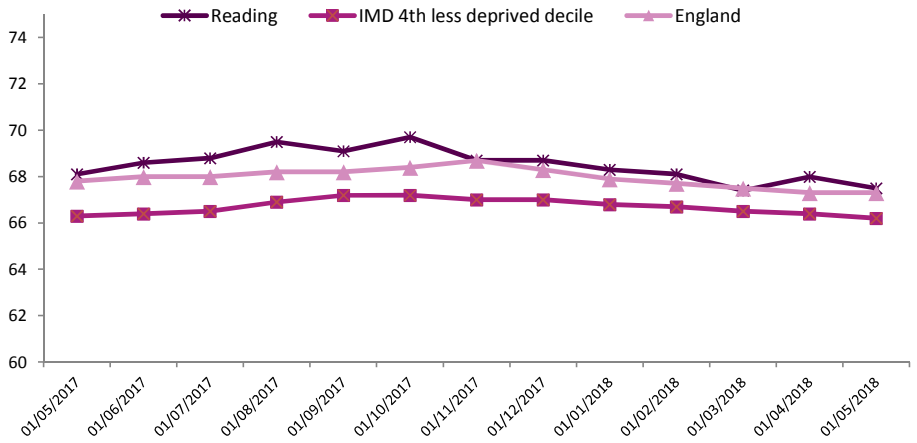
Data Source	NHS Digital
Denominator	Applying the reference rates to the registered population yields the number of people aged 65+ one would expect to have dementia within the subject population where:
Numerator	**Registered population** Patients aged 65+ registered for General Medical Services, counts by 5-year age and sex band from the National Health Application and Infrastructure Services (NHAIS / Exeter) system; extracted on the first day of each month following the reporting period end date of the numerator. **Reference rates: sampled dementia prevalence** Age 65+ age and sex-specific dementia prevalence rates. Source: MRC CFAS II.

Period	Reading	IMD 4th less deprived decile	England
31/05/2017	68.1	66.3	67.8
30/06/2017	68.6	66.4	68
31/07/2017	68.8	66.5	68
31/08/2017	69.5	66.9	68.2
30/09/2017	69.1	67.2	68.2
31/10/2017	69.7	67.2	68.4
30/11/2017	68.7	67	68.7
31/12/2017	68.7	67	68.3
31/01/2018	68.3	66.8	67.9
28/02/2018	68.1	66.7	67.7
31/03/2018	67.4	66.5	67.5
30/04/2018	68	66.4	67.3
31/05/2018	67.5	66.2	67.3



Indicator number	**NA**
Outcomes Framework	**NA**
Indicator full name	**No. of Dementia Friends**

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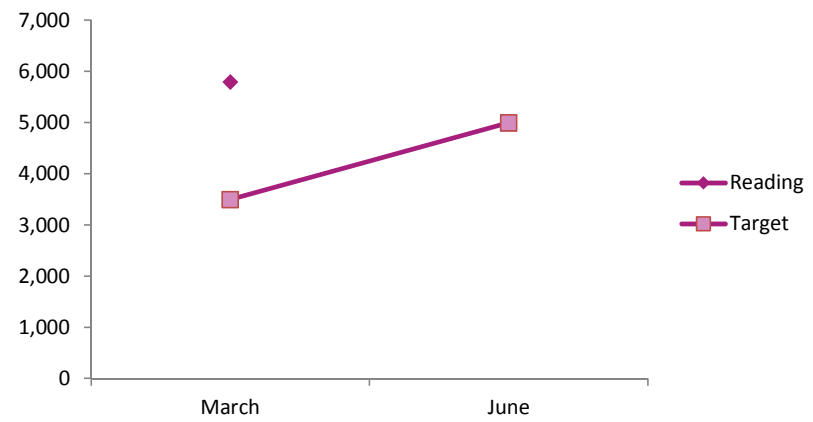
Period	Reading	Target
March	5,800	3,500
June		5,000

Data Source	Locally Recorded
Definition	No. of people who have completed a 45 minute training session and agreed to be a dementia friend



Indicator number	**2.20iii**
Outcomes Framework	**Public Health Outcomes Framework**
Indicator full name	**Cancer screening coverage - bowel cancer**

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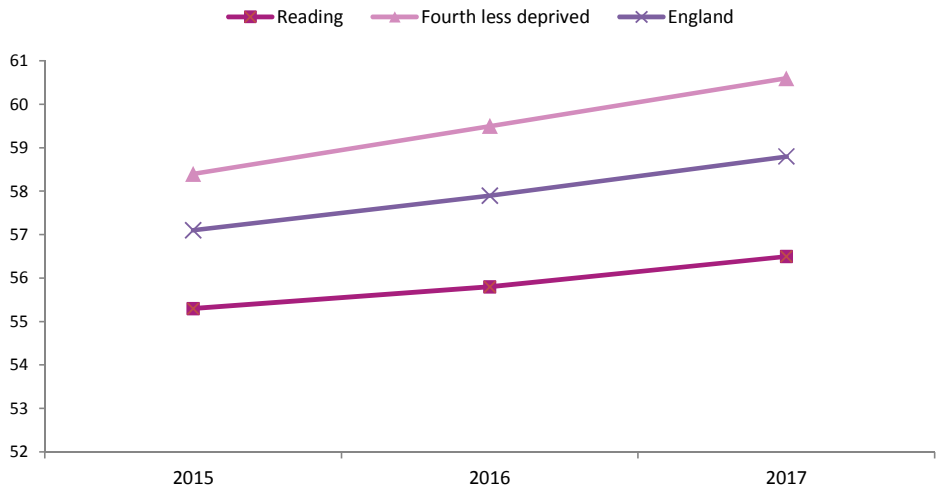
Period	Reading	Fourth less deprived	England
2015	55.3	58.4	57.1
2016	55.8	59.5	57.9
2017	56.5	*60.6*	58.8

Data Source	Health and Social Care Information Centre (Open Exeter)/Public Health England
Denominator	Number of people aged 60-74 resident in the area (determined by postcode of residence) who are eligible for bowel screening at a given point in time (excluding those with no functioning colon (e,g, after surgery) or have made an informed decision to opt out.
Numerator	Number of people aged 60-74 resident in the area (determined by postcode of residence) with a screening test result recorded in the previous 2½ years Target is the NHS England minimum coverage standard https://www.england.nhs.uk/wp-content/uploads/2017/04/service-spec-26.pdf



Indicator number	**2.20i**
Outcomes Framework	**Public Health Outcomes Framework**
Indicator full name	**Cancer screening coverage - breast cancer**

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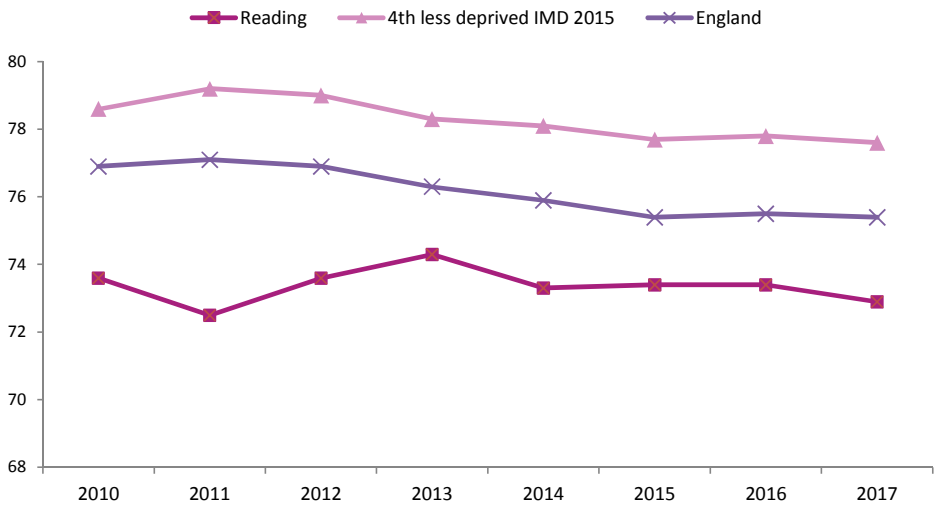
Data Source	Health and Social Care Information Centre (Open Exeter)/Public Health England
Denominator	Number of women aged 53-70 resident in the area (determined by postcode of residence) who are eligible for breast screening at a given point in time.
Numerator	Number of women aged 53-70 resident in the area (determined by postcode of residence) with a screening test result recorded in the previous three years Target is the NHS England minimum coverage standard https://www.england.nhs.uk/wp-content/uploads/2017/04/service-spec-24.pdf

Period	Reading	4th less deprived IMD 2015	England
2010	73.6	78.6	76.9
2011	72.5	79.2	77.1
2012	73.6	79	76.9
2013	74.3	78.3	76.3
2014	73.3	78.1	75.9
2015	73.4	77.7	75.4
2016	73.4	77.8	75.5
2017	72.9	77.6	75.4



Indicator number	**3.05ii**
Outcomes Framework	**Public Health Outcomes Framework**
Indicator full name	**Incidence of TB (three year average)**

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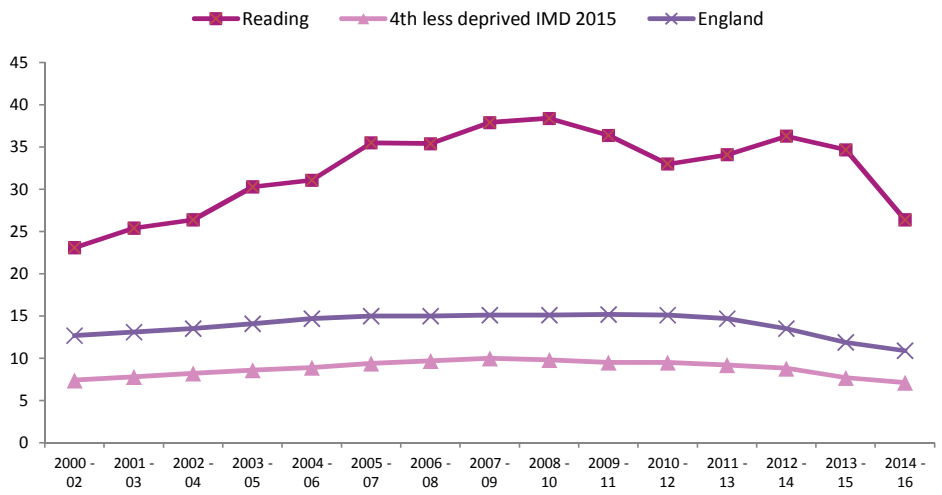
Data Source	Enhanced Tuberculosis Surveillance system (ETS) and Office for National Statistics (ONS)
Denominator	Sum of the Office for National Statistics (ONS) mid-year population estimates for each year of the three year time period
Numerator	Sum of the number of new TB cases notified to the Enhanced Tuberculosis Surveillance system (ETS) over a three year time period



Period	Reading	4th less deprived IMD 2015	England
2000 - 02	23.1	7.4	12.7
2001 - 03	25.4	7.8	13.1
2002 - 04	26.4	8.2	13.5
2003 - 05	30.3	8.6	14.1
2004 - 06	31.1	8.9	14.7
2005 - 07	35.5	9.4	15
2006 - 08	35.4	9.7	15
2007 - 09	37.9	10	15.1
2008 - 10	38.4	9.8	15.1
2009 - 11	36.4	9.5	15.2
2010 - 12	33	9.5	15.1
2011 - 13	34.1	9.2	14.7
2012 - 14	36.3	8.8	13.5
2013 - 15	34.7	7.7	11.9
2014 - 16	26.4	7.1	10.9

Indicator number	**4.10**
Outcomes Framework	**Public Health Outcomes Framework**
Indicator full name	**Age-standardised mortality rate from suicide and injury of undetermined intent per 100,000 population**

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Data Source	Public Health England (based on ONS)
Denominator	ONS 2011 census based mid-year population estimates
Numerator	Number of deaths from suicide and injury from undetermined intent ICD10 codes X60-X84 (age 10+), Y10-34 (age 15+).

Period	Reading	4th less deprived IMD 2015	England
2001 - 03	11.5	-	10.3
2002 - 04	10.7	-	10.2
2003 - 05	10.4	-	10.1
2004 - 06	10	-	9.8
2005 - 07	9.6	-	9.4
2006 - 08	11.2	-	9.2
2007 - 09	10.9	-	9.3
2008 - 10	8.8	-	9.4
2009 - 11	7.4	-	9.5
2010 - 12	7.7	-	9.5
2011 - 13	9.3	-	9.8
2012 - 14	9.8	-	10
2013 - 15	11	10.5	10.1
2014 - 16	9.9	*10.2*	9.9

Updates to the health and wellbeing dashboard

- **Updates since last report**

  No. of Dementia Friends (local indicator) (Priority 5) updated with Q1 performance
  Health checks indicators updated with Q4 (13th June 2018)

  Alcohol treatment completion updated with Q4 performance (10th May 2018)

  Dementia diagnosis rate (14th June 2018 - updated with April and May performance)
  % Physically active (May 2018)
  Smoking Prevalence - all adults
  Smoking Prevalence - routine and manual professions

- **Updates expected before October 2018 (dates are provisional)**

  No. of Dementia Friends (local indicator) (Priority 5) updated with Q2 performance
  Health checks indicators updated with Q1 (Expected end of August 2018)
  Alcohol treatment completion updated with Q1 performance (expected September 2018)
  Dementia Diagnosis rate - monthly
  % pupils with social, emotional and mental health needs (primary, secondary and all schools)

Indicator	Expected date of update (PHOF Indicators)	Local/Quarterly data available?
2.12 Excess weight in adults	November	No
2.13i % of adults physically active	May	No
2.06i % 4-5 year olds classified as overweight/obese	February	No
2.06ii % 10-11 year olds classified as overweight/obese	February	No
2.03 Smoking status at the time of delivery	November	No
2.14 Smoking prevalence - all adults - current smokers	August	No
2.14 Smoking prevalance - routine and manual - current smokers	August	No
2.22iii Cumulative % of those aged 40-74 offered a healthcheck 2013/14 - 16/17	NA	Updates are published quarterly
2.22 iv Cumulative % of those offered a healthcheck who received a healthcheck 2013/14 - 16/17	NA	Updates are published quarterly
2.22 v Cumulative % of those aged 40-74 who received a healthcheck 2013/14 - 16/17	NA	Updates are published quarterly
1.18i/1l % of adult social care users with as much social contact as they would like	November	Local data but collected annually
1.18ii/1l % of adult carers with as much social contact as they would like	November	Local data but collected bi-annually
Placeholder - Loneliness and Social Isolation	NA	
2.15iii Successful treatment of alcohol treatment	NA	Updates are published quarterly
2.18 Admission episodes for alcohol related conditions (DSR per 100,000)	May	No
% pupils with social, emotional and mental health needs (primary, secondary and all schools)	August	No
4.16/2.6i Estimated diagnosis rate for people with dementia	August	Monthly
No. Dementia Friends (Local Indicator)	NA	Yes
Placeholder - ASCOF measure of post-diagnosis care	NA	
2.20iii Cancer screening coverage - bowel cancer	February	No.
2.20i Cancer screening coverage - breast cancer	February	No.
3.05ii Incidence of TB (three year average)	November	No.
4.10 Age-standardised mortality rate from suicide and injury of undetermined intent	November	No.

READING HEALTH AND WELLBEING BOARD

DATE OF MEETING:	**13 JULY 2018**	**AGENDA ITEM:**	**12**
REPORT TITLE:	**CHILDREN'S ORAL HEALTH IN READING**		
REPORT AUTHOR:	**DR. MARION GIBBON**	**TEL:**	
JOB TITLE:	**PUBLIC HEALTH CONSULTANT**	**E-MAIL:**	**Marion.Gibbon@reading.gov.uk**
ORGANISATION:	**READING BOROUGH COUNCIL**		

1. PURPOSE OF REPORT AND EXECUTIVE SUMMARY

1.1 This report presents an analysis of the 2015 children's dental health survey data for Reading (published 2017), and makes the case for the development of an oral health strategy for Reading to complement the Healthy Weight Strategy and provide a framework for raising the profile of oral health across other relevant policies and service specifications.

2. RECOMMENDED ACTION

2.1 That the Health and Wellbeing Board accepts the proposal to develop an oral health strategy for Reading, and instructs officers to report back on progress to a future meeting of this Board.

3. POLICY CONTEXT

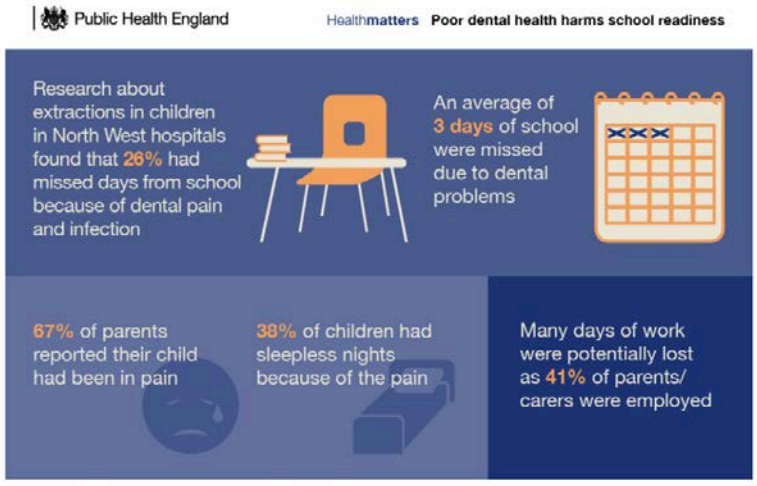
3.1 Oral health is important for general health and wellbeing. Poor oral health can affect someone's ability to eat, speak, smile and socialise normally, for example, due to pain or social embarrassment (see the Department of Health's Dental quality and outcomes framework). Oral health problems include gum (periodontal) disease, tooth decay (dental caries), tooth loss and oral cancers.

3.2 The level of dental decay in five-year-old children is a useful indicator of the success of a range of programmes and services that aim to improve the general health and wellbeing of young children. In the Public Health Outcomes Framework, one of the indicators is the dental decay level in children aged five years (PHE, 2014). Tooth decay is the most common oral disease affecting children and young people in England, yet it is largely preventable. Although oral health is improving in England almost a quarter (24.7%) of 5 year olds have tooth decay, so 1 in 4 children will have tooth decay when they start school. Each child with tooth decay will have on average 3 to 4 teeth affected (Applying All our Health, PHE)

3.3 There is a strong relationship between deprivation and both obesity and dental caries in children. Obesity rates are highest for children from the most deprived areas and this is getting worse. (Health and Social Care Information Centre (2015) National Child Measurement Programme, England 2015/16) Children aged 5 and from the poorest

income groups are twice as likely to be obese compared to their most well off counterparts and by age 11 they are three times as likely (Goisis, A., Sacker, A. and Kelly, Y. 2016). The European Journal of Public Health. Similarly, data from the National Dental Epidemiology Programme for England shows that IMD scores explain 44% of the variation in the severity of tooth decay across local authorities. (The relationship between dental caries and obesity in children; an evidence review, PHE 2015).

3.4 Research undertaken in the North West hospitals found that many children had missed days from school because of dental health pain and infection. Children in more deprived areas have been found to have more dental decay those living in wealthier areas.



Source: Health matters: child dental health https://www.gov.uk/government/publications/health-matters-child-dental-health/health-matters-child-dental-health

3.5 Poor oral health can be caused by many factors including:

- social inequalities where the imbalance in income, education, employment and neighbourhood circumstances affect the life chances of children's development
- poor nutrition and infant feeding with high and frequent consumption of free sugars
- lack of access to fluoride including late commencing or infrequent tooth brushing with low or no fluoride toothpaste

Children who already have evidence of oral disease including previous decay experience or previous extractions under general anaesthesia and those with medical conditions such as cardiac problems, cleft lip and palate and childhood cancers are also at increased risk of poor oral health.

3.6 Regularly consuming foods and drinks high in free sugars increases the risk of obesity and tooth decay. Ideally, no more than 5% of the energy we consume should come from free sugars. Currently, children and adults across the UK are consuming 2 to 3 times that amount. The Scientific Advisory Committee on Nutrition (SCAN) Carbohydrates and Health report (2015) found that high levels of sugar consumption are associated with a greater risk of tooth decay. This report recommends that for all age groups from 2 years upwards, the average intake of free sugars should not exceed 5% of total dietary energy intake. Younger children should have even less than this.

3.7 Increasing the percentage of total dietary energy consumed as free sugars leads to increased total energy intake. For children and adolescents, the consumption of sugar-sweetened beverages was found to lead to greater weight gain and increases in body mass index.

The recommended intake of free sugars is no more than:

- 19g (5 sugar cubes) per day for 4 to 6 year olds
- 24g (6 sugar cubes) per day for 6 to 10 year olds
- 30g (7 sugar cubes) per day for 11 years and older

3.8 A 2015 review of the evidence for action on Sugar Reduction published by PHE, summarised eight actions that are most likely to reduce population-level sugar consumption, some of these are at national level and others at local level.

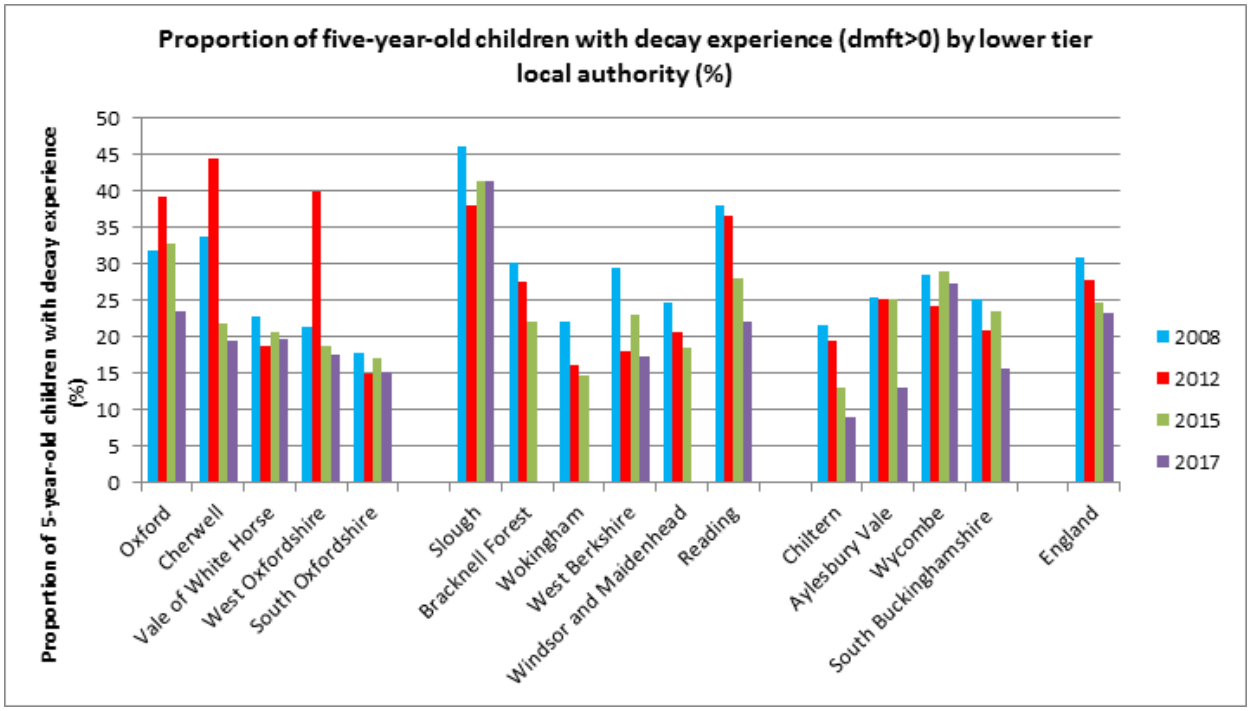
- clearly defining what constitutes a high sugar food;
- restricting marketing and advertising and price promotions for high sugar foods
- taxing sugar-sweetened drinks and high-sugar foods
- reducing sugar content and portion size
- implementing government buying standards across the public sector to provide healthier foods
- improving professional diet and health training
- continuing to raise awareness and provide practical steps to help people reduce their sugar intake

3.9 The National Childhood Obesity Strategy, published in 2017 builds on this and other evidence and aims to reduce sugar consumption through the introduction of a soft drinks industry levy on producers and importers to create incentives for action, and by implementing a broad structured sugar reduction programme to remove sugar from the products eat most. This involves challenging the food and drinks industry to reduce overall sugar across a range of products by 20% by 2020. Additionally the strategy commits to supporting early years settings by producing revised menus and voluntary guidelines for early-years settings to help them meet Government Dietary recommendations. The "Sugar Smart" campaign part of the PHE 'Change 4 Life' campaign provides families with the knowledge and tools to help cut down on sugar. The Sugar Smart mobile App uses technology to help people make the best use of information to inform eating decisions.

4. THE PROPOSAL

Current Position

4.1 Since 1973, a survey has been carried out every ten years into the dental health of 5, 8, 12 and 15 year old children in England, Wales, and Northern Ireland. The most recent survey (2015) was published in March 2017 by Public Health England. There has been a trend showing a reduction in dental caries in the South East. Reading has shown the greatest reduction in the proportion of five-year old children with decayed, missing or filled teeth as shown below. However, we remain third highest in the region.



4.2 In the 2015 National Dental Epidemiology Programme survey, 398 children were sampled in Reading. Parental consent was provided for 295 (67.1%) to take part in the survey, and they were clinically examined at school by trained and calibrated examiners, who used the national standard. Just under 72% of children in the survey were free from obvious dental decay.This has improved from 62.3% in 2008 and 63.5% in 2012, and is slightly lower but not statistically different from the England levels - but significantly worse than the South East. On average, five year olds in Reading have just under one (0.95) decayed, missing or filled (DMF) teeth. This compares with 0.84 DMF teeth for five year olds in England as a whole. These and a range of other indicators are shown in Table 1.

4.3 At the time of the 2012-13 survey, incisor caries prevalence, proportion of three year olds free from decay and the average number of decayed missing or filled teeth in three year olds in Reading were all significantly worse than England. In 2008/9 the proportion of twelve year olds free from dental decay and the average number of decayed, missing or filled teeth among children in Reading were worse than the England level but not significantly so.

Table 1: Results of dental survey of 5 year-olds 2015

	Reading Local Authority	Statistical neighbour within South East (Milton Keynes Local Authority)	South East England	England
4.02 Proportion of five year old children free from dental decay	71.9%	78.3%	79.9%	75.2%
Proportion of five year old children with decay experience	28.1%	21.5%	20.0%	24.7%
Average number of decayed missing or filled teeth in five year olds	0.95	-	0.84	0.84
Average number of decayed	3.4	3.0	3.2	3.4

missing or filled teeth in those with decay experience				
Proportion with active decay	24.5%	18.6%	16.8%	21.5%
Proportion with experience of extraction	3.1%	2.1%	1.9%	2.5%
Proportion with dental abscess	1.7%	0.9%	0.8%	1.4%
Proportion with teeth decayed into pulp	2.3%	4.3%	2.4%	3.6%
Proportion with decay affecting incisors	7.5%	4.7%	3.6%	5.6%
Proportion with high levels of plaque present on upper front teeth	0.3%	0.6%	0.9%	1.7%

Source: Dental health of five-year-old children, PHE 2017

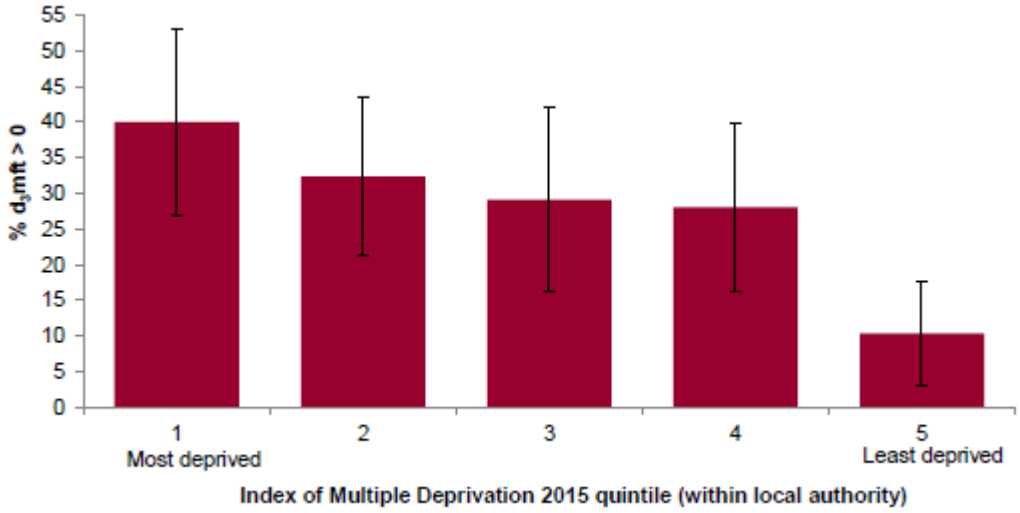
4.4 Other indicators of children's oral health for Reading, taken from previous surveys are shown in Table 2.

	Period	Reading Local Authority	South East England	England
Incisor caries prevalence in three year olds	**2012/13**	10.6%	3.1%	3.9%
Proportion of three year olds free from dental decay	**2012/13**	82.6%	91.6%	88.4%
Average number of decayed missing or filled teeth in three year olds	**2012/13**	0.74	0.27	0.36
Proportion of twelve year olds free from dental decay	**2008/9**	64.4%	66.4%	43.4%
Average number of decayed missing or filled teeth in twelve year olds	**2008/9**	0.82	0.74	1.61

Source: PHE Oral Health Profile, accessed December 2017

4.5 Figure 1 shows the percentage of decayed, missing or filled teeth by deprivation decile for Reading

Figure 1: Prevalence of decay by Index of Multiple Deprivation 2015 quintiles for Reading local authority (including 95% confidence limits shown as black bars).



Source: Dental health of five-year-old children, PHE 2017

It is important to consider deprivation when looking at oral health. It is apparent from Figure 1 that the south of Reading has more dental health problems than that of the north. Targeting of oral health promotion can be made towards the children that are at higher risk of dental caries.

4.6 In Reading the estimated number of hospitalisations for tooth extractions in 2015/16 is shown below:

Table 1: Estimated number of admissions for tooth extractions in 2015/16

Berkshire West CCG	Estimated number of admissions	Estimated crude rate per 100,000
South Reading locality	52	202
North and West Reading locality	30	154

This is an estimate as extractions are not carried out in the acute setting but through the community health trust. This means that the data is not available through Hospital Episode Statistics and hence it being necessary to work out an estimate using national level data.

Options Proposed

4.7 The National Institute for Clinical Excellence (NICE) has published a series of recommendations for local authorities on undertaking oral health needs assessments, developing a local strategy on oral health and delivering community-based interventions and activities. Reading's progress against these recommendations is summarised in the table below.

Recommendation	Reading position
1 Ensure oral health is a key health and wellbeing priority	In the Health and Wellbeing Strategy

	Priority for Children's Centres
2 Carry out an oral health needs assessment	An oral health needs assessment (NA) has been undertaken
3 Use a range of data sources to inform the oral health needs assessment	A range of data sources have been used to inform the NA
4 Develop an oral health strategy	It is recommended that Reading now develops an oral health strategy
5 Ensure public service environments promote oral health	**Promoted in Children's Centres** This would be part of the strategy
6 Include information and advice on oral health in all local health and wellbeing policies	Once strategy is developed this would be developed in tandem
7 Ensure frontline health and social care staff can give advice on the importance of oral health	**Information and advice already given in Children's Centres** With the development of the Integrated Wellbeing service this could be incorporated
8 Incorporate oral health promotion in existing services for all children, young people and adults at high risk of poor oral health	**Oral Health promotion included in Children's Centres planning and activities** As in 7
9 Commission training for health and social care staff working with children, young people and adults at high risk of poor oral health	It is recommended that training should be commissioned
10 Promote oral health in the workplace	It is recommended that oral health is promoted in the workplace
11 Commission tailored oral health promotion services for adults at high risk of poor oral health	This is recommended and will be discussed with the DACHS commissioner
12 Include oral health promotion in specifications for all early years services	**Included in 0-19 health contract** A review will be undertaken and oral health promotion can be included in all service specifications where appropriate
13 Ensure all early years services provide oral health information and advice	**Provided in all Children's Centre activities** As in 7
14 Ensure early years services provide additional tailored information and advice for groups at high risk of poor oral health	**Provided in all Children's Centre targeted groups and 1-1 work with families** As in 7

15 Consider supervised tooth brushing schemes for nurseries in areas where children are at high risk of poor oral health	This will be considered within the oral health strategy
16 Consider fluoride varnish programmes for nurseries in areas where children are at high risk of poor oral health	As above
17 Raise awareness of the importance of oral health, as part of a 'whole-school' approach in all primary schools	As above
18 Introduce specific schemes to improve and protect oral health in primary schools in areas where children are at high risk of poor oral health	As above
19 Consider supervised tooth brushing schemes for primary schools in areas where children are at high risk of poor oral health	As above
20 Consider fluoride varnish programmes for primary schools in areas where children are at high risk of poor oral health	As above
21 Promote a 'whole school' approach to oral health in all secondary schools	As above

4.8 Reading already has a good foundation for the development of an oral health strategy, starting with its Health and Wellbeing Strategy and then significantly enhanced by the Council's position statement on healthy weight.

The vision Reading has is to ensure children and adults in Reading to have the opportunity to achieve and maintain a healthy weight throughout their lives, by supporting them to make healthy diet choices and choose a physically active lifestyle.

The objectives of this document are to:

- provide a framework for the co-ordination of our work to tackle obesity.

- enlist the support and commitment of the whole Council and partners in the public, private and voluntary sectors to help people in Reading to:
  - recognise the importance of a healthy weight and be able to identify what a healthy weight is.
  - have access to accurate, relevant information and support to help them to achieve and maintain a healthy weight across the life course.
  - be physically active in every-day life and choose active travel as a safe, attractive and convenient option.
  - access acceptable, enjoyable, healthy food for themselves and their families both inside and outside the home.

4.9 Health Education England (HEE) and PHE have launched a suite of resources aimed at supporting the health care and wider workforce to "Make Every Contact Count". These resources include training on influencing behaviour change and initiating difficult conversations about health and wellbeing, as well as targeted training for Health Visitors and School Nurses given their unique position. Reading Borough Council is working with partners on the rollout of a local Make Every Contact Count (MECC) programme to help take healthy lifestyle messages and support to a wider audience, which will include support to protect children's oral health.

4.10 The logical next step is for Reading Borough Council to take the lead on developing a partnership strategy for oral health. This would address:

- incorporating the importance of oral health into all relevant policies and service specifications;
- developing training for frontline staff that emphasises the importance of oral health and enables them to give appropriate advice;
- promoting good oral health in the workplace;
- deciding on priorities for schools and how services might be most effectively targeted to those that need them the most.

5. CONTRIBUTION TO READING'S HEALTH AND WELLBEING STRATEGIC AIMS

5.1 The first priority set out in Reading's Health and Wellbeing Strategy 2017-20 is supporting people to make healthy lifestyle choices - with a focus on tooth decay alongside obesity, physical activity and smoking

5.2 Many of the risk factors for oral health – diet, oral hygiene, smoking, alcohol, stress and trauma – are the same as for many chronic conditions, such as cancer, diabetes and heart disease. As a result, interventions that aim to tackle these risk factors (taking a 'common risk factor approach') will improve general health as well as oral health

5.3 The proposal recognises that plans in support of Reading's 2017-20 Health and Wellbeing Strategy should be built on three foundations - safeguarding vulnerable adults and children, recognising and supporting all carers, and high quality co-ordinated information to support wellbeing. These would be included in the proposed oral health strategy.

6. COMMUNITY & STAKEHOLDER ENGAGEMENT

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 development of an oral health strategy for Reading will involve consultation with partners and members of the public to agree local priorities and approaches, building on the public consultation feedback which led to oral health being adopted as one of the 2017-20 Health and Wellbeing Strategy goals, within the 'healthy lifestyles' priority.

7. EQUALITY IMPACT ASSESSMENT

7.1 Under the Equality Act 2010, Section 149, a public authority must, in the exercise of its functions, have due regard to the need to—

- eliminate discrimination, harassment, victimisation and any other conduct that is prohibited by or under this Act;
- advance equality of opportunity between persons who share a relevant protected characteristic and persons who do not share it;
- foster good relations between persons who share a relevant protected characteristic and persons who do not share it.

7.2 An Equality Impact Assessment (EIA) will be prepared as part of the process of developing an oral health strategy and presented to this Board to inform its decision on whether to adopt the strategy.

8. LEGAL IMPLICATIONS

8.1 There are no direct legal implications arising from this report.

9. FINANCIAL IMPLICATIONS

9.1 The costs of developing an oral health strategy will be met from existing resources. The strategy will set out the financial implications of implementation which will be presented to this Board for consideration.

10. BACKGROUND PAPERS

Reading Health and Wellbeing Strategy 2017-20

Public Health England. Local authorities improving oral health: commissioning better oral health for children and young people. An evidence-informed toolkit for local authorities. 2014; Available from: https://www.gov.uk/government/uploads/system/uploads/attachment_data/file/321503/CBOHMaindocumentJUNE2014.pdf

Health Matters: Child dental health Posted by:Sandra White, Posted on:14 June 2017 - Categories:Health Matters https://publichealthmatters.blog.gov.uk/2017/06/14/health-matters-child-dental-health

READING BOROUGH COUNCIL

REPORT BY: Director of Adults Social Care and Health Services

TO:	**Health and Wellbeing Board**		
DATE:	**13th July 2018**	**AGENDA ITEM:**	**13**
TITLE:	**RBC & CCG Response to Healthwatch Report on Analysis of Tuberculosis (TB) Campaign & Action Plan**		
LEAD COUNCILLOR:	**Councillor Hoskin**	**PORTFOLIO:**	**Health, Wellbeing & Sport**
SERVICE:	**Wellbeing**	**WARDS:**	**BOROUGH WIDE**
LEAD OFFICER:	**Jo Jefferies**	**TEL:**	**01344 352745**
JOB TITLE:	**Consultant in Public Health Protection**	**E-MAIL:**	**Jo.Jefferies@bracknell-forest.gov.uk**

1. PURPOSE OF REPORT AND EXECUTIVE SUMMARY

1.1 The purpose of this report is to provide an information update to Reading Health and Wellbeing Board on activities to understand and improve upon the knowledge and understanding of the local community in regards to active and latent tuberculosis (TB) and of local services that are available to identify and treat latent TB.

1.2 A strong TB pathway with good treatment completion will contribute to prevention and control of TB, helping to reduce the number of people affected by TB in Reading and to reduce the stigma that sometimes exists around the disease and which can prevent people from accessing TB services.

1.3 Since South Reading Clinical Commissioning Group (CCG) (now Berkshire West CCG) first received funding as part of the National Latent TB programme in 2016, they have worked with Reading Borough Council (RBC), local GP practices and the New Entrant Screening Service at Royal Berkshire Hospital (RBH) to successfully implement and embed a referral pathway for new registrants who have entered the UK in the previous 5 years from countries with a high incidence of TB. The success of this pathway is dependent on patients taking up the offer of latent TB screening.

1.4 It is known that TB is considered to be stigmatising in some communities and that a lack of knowledge about latent TB and the availability of free screening and treatment for latent and active TB regardless of immigration status may prevent people from accessing services.

1.5 In order to better understand knowledge, attitudes and behaviours of local people in regards to TB and TB services and to inform future engagement work, Healthwatch Reading were commissioned to undertake a survey; this was successfully delivered to over 300 people living in Reading and particularly reached out to people and communities at increased risk of latent TB.

1.6 The Healthwatch TB survey result, that was reported to the March Health and Wellbeing Board, have provided us with a better understanding of how local people think about TB during the first phase of a communication and engagement campaign focussing on latent TB.
It has identified that while referrals are starting to be made effectively, a substantial proportion of people invited choose not to attend their screening appointment, therefore there is still work to do to tailor this campaign so that people are better informed about the reason they are being asked to attend the appointment. The survey also tells us that stigma around TB is still an issue for some communities and as a system we recognise that further work with affected communities is needed.

1.2 Appendix 1- Healthwatch Reading TB Survey Report
Appendix 2- Berkshire TB Action Plan May 2018

2. RECOMMENDED ACTION

2.1 ***HWB to support plans for further community engagement activities aimed to identify, develop and support local community TB champions***

3. POLICY CONTEXT

3.1 The Collaborative TB Strategy for England sets out ten key aims to achieve a year-on-year decrease in incidence, a reduction in health inequalities and, ultimately, the elimination of TB as a public health problem in England. Reading's Health & Wellbeing Strategy aims to promote and protect the health of all communities, particularly those disadvantaged and TB is seen as a cause of health inequality in Reading. Antimicrobial resistance is one of the biggest challenges facing the world as evidenced by the high level meeting of the United Nations in September 2016, only the fourth time a health issue has been taken up by the UN General Assembly.

3.2 Reducing the number of people living with TB is identified as 'Priority 8' in the Reading Health and Wellbeing Strategy 2017-2020. By actively promoting latent TB testing to eligible new entrants to the UK and tackling TB in underserved communities, the local authority, in partnership with other stakeholders can help reduce health inequalities in Reading.

4. THE PROPOSAL

4.1 Current Position: Recent data from Public Health England shows, in 2016, 27 cases of TB were reported in Reading, with an incidence rate of 17 per 100,000 populations. The TB rate in Reading has sharply decreased since 2014 but remains above South East and England rates.
The age group with the highest number of cases was 40-49 years old, followed by 60-69. The most common countries of birth for those notified in 2016 were India and Pakistan.

4.2 Actions as a result of the survey:
The results of the Healthwatch Reading survey were discussed at a Berkshire wide TB workshop on 5 December 2017 with the aim of reflecting on our progress so far and setting our priorities and activities for 2018/19.
The outputs from the workshop informed the action plan which is being managed and implemented by Berkshire TB Operational Group which is a Berkshire-wide group that ensures the delivery of Latent TB Infection (LTBI) objectives through collaborative working across providers, CCG, primary care & local authority public health. The latent TB programme is part of the wider Berkshire TB strategy.

5. CONTRIBUTION TO READING'S HEALTH AND WELLBEING STRATEGIC AIMS

5.1 The activities contribute to the following Council's strategic aims:

- To promote equality, social inclusion and a safe and healthy environment for all
- Ensures that all vulnerable residents are protected and cared for
- Contributes to the narrowing of health gaps in Reading

5.2 The activities contribute to Reading's health and wellbeing strategic aim Priority 8: Reducing the number of people with tuberculosis.

6. COMMUNITY ENGAGEMENT AND INFORMATION

6.1 As described in section 4 above, a range of community engagement and information promotion activities have been undertaken on TB including:

Workshops were held for health professionals and for RBC staff during March 2017. Sessions have also been delivered to other groups by the New Entrant Screening Nurse/TB nurse team from RBH.

A workshop for the local teams delivering latent TB screening programme across Berkshire was held in December 2017.The aim was to: share and celebrate the journey so far from each team on the ground; agree future learning and best practice models; and develop action plans for the end of 2017-18 and 2018-19.This was attended by National leads from NHS England and Public Health England as well as the South East TB Control Board. The local work on latent TB screening in South Reading and Slough CCGs was recognised as excellent by the national team, particularly the effectiveness of our partnership working. Key learnings from the workshop identified that during 2018-19 local partners should:

- Maintain and build on the work that has been done to ensure a flow of referrals to the new entrant screening programme from GP practices.
- Continue to focus on reducing the number of people who do not attend their appointments.
- Improve the way that data is reported and shared between local partners and reported to Public Health England.
- Use findings from the Healthwatch survey to maintain and increase awareness of TB and the new entrant screening programme and to break down stigma that prevents access to services.
- Continue to reach out to underserved groups to raise awareness of the signs and symptoms of active TB and how to access services.

Local authority Public Health team took part in this year's theme 'Light up the World for TB 'on 24 March 2018. Christchurch Pedestrian Bridge was lit up in red to highlight the issue of TB in Reading and raise awareness in the fight against TB. Cllr Graeme Hoskin, Reading's lead councillor for health, wellbeing & sport, Wellbeing Team, representatives from CCG and TB teams from Royal Berkshire Hospital supported this event.

Presentation by Royal Berkshire Hospital nurses on the secondary care model for LTBI screening at the national TB nurse conference in June 2017. Sharing the challenges faced, the achievements and excellent collaborative working between primary and secondary interface in Berkshire.

Royal Berkshire Hospital nurses presented the local LTBI screening service at the GP Respiratory update as well as regular updates to Health Care Professionals and voluntary groups.

Community engagement events were organised at the following venues: Southcote Fair and Women's World Café Day, targeting staff at Royal Berkshire Hospital, Compass Recovery College Prospectus Launch event, New Directions event, Older People's Day and Carer's week 2018. The University of Reading Fresher's Fayre was attended in September to reach students who may be eligible for screening.

TB information stands were organised at Central and Battle library where members of public were given TB related information and information on new entrant screening services.

World TB Day 2018 promotion via local authority and CCG web pages.

TB awareness sessions organised for the Nepalese and Pakistani community.

7. EQUALITY IMPACT ASSESSMENT

7.1 Although no formal EIA has been undertaken by the local authority, the Healthwatch survey materials and methodology was developed to take account of the ethnicity of the target groups. All local latent TB resources are available in four different languages using language and images that the target populations could relate to.

8. LEGAL IMPLICATIONS

8.1 No legal implications of the survey or any proposed actions as a result of it's findings.

9. FINANCIAL IMPLICATIONS

9.1 Reading, as with Slough CCG, is one of only a few places in England to have new entrant screening services in secondary care. TB and Latent TB screening for residents in Berkshire West is offered at the Respiratory Medicine Department at the Royal Berkshire Hospital, although predominately utilised by South Reading residents, funded by Berkshire West CCG. This is a high quality service, offering LTBI screening to new entrants aged from countries with TB incidence of >40/100,000 of all ages.

NHS England reimburses the CCG for the element of the contract where South Reading patients aged 16-35 from countries with a TB incidence of more than

150/100,000 for screening and treatment. The CCG has also received funding for a project manager and community engagement. There are no financial implications for Reading Borough Council.

10. BACKGROUND PAPERS

- Reading TB Profile 2016
- Tackling TB Local Government's Public Health Role, LGA & PHE, 2014
- Tackling TB in Underserved Population: A Resource for TB Control Boards and their partners, PHE, 2017
- Tuberculosis Guideline NG33, NICE, January 2016
- Collaborative TB Strategy for England: 2015 to 2020, NHE & PHE, 2015
- Healthwatch TB Survey Report 2017
- Thames valley TB Strategy 2018-2020
- Berkshire TB Strategy 2017-2019

healthwatch Reading
advice • advocacy • action

Reading Borough Council
Working better with you

NHS
South Reading
Clinical Commissioning Group

What do Reading people know about TB?

Contact Healthwatch Reading at:
3rd floor, Reading Central Library
Abbey Square, Reading
RG1 3BQ
Telephone 0118 937 2295
Email info@healthwatchreading.co.uk

Contents

What do Reading people know about TB?

A community survey led by Healthwatch Reading

Survey aim: Reading Borough Council Public Health Team asked Healthwatch Reading to undertake a survey to provide a baseline of public awareness against which to evaluate the success of current and future TB campaigns.

About the survey respondents:

Total: 326 people, 48% of whom were aged 16-34, the main target group

Ethnicity: Most (55%) described as White British, then 8% Pakistani, 6% Indian, 6% other White, 5% Black African, 3% Mixed, and 10% other (mostly Nepalese)

Birth country: Most (62%) were born in the UK, then 8% from Nepal, 5% Pakistan, 4% India and the rest from a variety of countries.

Time in the UK: 31 people had been living here for five years or less, 74 had been here for between 6 and 60-plus years; the majority had always lived here

Residence: Most respondents (56%) said they lived in the Reading RG1 and RG2 postcodes. A small number lived outside of Reading borough, including Slough, Bracknell and Maidenhead.

Survey duration: The project ran from 1 August 2017 and 31 October 2017.

Survey method: Healthwatch Reading visited 12 community groups or events to ask and/or assist people in completing the anonymous survey. The survey questions and format were decided by Public Health.

Community impact: Reading Borough Council's Public Health team and South Reading Clinical Commissioning Group have welcomed the report, saying it will help influence a forthcoming TB action plan. They have also acknowledged the need to work with communities on reducing the stigma of TB.

Main survey findings:

- 91% had heard of TB before this survey
- 80% or more people knew that persistent coughing, or coughing up blood are symptoms of TB; the least known sympton was swollen feet
- 60% correctly identified some TB risk factors e.g. living in overcrowded homes
- 51% believed (wrongly) that a person with 'sleeping TB' can pass it on
- 32% believed (wrongly) that the BCG vaccine protects you from TB for life
- 25% do not know that you can carry TB germs even if an X-ray shows you have a clear chest
- 30% believed (wrongly) that having a TB test/treatment can affect your UK immigration status if you come from another country
- 36% would be embarrassed to tell family or friends if they had TB
- 41% do not feel that TB is relevant to them or their family
- Most people learned about TB from friends/family (36%), TV or school
- 83% believe NHS staff would treat TB-infected people with respect
- 65% of people do not feel that Reading residents know enough about TB

Introduction

About Healthwatch Reading

Healthwatch Reading was launched in April 2013 as part of a new national network of organisations in every local authority area, to give the public a greater say and influence over NHS and social care services.

Healthwatch Reading has a strong track record of reaching out and listening to diverse communities including people with mental health needs, the Nepalese and Polish communities, and the wide variety of people who visit local GP surgeries and A&E. Healthwatch Reading also speaks up for people via its place on the Reading Health and Wellbeing Board (HWBB), which oversees progress on local priorities to improve health and wellbeing of the Reading population.

Background: TB in Reading[1]

Latest data shows there were 25 notified cases of TB in Reading people, in 2015, a higher than average rate compared with England and the South East of England. These cases mostly affected people who were aged on average, 41 years, and living in the Reading Borough Council wards of Park, Abbey and Whitley, according to a paper presented to the Reading HWBB in July 2017.

These high rates spurred the HWBB to set a priority to reduce TB incidence, in the Reading Health and Wellbeing Strategy 2017-2020. Other actions have included:

- The launch of a local plan in 2015, to increase primary care referrals to the hospital-based new entrant screening service to offer free testing for latent TB countries into the UK in the previous five years. Since early 2016 it has tested 85% out of 271 invited for screening and found 20% carried TB (and could be offered treatment);
- An awareness event was held in January 2016 for Reading healthcare workers, to encourage them to refer eligible people to the new service;
- A public awareness event was held on 24 March 2017 (World TB Day), Broad St Mall, Reading, covering symptoms, risk factors, testing and treatment.

Aims of the survey

Reading Borough Council Public Health Team, with funding from South Reading CCG, commissioned Healthwatch Reading to undertake a knowledge, attitude and belief survey about TB. Healthwatch Reading was selected for its expertise in public engagement.

The project aims were to:

- provide a baseline against which to evaluate the success of current and future TB campaigns;
- provide insight into the knowlegde, attitudes and behaviours of local populations around TB, with a focus on surveying population groups living in the areas of South Reading where TB is more common; and
- signpost people to further information, resources or local screening services.

[1] Report to 14 July 2017 meeting of Reading Health and Wellbeing Board http://www.reading.gov.uk/media/7436/Item12/pdf/Item12.pdf

How the survey was carried out

Healthwatch Reading staff aimed to survey at least 150 people, particularly 18-34 year-olds who might have been born in, or had lived during the previous five years, in one of 58 countries outside of the UK where TB rates are high. (See Appendix 1 for full demographics)

We approached 12 different community events, community groups or service providers which we believed offered an opportunity to reach a diverse group of people. All 12 agreed to let us visit to promote and carry out our survey.

The survey locations included:

- a 'fresher's fair' at Reading College
- a 'fresher's fair' at the University of Reading
- the Indian Community Centre
- the Pakistani Community Centre
- a South Reading GP surgery waiting room
- a local homeless hostel
- a mental health event at a South Reading community centre
- a Baptist church community group
- the Reading Older People's Working Group.

(See Appendix 2 for a full list of survey events and dates)

During the project duration we also promoted the survey on the Healthwatch Reading website, through an electronic and postal monthly newsletter, at local Patient Voice meetings and through Facebook and Twitter channels.

Local Freshers Fairs were a great venue to capture responses from a high number of young people.

Our promotional material included artwork – particularly flags of countries where TB rates are high, and text translated into other languages – which are provided freely to local areas by the national charity TB Alert.

We exceeded our target for respondents, by surveying 326 people in total, due to high responses from students at the fresher fairs.

The ethnicity of respondents was in line with Reading's official population figures set out in the Joint Strategic Needs Assessment (JSNA), including:

- White British (55% of survey respondents) - compared with 66.9% JSNA figure;
- Pakistani (8%) - compared with 4.5% JSNA;
- Indian (6%) - compared with 4.2% JSNA. (See Appendix 1 for full ethnicity breakdown).

Colourful promotional material - and a freebie! - were used to engage potential survey respondents.

Apart from seven surveys completed online, the majority of people filled in a paper copy. Healthwatch Reading knew from previous projects that survey responses can be higher if people are personally approached by a person who can:

- explain the reason why their views are important and the potential impact for local people

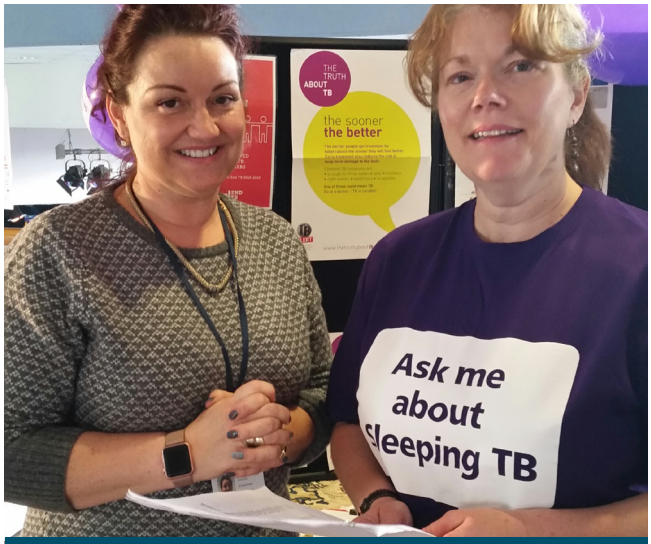
Our project work also involves liaising with other experts in community engagement - such as Cecily Mwaniki, from Berkshire Healthcare NHS Foundation Trust.

Visiting community groups in person was an important way of promoting inclusion, explaining survey questions, and showing people their views were valued.

We brought our portable info & advice stand to a variety of community events to promote the survey.

- assure people that their views are anonymous
- assist in explaining or simplifying questions that people might not understand because they do not understand English or have lower than average literacy levels
- provide information about accessing local services related to the survey topic.

The survey was designed by Public Health, based on a validated World Health Organisation survey. This type of survey is 'quantitative', which aims to generate data from answers to set questions, from enough people to be representative of the group you are interested in. This is different from 'qualitative' research, where people are given an opportunity to share their experiences and views in more depth, such as through a semi-structured interview or conversation.



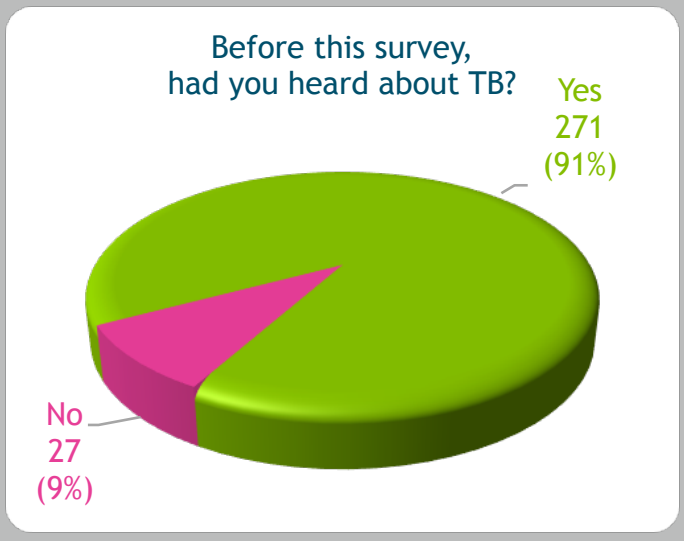
We also worked in partnership with NHS staff during the project to gather intelligence on TB, treatment, and target groups, including TB nurses Kay Perry, TB Nurse from the Royal Berkshire Hospital and Chrissy Long, Latent TB Manager from the NHS South Reading CCG.

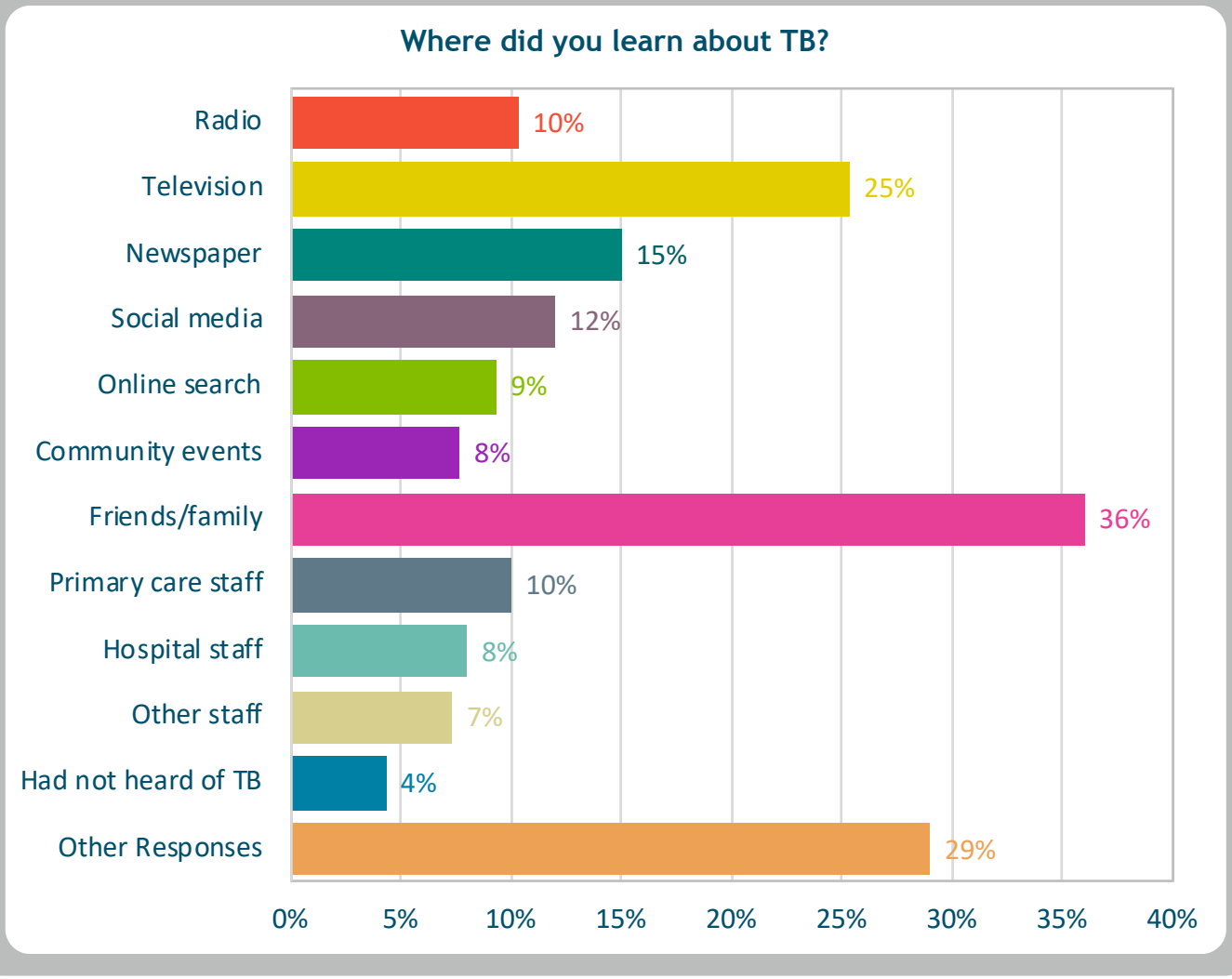
Survey Findings

General knowledge and awareness about TB

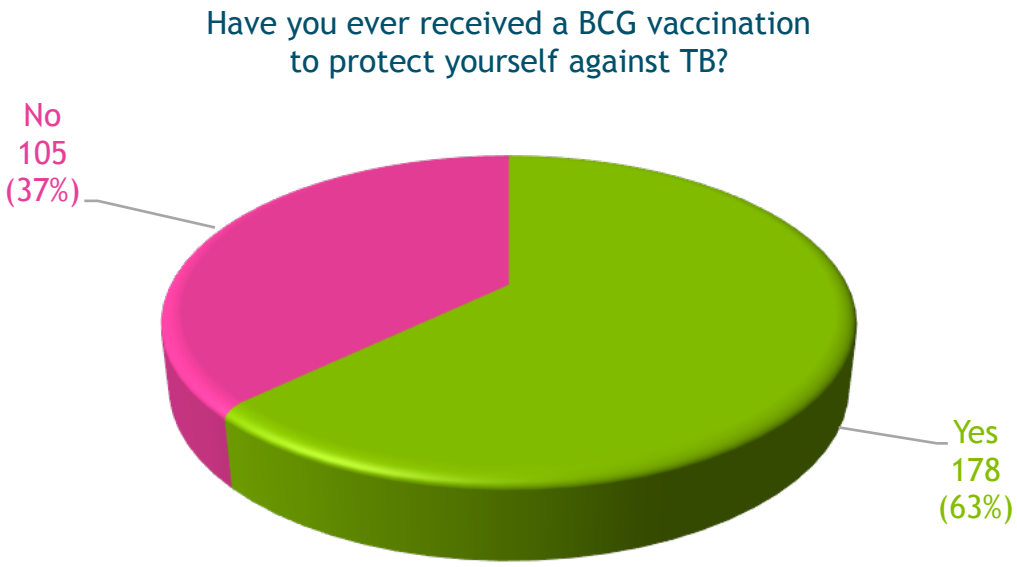
91% of people had heard about TB.

Most people learned about TB from family and friends. 'School' was the most common source of knowledge in the 'other' category.

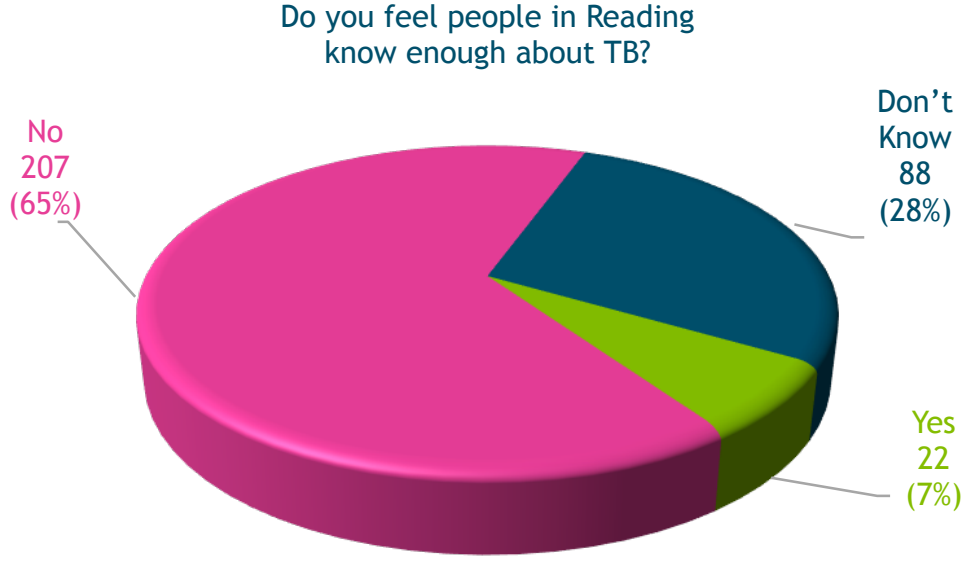




Nearly two-thirds of people (63%) had received a BCG vaccination to help protect against TB

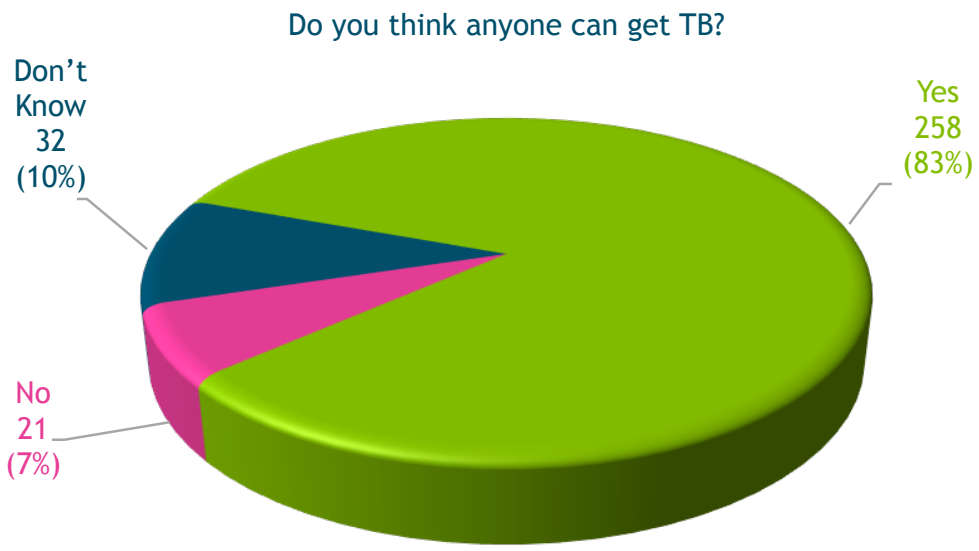


Almost two-thirds of people (63%) felt people in Reading did not know enough about TB

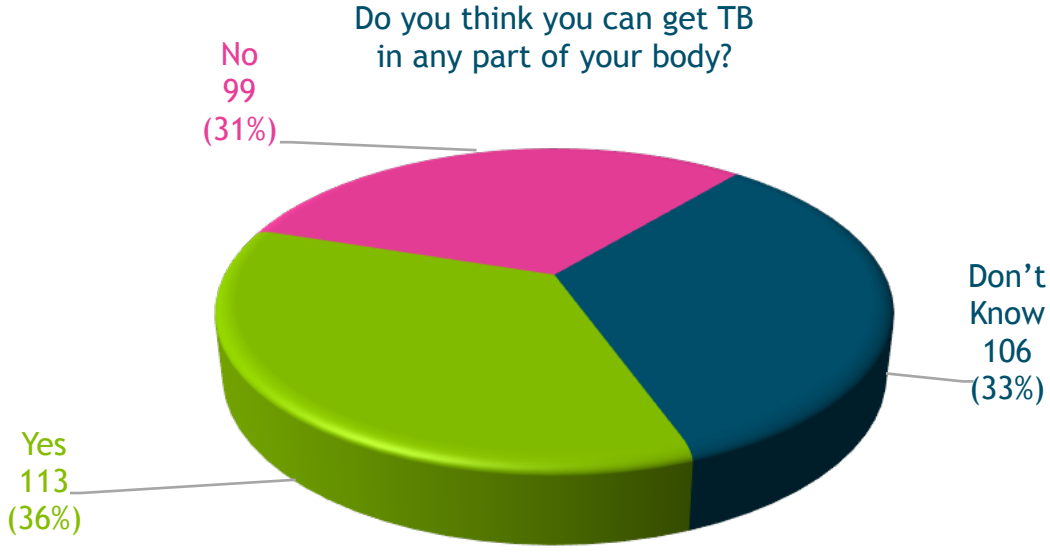


Knowledge about risk-factors, symptoms, prevention and treatment

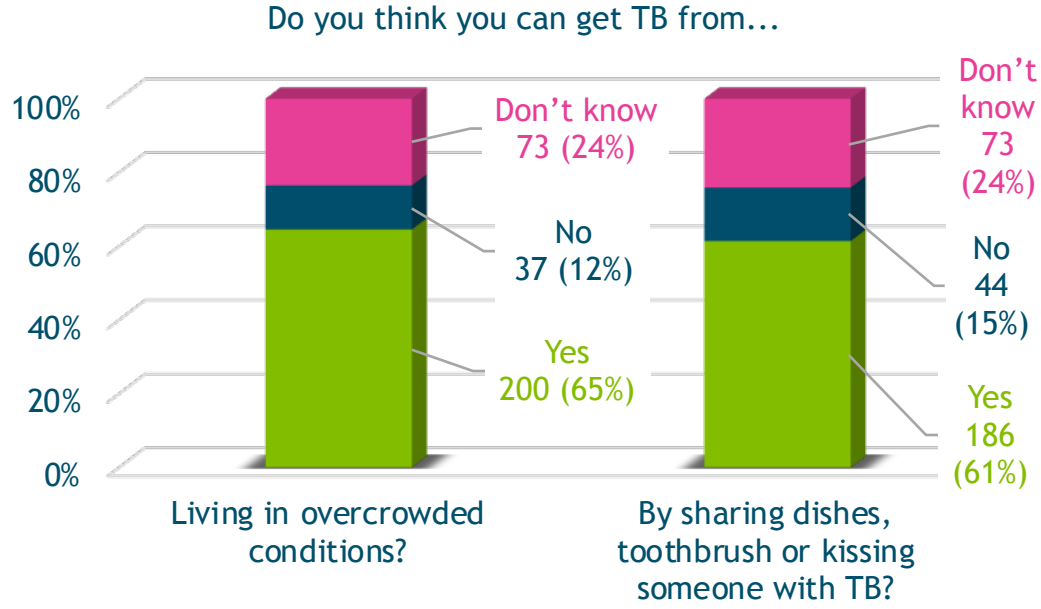
Most people (83%) knew that anyone can get TB



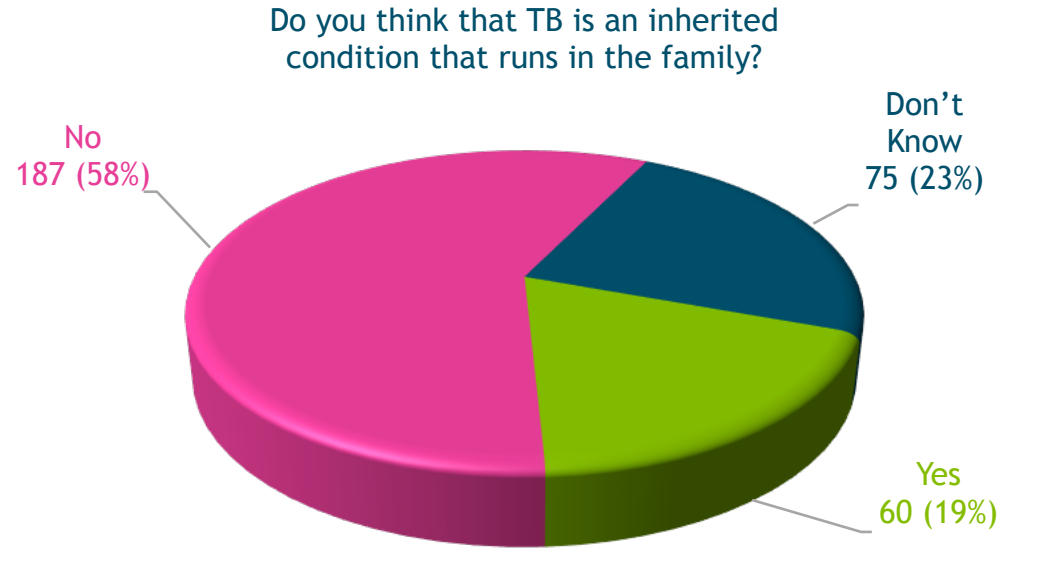
Only 35% knew that TB can affect any part of your body



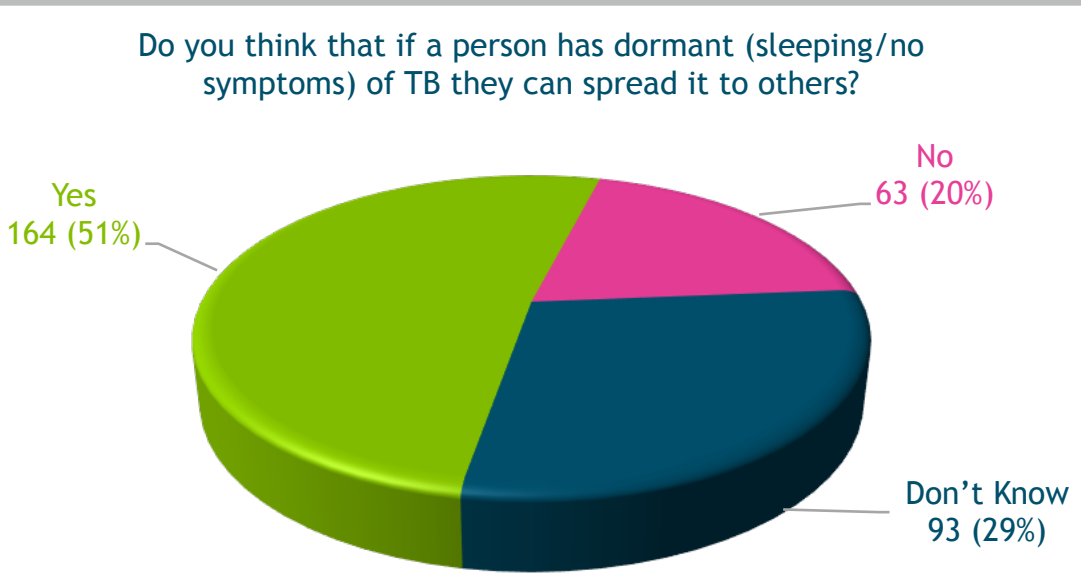
More than 60% knew rightly that living in crowded conditions is a risk factor for contracting TB. However 60% wrongly thought you could get TB by sharing toothbrushes with infected people, and nearly one-quarter were unsure.



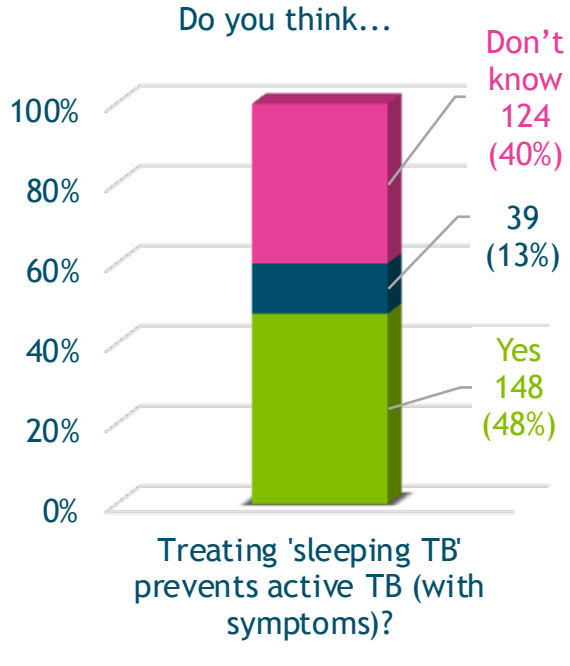
Nearly 60% knew that TB is not genetic, while 23% were unsure.



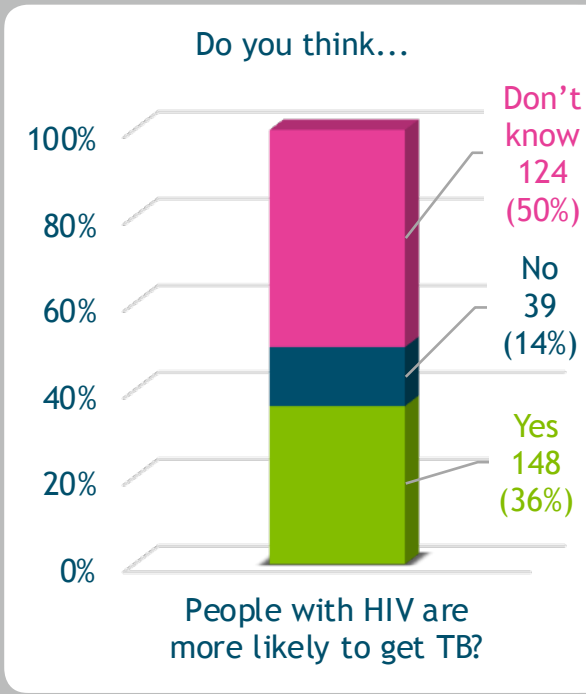
More than half (51%) mistakenly believed that people with latent (sleeping) TB could spread TB to others; 29% were unsure.



Less than half (48%) knew that treating latent TB can prevent active TB.

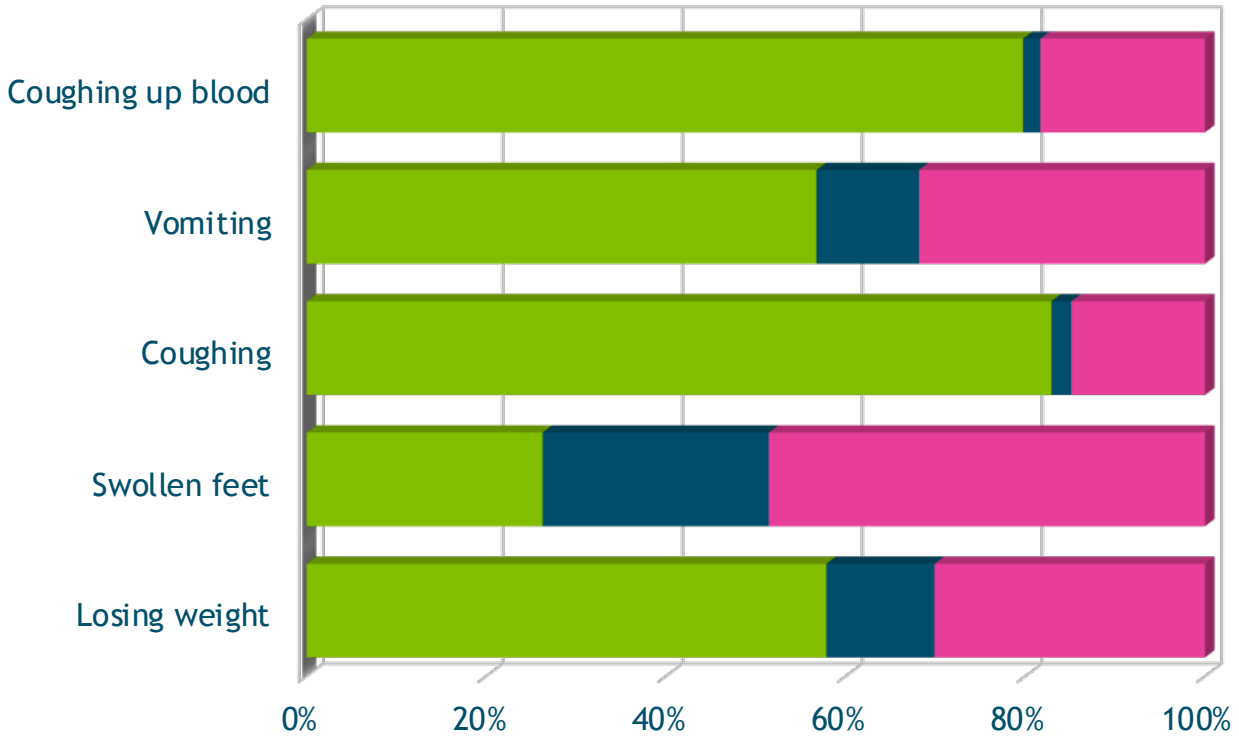


Only 36% knew that having HIV put you more at risk of TB.



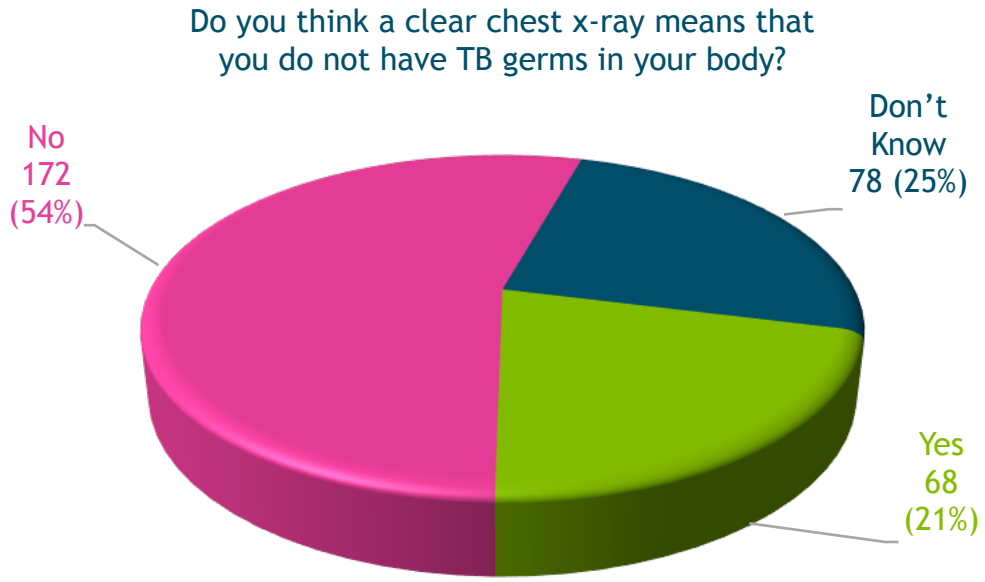
The most well-known symptoms of TB were coughing (83%), or coughing up blood (80%); the least known was swollen feet (26%)

How many of the following do you think are symptoms of TB?
Please tick as many as you think.

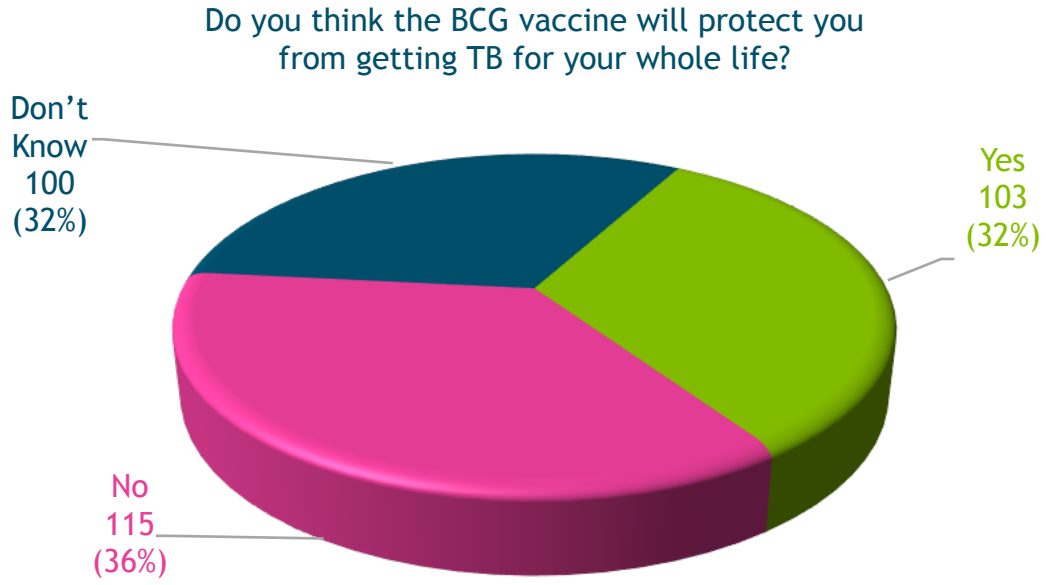


	Losing weight	Swollen feet	Coughing	Vomiting	Coughing up blood
Yes	173	72	262	164	248
No	36	69	7	33	6
Don't know	90	133	47	92	57

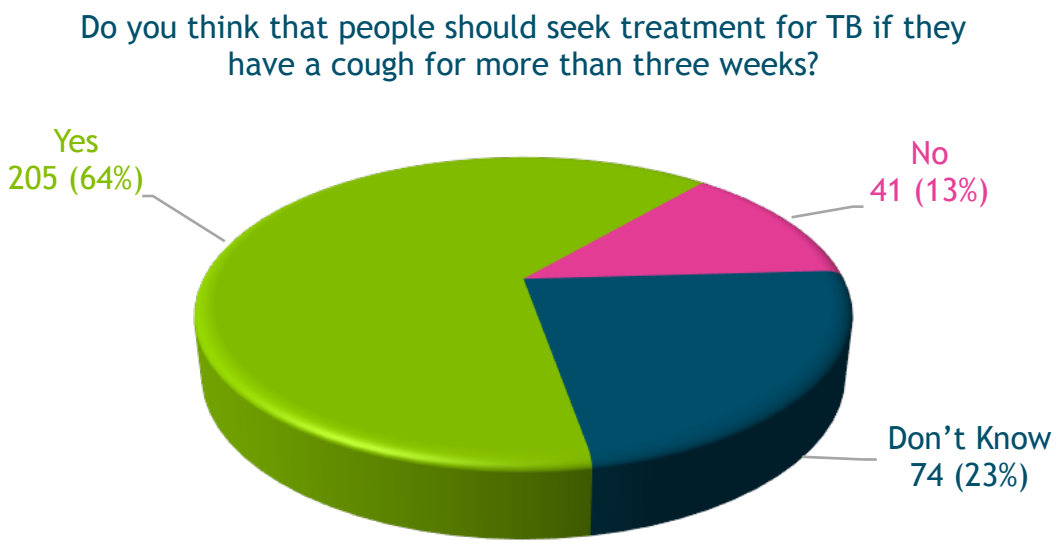
Only 54% knew that a clear chest X-ray does not mean you don't have TB germs in your body; 25% were unsure



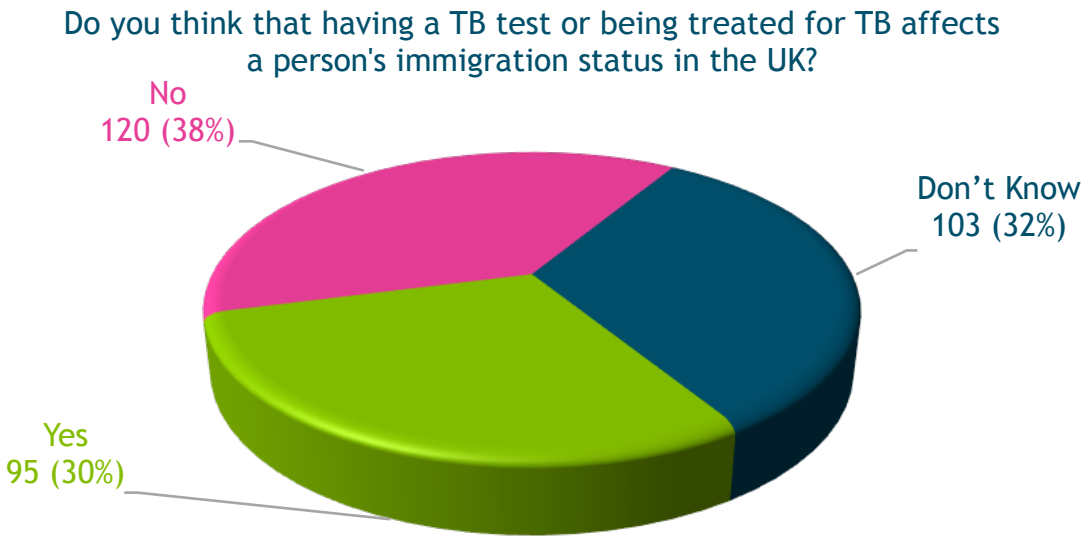
Only 36% knew that a BCG vaccine's protection may not last for life



Nearly two-thirds of people knew that people should seek treatment for TB if they have had a cough for more than three weeks



Only 37% knew that being tested or treated for TB does not affect a person's immigration status in the UK, 32% were unsure

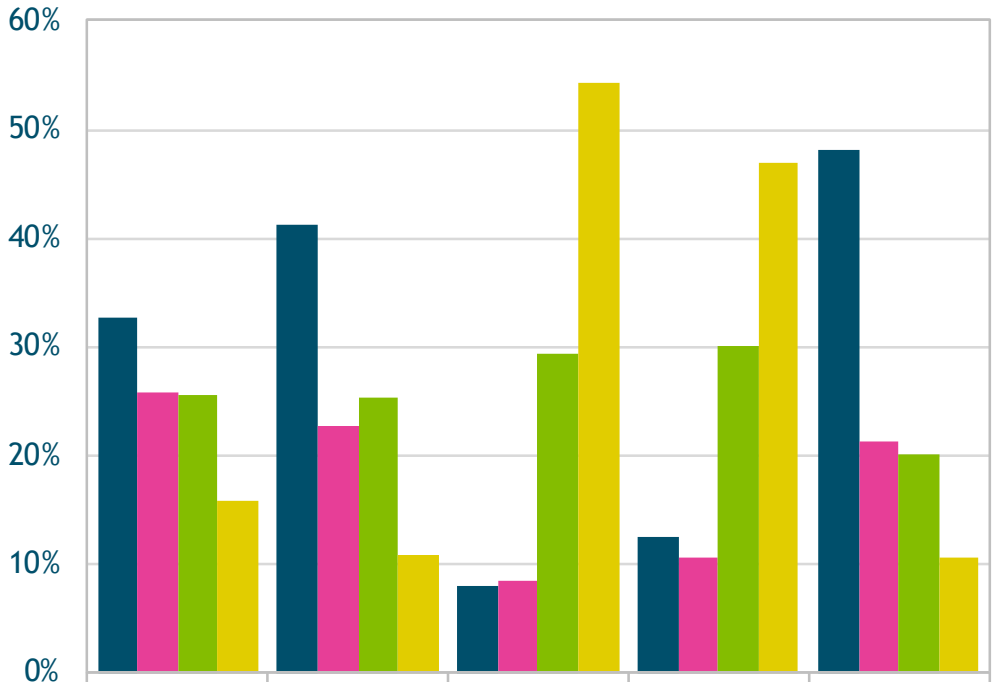


Personal attitudes about TB

- 77% would be worried about passing on TB germs if they had TB;
- 36% would be embarrassed to tell people if they had TB; and
- 30% felt friends or family would think badly of them if they had TB
- 41% believed TB was not relevant to them or their family

Respondents revealed the stigma surrounding TB but also showed confidence in NHS staff to treat them well.

Your feelings about TB. Please tick one box in the scale



	TB is not relevant to me or my family	You are or would be embarrassed to tell people you had TB?	A person with TB will be treated with respect by healthcare staff	You worry or would be worried about passing the TB germ to people you live with	Your friends/ family may think badly of you
You strongly disagree	33%	41%	8%	13%	48%
You disagree somewhat	26%	23%	8%	11%	21%
You agree somewhat	26%	25%	29%	30%	20%
You strongly agree	16%	11%	54%	47%	11%

Discussion

The survey findings suggest that most people in Reading have, at the very least, heard about TB. This could be because nearly two-thirds of respondents had previously received a BCG vaccine, which is given to offer protection from TB.

People were most knowledgeable about the facts that anyone can get TB, that symptoms can include coughing or coughing up blood.

However, people were less knowledgeable about other facts, such as symptoms also including weight loss, vomiting, or swollen feet; that having HIV can put you at greater risk of TB; or that the BCG vaccine is not a lifelong guarantee against TB.

The most worrying lack of knowledge surrounded latent, or 'sleeping' TB, with less than half of people not realising that treating latent TB can prevent people developing active TB with symptoms. More than half of people wrongly thought that people with latent TB can pass on TB germs to others, which may affect whether people agree to be tested for latent TB, due to fear or stigma. Three in 10 people felt family or friends would think badly of them if they had TB, and a greater number – 36% - would be embarrassed to tell people if they had TB. If people who have TB are afraid to be open with those closest to them, then this may affect their ability to take preventative measures to spread the infection.

The survey also revealed confusion about whether TB affects a person's immigration status, and this could be another barrier to people recently arrived in the UK from seeking testing or treatment. However, people expressed strong confidence in the NHS, with 83% believing healthcare staff would treat them with respect if they did have TB.

The survey suggests that people gain knowledge and awareness of TB mostly through family and friends, television, or education at school or university. Only 8% said they learned about TB from community events, and 18% from health professionals. In answering this question, people might have been recalling the first time ever they were made aware of TB, as the question did not specifically ask people if they recalled any locally run public awareness events in Reading.

Overall, there appears to be an appetite for further public awareness initiatives about TB, with nearly two-thirds believing that people in Reading do not know enough about TB.

The findings show that families and schools are the most common sources of current knowledge about TB, which may suggest that future awareness campaigns should involve individuals who are willing to spread correct information to their own families, and educational institutions that can build TB information into lessons, or host targeted sessions from experts.

To reach the most at-risk groups, materials or information should include translated, simple to understand text and/or photos or images. Verbal information sessions should also be supported by professional translators, as we found that some people could not take part in the survey due to language barriers.

The survey findings should inform the work of a dedicated Latent TB Programme Manager for South Reading, who has been in place since September 2017. Their role will be to work closely with TB nurses, Reading Public Health Team and community groups to reach out to less well-served communities to improve uptake of testing and encourage early presentation and timely onward referral with TB symptoms.

Discussion

Healthwatch Reading highlights a selection of other initiatives from across England that Reading services might consider trialling:

Find & Treat outreach service, University College London Hospitals NHS Foundation Trust

Find & Treat is a specialist outreach team working with more than 200 NHS and third sector, frontline services to tackle TB among homeless people, drug or alcohol users, vulnerable migrants, and people who have been in prison. The team includes former TB patients who work as peer advocates, TB nurse specialists, social and outreach workers, radiographers and expert technicians.

The service brings a mobile X-ray unit into all London boroughs to screen people for active TB. The outreach team also finds people who have stopped treatment before completing the full course, supports them to resume treatment, and provides practical assistance such as residential TB treatment for homeless people.

https://www.uclh.nhs.uk/OurServices/ServiceA-Z/HTD/Pages/MXU.aspx

Newham, east London, Latent TB screening and treatment closer to home

New patients joining GP surgeries at risk of latent TB, are offered free screening. If they test positive, they can choose to have treatment designed to prevent them from getting active TB, from one of 26 Newham pharmacies, closest to where they live. This convenience may increase the likelihood that people complete the full course of treatment. NHS officials are also working with the local housing department to ensure they take action against private landlords who allow overcrowded homes (where TB could be more likely to spread).

https://www.gov.uk/government/case-studies/pioneering-a-latent-tuberculosis-tb-programme-in-newham

Doncaster health bus reaching out to asylum seekers and refugees

Rotherham, Doncaster and South Humber NHS community trust launched a scheme in 2015 to send its brightly coloured health bus to visit the Doncaster Conversation Club every two months. The club is a regular group for asylum seekers and refugees who practise English and the visits allowed people to get on-the-spot testing for latent TB, and then treatment if they tested positive. Those who had been treated could then provide peer support and the regular bus visits allowed follow up care during treatment.

https://www.gov.uk/government/case-studies/identifying-and-treating-tuberculosis-tb-in-under-served-groups

Response

Response from South Reading Clinical Commissioning Group (CCG) and Reading Borough Council

South Reading CCG and Reading Borough Council thanks Healthwatch Reading for this comprehensive analysis of the knowledge, attitudes and behaviours of the local population relating to TB. As a locality we have higher rates of TB than neighbouring CCGs and the England average, so this is an important issue for the people of Reading and 'Reducing the Number of People with Tuberculosis' has been adopted as a priority of the Reading Health and Wellbeing Board. This survey enables us as a system to gain a better understanding of how local people think about TB during the first phase of a communication and engagement campaign focussing on sleeping (latent) TB. Together we have worked hard to widely promote the signs and symptoms to TB and latent TB at events and public engagement opportunities. We have created a set of locally tailored public information to raise the profile of TB and latent TB with the eligible community. We have worked with local GP practices to flow referrals through to secondary care for latent TB testing and this process is embedded and is starting to work well.

We acknowledge, however, that while referrals are starting to be made effectively, a substantial proportion of people invited choose not to attend their screening appointment. The results of the survey show that there is still work to tailor this campaign so that people are better informed about the reason they are being asked to attend the appointment. The survey also tells us that stigma around TB is still an issue for some communities and as a system we recognise that further work with affected communities is needed.

The results of this survey were discussed at a Berkshire wide TB workshop on 5 December 2017 with the aim of reflecting on our progress so far and setting our priorities and activities for 2018/19. The outputs from the workshop will form an action plan which will be managed and implemented by the Latent TB project manager who is part of the Berkshire TB Operational Group who will monitor the overall action plan. The latent TB programme is part of the wider Berkshire TB strategy and is overseen by the Berkshire TB Strategy Group.

Conclusion

This project exceeded its aim of surveying at least 150 people, with a total response of 326 people.

The findings show which facts about TB the public are most aware of, and where there are gaps or mistakes in knowledge. The survey also highlights personal fears or beliefs about TB that might affect uptake of screening or treatment.

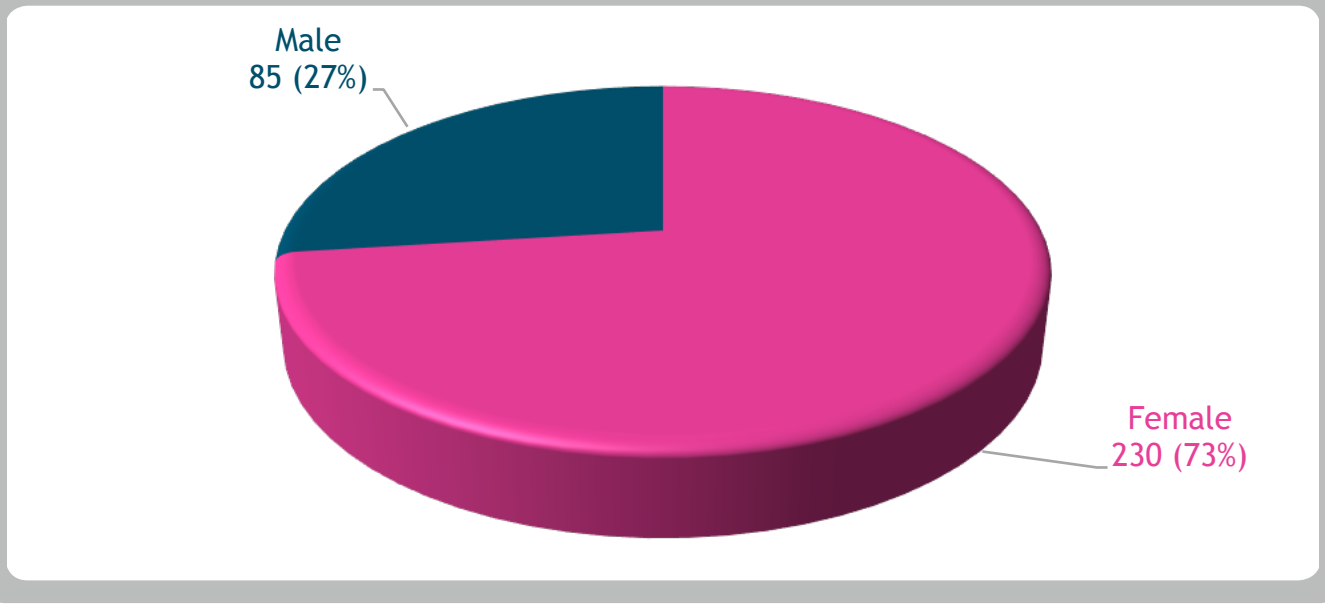
We are pleased that the findings will influence a forthcoming TB action plan and that the CCG and RBC have acknowledged the need to further work with affected communities on addressing the stigma surrounding TB.

We thank all the people in Reading who shared their views in survey responses, and the community groups and organisations that facilitated our efforts in reaching a wide range of people.

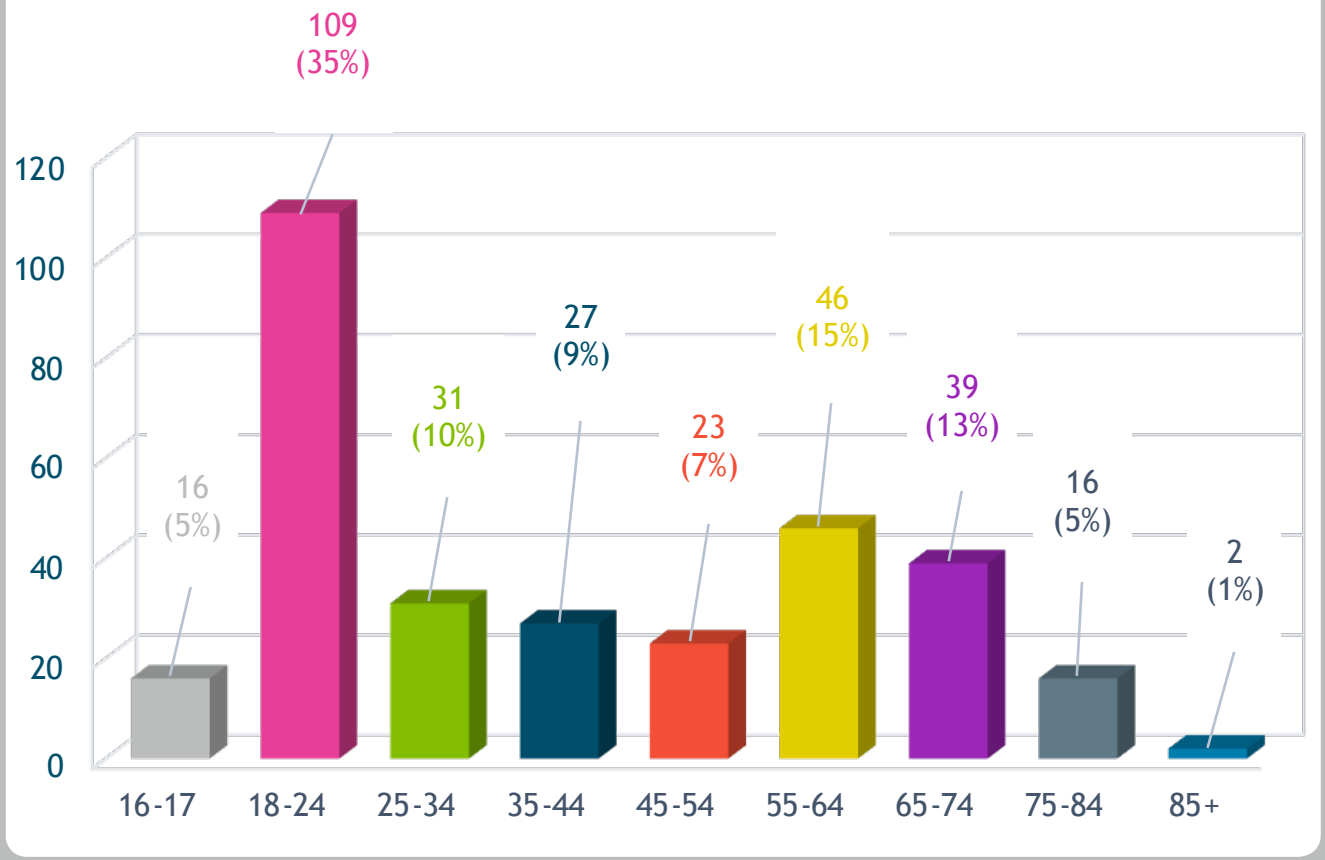
Appendix 1:

About the people who answered the survey

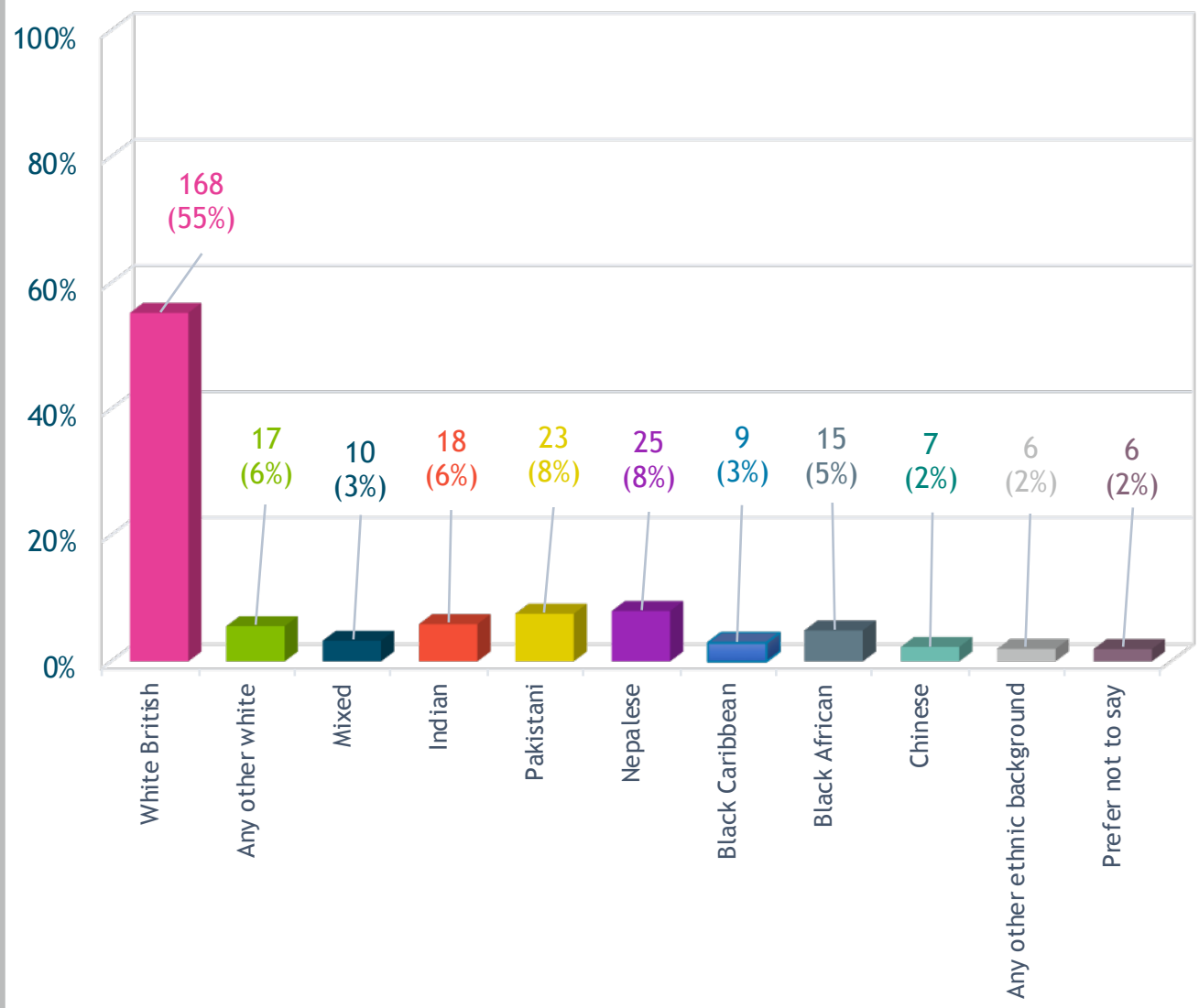
What is your gender?



How old are you?

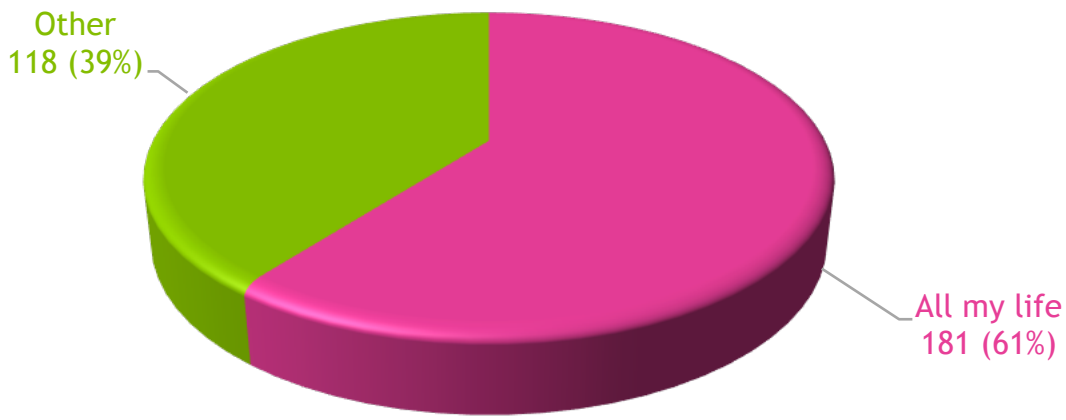


What is your ethnicity?



Appendix 1

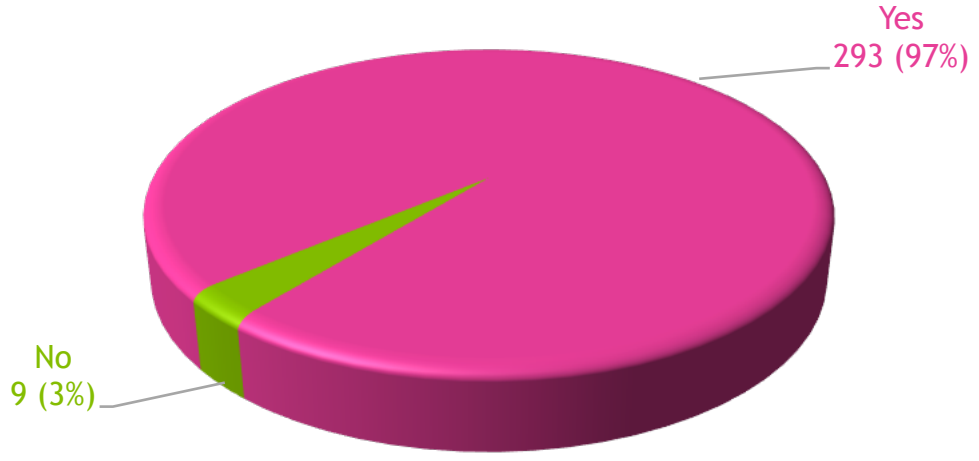
How many years have you been in the UK?



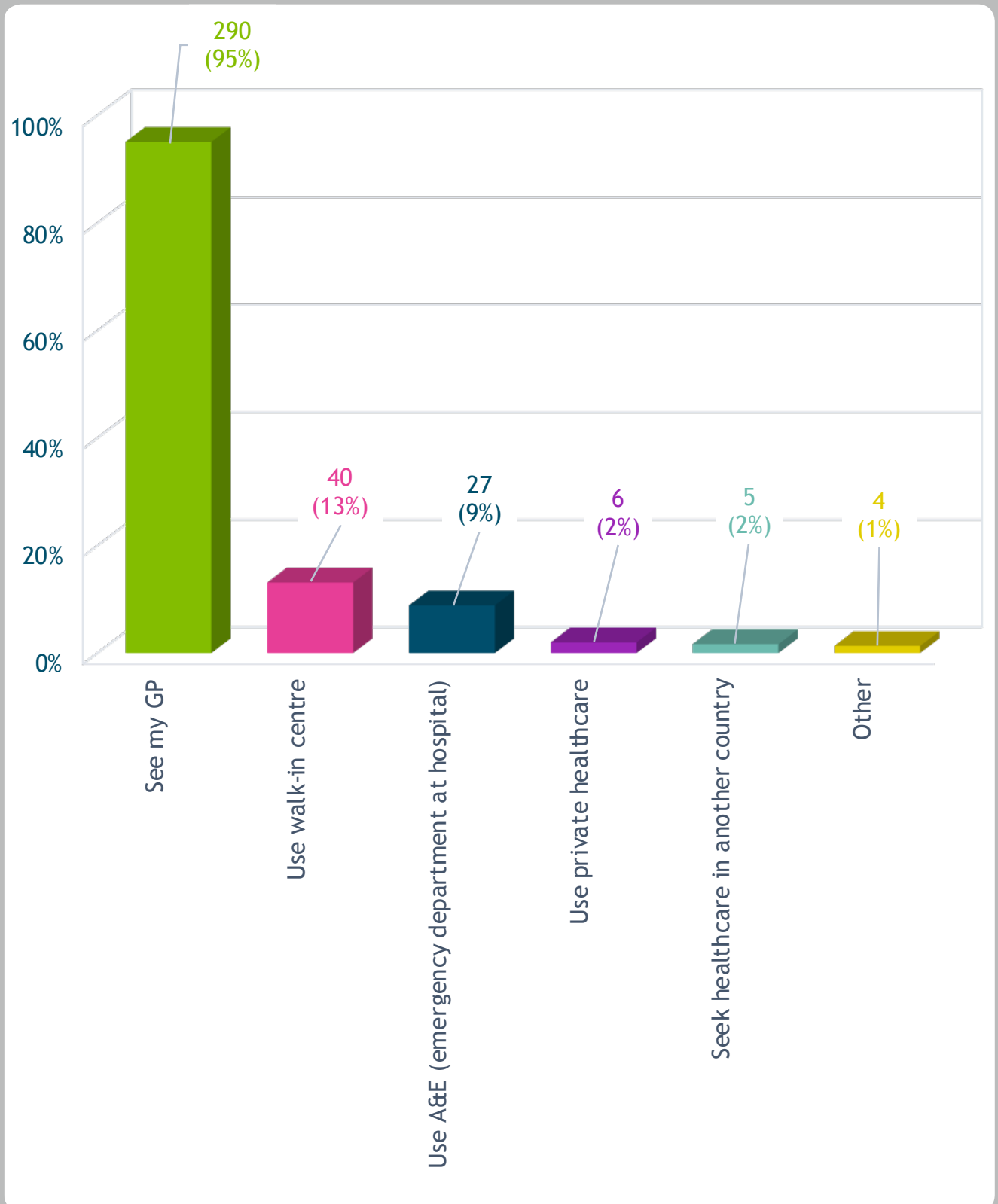
Other answers:

Up to 5 years ..... 31 people
6-10 years .....17 people
11-19 years ..... 18 people
20-29 years ..... 5 people
21-29 years..... 3 people
30-39 years..... 9 people
40-49 years..... 11 people
50-59 years..... 10 people
60 and over ..... 1 person

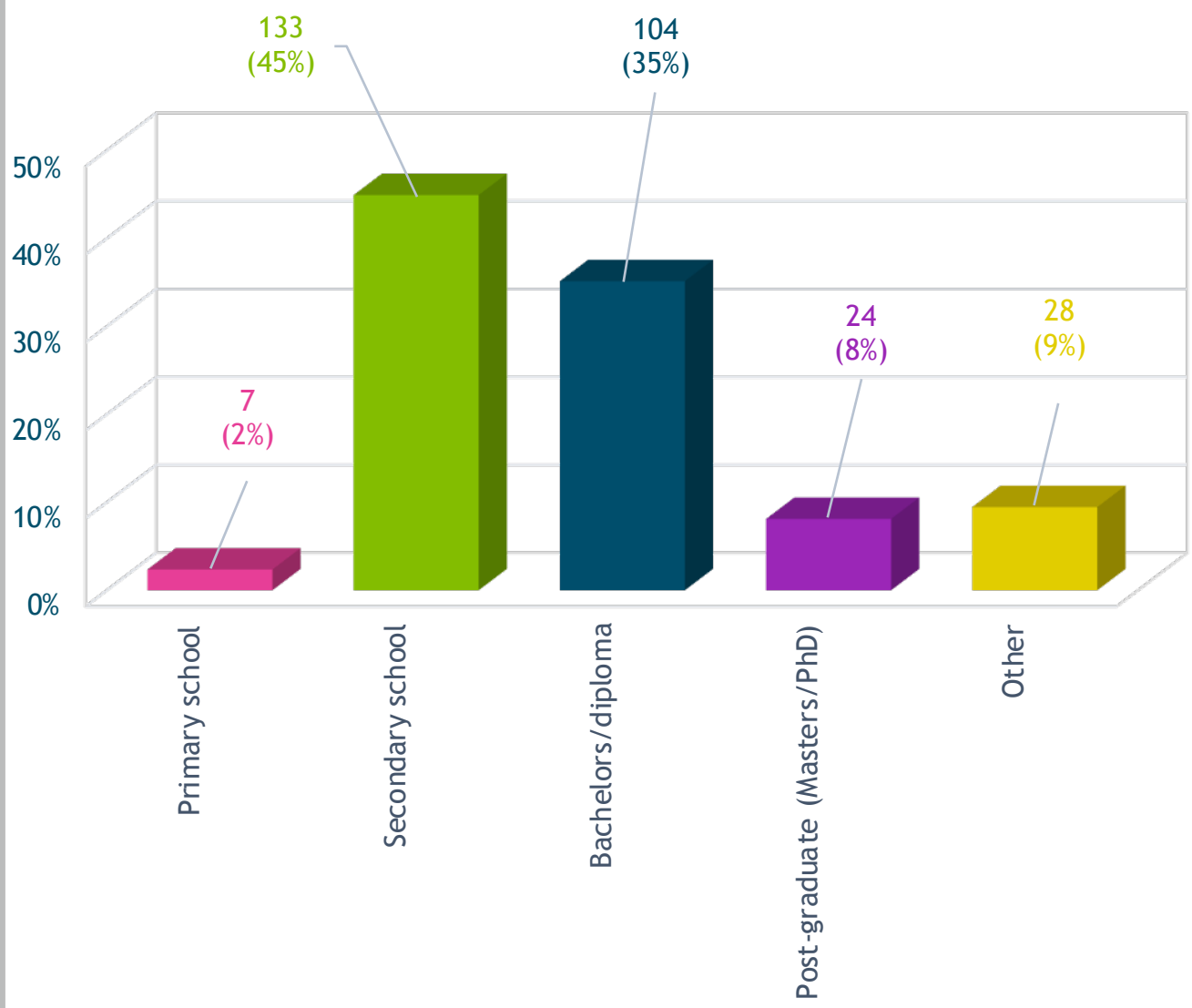
Are you registered with a GP surgery?



How do you normally access health care services?

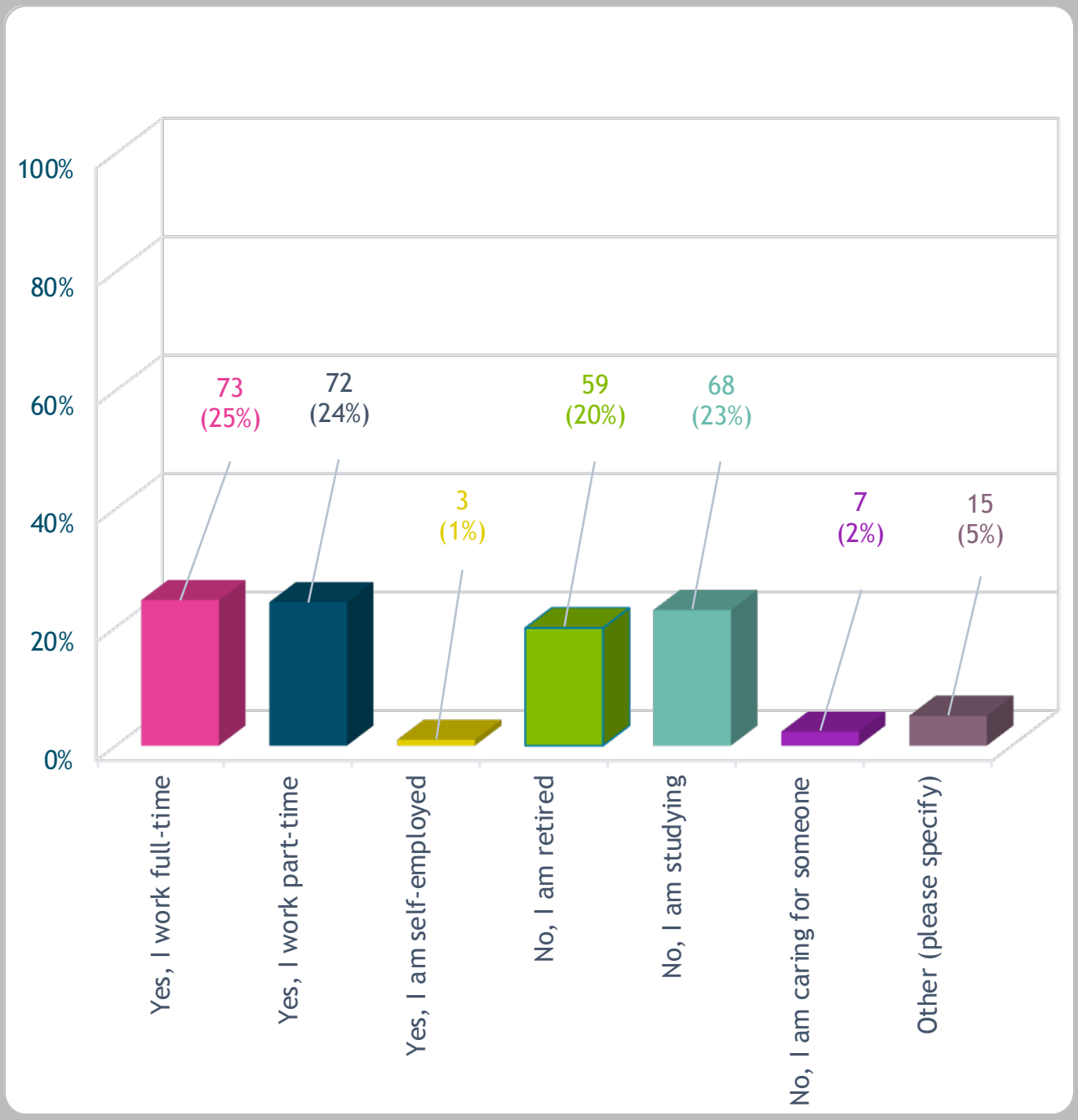


What is your highest level of education?



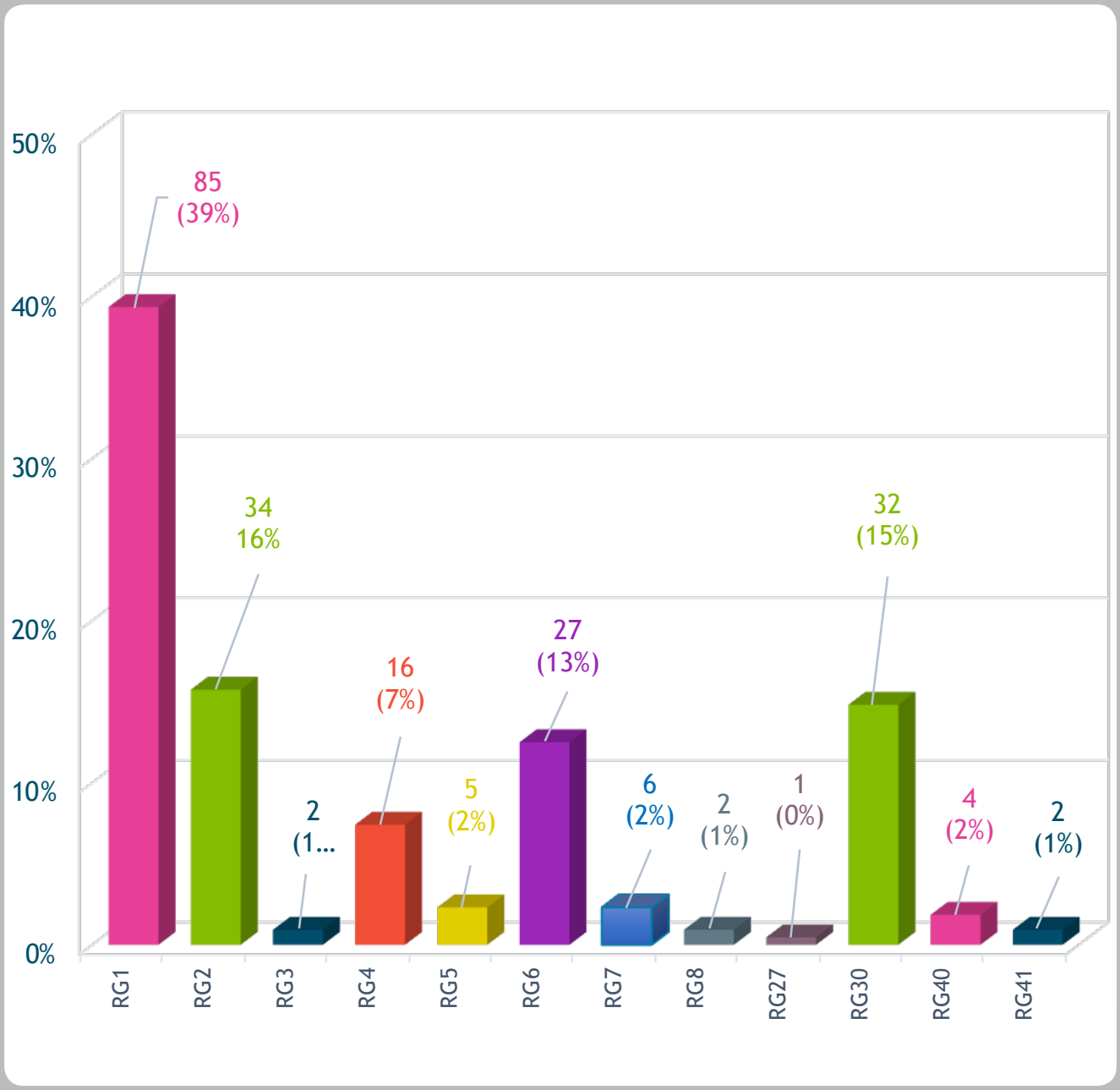
Other responses: mostly 'College'

Are you employed?



Other responses: mostly full-time mum/housewife

What is the first half of your postcode?



Other responses:

Tilehurst or Calcot Postcode ..... 9 people

Slough postcode..... 6 people

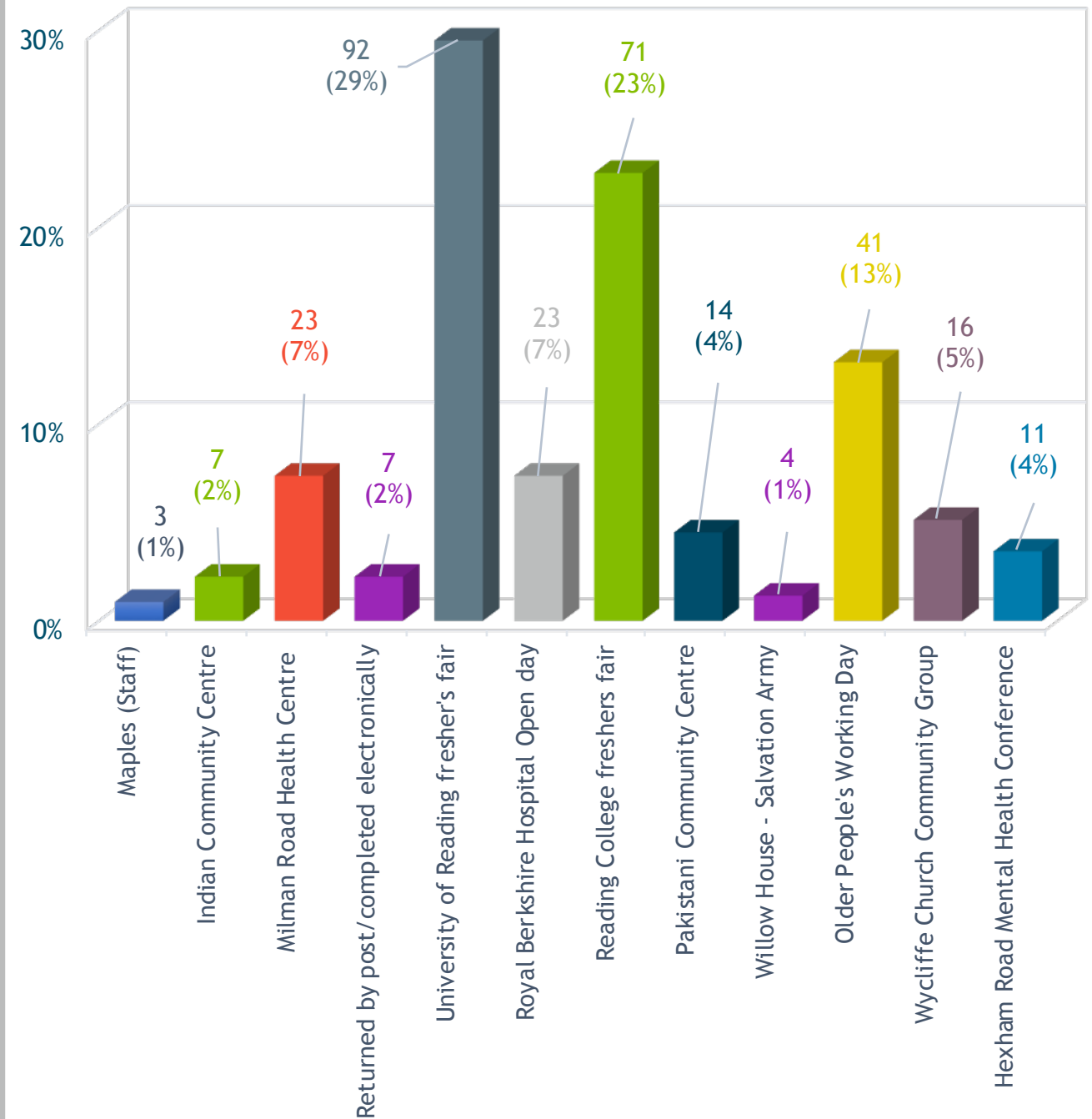
Bracknell postcode ..... 5 people

Maidenhead postcode ..... 4 people

Appendix 2:

Where and when the survey was conducted

Which Healthwatch Reading interview session?



Contact Healthwatch Reading at:
3rd floor, Reading Central Library
Abbey Square, Reading
RG1 3BQ
Telephone 0118 937 2295
Email info@healthwatchreading.co.uk

Key area	Priorities for Action	Proposed actions	Proposed organisation responsible	Key contact	Due date	RAG	Comments - following Berks TB Strategy Grp Feb 2018
1. Improve access to services and ensure early diagnosis		Develop and deliver impactful,public-facing communication and social marketing campaign to increase awareness of active and latent TB and local services among target communities and those working with them	Berks TB Comms Working Group / LTBI Ops group	Jo Jefferies	Feb-17	GREEN	in progress, on target
		Assess knowledge attitudes and behaviours relating to TB in local populations at increased risk and use output to inform communication and marketing campaigns	Berks TB Comms Working Group / LTBI Ops group	Jo Jefferies	Jun-17	GREEN	Survey in Reading completed. Survey results was presented at a Berksire wide TB workshop on 5 Dec and was reported to March HWBB
	Increase awareness about TB amongst local health and social care professionals as well as third sector organisations	Produce a calendar of local health and wellbeing events at which to include TB health promotion	Berks TB Comms Working Group / LTBI Ops group	Jacquline Riddles / Chrissy Long/Rojina Mandahar/Rukayat Akanji-Suleman	ongoing	AMBER	JR and KS met and put together a Comms plan summary for the remainder of the year. There are 8 key points and an action log. World TB Day events delivered
		Promote NESS at community health and wellbeing events and programmes included in calendar	Berks TB Comms Working Group / LTBI Ops group	Jo Jefferies	ongoing	GREEN	Latent TB community engagement events were delivered by RBC Wellbeing team during at Care's Day 2018 Slough BC team working with S4H to promote NESS and raise awareness of TB
2. Provide universal access to high quality diagnostics	**Ensure that any issues resulting from the transfer of pathology services from Royal Berkshire to Frimley Park are fed back to the trust and to the appropriate commissioner to ensure a 24 hour turnaround on microscopy and a responsive and high quality diagnostic service**	Keep and review log of issues	West Berkshire TB team EAST TB Teams	Sarah Menzies / Tracey Langham	ongoing	GREEN	Service has improved in both sites. 5 working day turn around in Slough
	Ensure appropriate provision of LTBI testing in line with national LTBI programme	Monitor update and LTBI and active TB rates / numbers of the two new entrant screening programmes in line with PHE requirements and through KPIs in local quarterly reports	CCG	Karen Grannum, Jo Greengrass	quarterly	GREEN	Quarterly reporting to CCGs and continuing submission of data to PHE for eligible new entrants
	Attempt to address barriers to access	Explore options for accessible service provision in Slough	CCG commissioners and FHFT Service lead	Jo Greengrass / Sarah Menzies	Dec-17	GREEN	Weekly NESS clinic now running at Upton Hospital Slough.

4. Ensure comprehensive contact tracing	**Continue to work closely with health protection colleagues to ensure robust and effective contact tracing takes place as standard participation in TV Cohort Review**	Continue participation in TV Cohort Review	NHS Providers and PHE		ongoing	GREEN	Ongoing
5. Improve BCG vaccination uptake	**Agree and implement an evidence-based Berkshire BCG immunisation policy**	Consider local incidence data, NICE guidance, BCG policy in Green Book and national service specification and discuss impications with all stakeholders including TB teams and midwifery colleagues	NHS England	Nisha J	Oct-18	GREEN	Risk-based strategy adopted by East and West Berkshire services. ACTION - Nisha to circulate final policy to maternity and TB Team COMPLETE
	Monitor provision and uptake of BCG vaccination as new policies are implemented	Develop / maintain robust systems for providers to record and report uptake via Annual BCG Audit	NHS England	Annual BCG Audit	Jul-18	AMBER	Clinical audit 3 -6 months after implementation of agreed policy. ACTION - Nisha to confirm dates NJ/JJ/SM to repeat audit carried out in RBH in FHFT - Nisha to link with Wexham Midwifery lead
	Ensure processes are in place to identify eligible babies, even in low-incidence areas	Ensure a processes for identification and follow up of eligible babies is included in BCG policy	NHSE with Midwifery and TB teams in FHFT and RBH	Nisha J	ongoing	GREEN	Nisha to share process with Group
		Monitor success of process for identiofication and follow up of babies in both high and low incidence areas	NHSE with Midwifery and TB teams in FHFT and RBH	Nisha J	ongoing	GREEN	NJ to update group
6. Reduce drug-resistant TB	**Mitigate the clinical and social risk factors associated with development of drug resistance in under-served populations by maintaining high treatment completion rates and ensuring thorough contact tracing around MDR cases**	Continue to provide DOTS to vulnerable patients where appropriate	NHS providers (RBH and FHFT)	Sarah Menzies / Tracey Langham	ongoing	GREEN	
		Develop and maintain links with services providing support to under-served groups in all LA local authority areas	TB Teams with support from LA Public Health and CCG	Sarah Menzies / Tracey Langham	ongoing	GREEN	Berks EastTB Team liaising with Homeless Support Group in Slough
	Work to develop the provision of in-reach services to under-served and high-risk populations	Maintain and continue to develop new links with community groups to identify opportunities for community-based LTBI testing and awareness of TB symptoms	LTBI programme manager / project manager NESS nurses	Jaqueline Riddles / Chrissy Long	Dec-17	GREEN	LTBI clinics now running in Upton Hosptioal Slough and Farnham Rd Practice. RM delivered TB 4 awareness sessions to Nepali, Pakistani & African groups as part of wider health & wellbeing engagement
	Align local service provision to these groups as	develop and promote referal pathways into NESS from non-NHS providers	LTBI programme manager / project manager NESS nurses	Jaqueline Riddles / Chrissy Long	Dec-17	AMBER	Update required from Ops Group

7. Tackle TB in under-served populations	**per NICE recommendations**	Reduce barriers for GP registration of underserved population with transient accomodation by ensuring practices are aware that they can register patients without proof of address	CCG	Jo Greengrass / Karen Grannum	Dec-17	GREEN	
	Increase awareness about TB, latent TB and NES services among high risk and under-served groups	Continue to deliver impactful,public-facing communication and social marketing campaigns to increase awareness of active and latent TB and local services among under-served groups	Berks TB Comms Working Group / LTBI Ops group	Jaqueline Riddles / Chrissy Long	ongoing	GREEN	JR and KS met and put together a Comms plan summary for the remainder of the year. There are 8 key points and an action log.
	Develop robust pathways to enable timely discharge of patients into appropriate accomodation	Work to develop a clear pathway for housing homeless cases of TB both with and without recourse to public funds	LA public health / NESS nurses	Clare Humphreys/Jo Jefferies	Dec-17	AMBER	TV Guidance Document Produced by PHEC and used to guide action in two cases. Draft MOU developed for Slough BC and Berkshire East CCG - **with SBC for final sign off June 2018.** Work is in progress to develop an MOU between the CCGs and local authorities across Berkshire West to ensure provision of accommodation to homeless TB patients with no recourse to public funds
8. Systematically implement new entrant screening	**Ensure that new entrants are referred routinely to local services for screening by strengthening local pathways**	review NESS KPIs to identify blocks in pathway and identify solutions	CCG commissioners with support from LA PH and PHE	Jaqueline Riddles / Chrissy Lor	Dec-17	AMBER	see below
		Work to review and reduce 'Do Not Attend' appointments in NESS clinics	CCG commissioners and NESS teams	Jaqueline Riddles / Chrissy Lor	Dec-17	AMBER	DNA's have reduced to 28% in Slough service in Q2 2018. In Reading, practices are visited regularly to encourage effective referrals by using
		Set up Operational Group to develop and share best practice and coordinate approaches	CCG commissioners with support from LA PH and PHE	Jaqueline Riddles / Chrissy Lor	Jun-17	GREEN	Group set up and is reporting to TB Strategy Group.
		Review entry to NESS pathway from non-GP sources including GUM, DAAT, Social Care and community / self referal	CCG commissioners with support from LA PH and PHE	Jaqueline Riddles / Chrissy Lor	Dec-17	AMBER	update from LTBI Ops Group required for this work
9. Strengthen surveillance	**Use available data sources to monitor and drive improvement in performance**	Utilise TB dashboard, feed ETS and new LTBI surveillance data into Thames Valley TB cohort review	PHE / LA Public Health	Clare Humphreys	ongoing	GREEN	

and monitoring	**Gather service-user views on local services to identify and address potential issues and barriers to care**	Repeat patient survey annually	TB teams	Sarah Menzies / Tracey Langham	Baseline survey before March 2017	GREEN	Findings presented at TB Strategy Group Feb 2018
10. Ensure an appropriate workforce to deliver TB control	**Work with commissioners to ensure robust plans are in place for maintaining recommended levels of staffing for current and near-term future capacity**	Workforce ratios referred to in new service specifications - case load and staff capacity and skill mix to be reviewed after 6 months	TB teams	Jo Greengrass / Karen Grannum	Sep-17	GREEN	Monitored through commissioner / provider meetings

TO:	**Health & Wellbeing Board**		
DATE:	**13 July 2018**	**AGENDA ITEM:**	**14**
TITLE:	**A Healthy Weight Statement for Reading – Implementation plan update**		
LEAD OFFICER:	**Melissa Montague**	**TEL: 0118 937 4805**	
JOB TITLE:	**Public Health Programme Officer**	**E-MAIL: Melissa.montague@reading.gov.uk**	

1. PURPOSE OF REPORT AND EXECUTIVE SUMMARY

1.1 To share with the Board an update on the implementation plan for the Healthy Weight Strategy for Reading

1.2 Appendix A – Healthy Weight Strategy Implementation Plan update.

2. RECOMMENDED ACTION

2.1 That the Board recognises the impact of budget reductions on the delivery of the Reading Healthy Weight Strategy, and acknowledges the essential re-evaluation of how the Council can support residents to achieve a healthy weight in light of reduced resources and service decommissioning.

3. POLICY CONTEXT

3.1 The Healthy Weight Strategy for Reading was developed in the context of the Government's national strategy – 'Childhood Obesity: a plan for action', local priorities identified in Reading's JSNA modules on obesity and physical activity, and Reading's Health and Wellbeing Strategy 2017-2020 (i.e. Priority 1 - 'Supporting people to make healthy lifestyle choices' - with a focus on tooth decay, obesity and physical activity').

4. THE PROPOSAL

4.1 The Healthy Weight Strategy for Reading was endorsed by the Health and Wellbeing Board on 27th January 2017. Throughout 2017, a multi-agency task and finish group held a series of meetings to develop the implementation plan and a very positive report was brought to the Health and Wellbeing Board in July 2017 to update on work to meet the following objectives:

- Provision of information and support to help people manage their weight;
- A continued focus on helping the least active members of the population to move more;

- Strengthening our work with schools and families to help more children be a healthy weight;
- Provision of support for parents in early years settings to help family members be a healthy weight; and
- Supporting/encouraging teenagers to eat healthily and have active lifestyles.

4.2 Reading's Healthy Weight Strategy has now been used as a model by the local authorities in West Berkshire and Wokingham. With rising need and the recognition of a need to focus on tackling obesity, a Berkshire-wide obesity leads network has been established which will help to facilitate a more consistent approach across the county.

4.3 Setting Reading Borough Council's budget for 2018-19 was exceptionally challenging in light of other pressures. Unfortunately, this includes a 100% reduction in the budget allocated to deliver the Healthy Weight Strategy, and all public health commissioned Tier 2 weight management programmes for adults and children will cease in September 2018. Work has progressed on the implementation of the Reading Healthy Weight Strategy since the last update to this Board (July 2017) but it has only been possible to take forward many of the planned actions on a skeleton basis.

Work which has been progressed includes:

4.4 Progress in relation to 'Provision of information and support to help people manage their weight' includes the following.

- The dedicated 'Healthy Weight' page on the Reading Services Guide is regularly being updated with information and signposting to Public Health England materials and services which support a healthy weight.
- 'Making Every Contact Count' training has been delivered to staff who work with vulnerable families. This training will support staff to raise the issue of health damaging lifestyle behaviours, including excess weight and sedentary lifestyles; and signpost them to sources of information and support.
- A Making Every Contact Count online introductory module has been made available to Reading Borough Council Staff.

4.5 Progress in relation to 'Strengthening our work with schools and families to help more children be a healthy weight' includes the following.

- A legacy pack for schools who host Reading Borough Council's commissioned child healthy lifestyle and weight management programme was introduced to schools in September 2017 to encourage continued support of the principles and activity element of Let's Get Going in the school environment after the initial facilitated course ends. The pack has been well received but further roll out will no longer be possible due to decommissioning of the Child Healthy Lifestyle and Weight Management Programme in September 2018.

4.6 Progress in relation to 'A continued focus on helping the least active members of the population to move more' includes the following.

- The Bikeability scheme exceeded number of funded places in 2017/18 with over 1400 children receiving some form of Bikeability training
- The Heights School and Moorlands Primary School are expected to be awarded their Modeshift STARS Bronze Award for encouraging sustainable travel to school in June 2018. Further schools will also be encouraged to take part to ensure their travel plans remain up-to-date and sustainable travel encouraged.
- The EMPOWER initiative has been completed.
- New National Cycle Network route NCN 422, connecting Newbury to Ascot via Reading, is due for completion in summer 2018.
- Technical support to develop the new 'Walking and Cycling Infrastructure strategy' is expected to be drawn down from June 2018.

- Feedback on a draft network of routes and list of schemes is to be produced in Autumn 2018, and the plan is expected to be adopted in spring 2019 as part of our fourth Local Transport Plan.
- As an element of supporting the 'Time to Change Pledge', a series of early morning, lunchtime and after work exercise classes have been organised for Council staff.
- The new leisure service contract is out to tender and includes a focus on the delivery of health and wellbeing activities as well as core leisure functions (see action plan for details).

4.7 Progress in relation to 'Special Educational Needs Local Offer' includes the following.

- There are now 165 services listed under the Special Needs Activities section of the Local Offer; sub categories include Clubs & Groups, Days Out, Holiday Clubs, Sports & Leisure, Supported Holiday and the Great Outdoors. These are all widely promoted to parent carers through the SEND Local Offer website, Local Offer-Disc Newsletter, Facebook and regular email updates. The Council is working closely with schools (SENCOs), community and voluntary organisations to promote activities.

4.8 Progress in relation to 'Partnership with Reading Museum' includes the following.

- Reading Museum has organised 62 specialist guided tours with 474 visitors and 14 tours around the Abbey Quarter with 135 visitors. Each tour involves approximately 1 hour of walking.
- A bid was submitted to the Esmee Fairburn Foundation. Although unsuccessful on this occasion, this provides a foundation for other bids to be submitted as opportunities arise.
- The 'Happy Museum' affiliation informs partnership working with the MERL (Museum of English Rural Life) – with health & wellbeing a central strand of the investment under the Arts Council National Portfolio Organisation (NPO) status. The NPO is a 4 year project which started in April 2018.

4.9 Progress in relation to 'Workplace Health' includes the following.

- Reading Borough Council received an award for 'most CO2 saved' through Active Travel as part of this year's Active Workplace challenge.
- Lunchtime and out of hours exercise classes for staff being trialled at RBC sites including Yoga, Pilates and Circuit training.

4.10 Additional plans have now been put on hold because of the removal of the dedicated strategy implementation budget and that for the tier 2 programmes for weight management. These include the following.

- The introduction of an intervention to promote healthy eating and physical activity in Early Years settings which has been successfully implemented at minimal cost in neighbouring local authorities.
- The introduction of an online weight management programme for overweight adults who need a moderate amount of support to make changes to their eating and physical activity behaviours to manage their weight. This programme would have allowed us not only to significantly increase our capacity to support the 59.2% of the adult population of Reading who are overweight or obese; but also would have allowed us to target our tier 2 group programme more effectively to those who have a higher BMI (30+).
- Consultation with local teenagers and the subsequent development of a healthy weight programme for young people bridging the gap between children and adults weight management services.
- A promising partnership between Reading Libraries, Reading Sport and Leisure and Public Health allowed us to run some interactive sessions linked to the very popular 'Rhymetime' sessions, which encouraged families with young children to

adopt healthy eating and physical activity for all the family. These sessions were supported by the providers of our tier 2 weight management services which are due to be decommissioned in September, so we have been unable to plan further initiatives in this setting.

4.11 Whilst most of the Reading Public Health Grant is managed directly by the Wellbeing (including Public Health) Team, some of the monies have been reallocated to various other teams across the Council to deliver services which meet public health outcomes. As it is a legal requirement for the ring fenced Public Health budget to be used to deliver on public health outcomes, each department receiving public health funding will be required to complete a Memorandum of Understanding to demonstrate how the monies will be used. The Wellbeing Team will be involved in developing and monitoring these memoranda, and will use this opportunity to identify how actions to promote healthy weight can be incorporated.

4.12 The Wellbeing / Public Health team is also investigating innovative models of delivering services for healthy lifestyle behaviours including an integrated hub model, which will look at tackling 'Multiple Unhealthy Risk Factors' – including diet and levels of physical activity. Such a model will take a person-centred, holistic approach whilst delivering an excellent and cost effective service to the end user. We envisage that the model will improve co-ordination across public health services and provide efficient referral routes via a single point of entry approach.

5. CONTRIBUTION TO STRATEGIC AIMS

5.1 The Healthy Weight Strategy for Reading contributes towards a number of Public Health Outcome Framework indicators, including:

- reducing sickness absence,
- utilisation of outdoor space for exercise / leisure purposes,
- reducing weight in 4-5 year olds and 10-11 year olds,
- reducing excess weight in adults,
- percentage of physically active and inactive adults
- reducing obesity related co-morbidities such as diabetes.

The Strategy also supports delivery of Priority 1 in the 2017-20 Health and Wellbeing Strategy, i.e. Support people to make healthy lifestyle choices with a focus on tooth decay, obesity and physical activity.

6. COMMUNITY ENGAGEMENT AND INFORMATION

6.1 The Wellbeing Team will continue to engage with other Council departments and local stakeholders on the Healthy Weight Implementation Plan through the task and finish group, forums and dialogue.

7. EQUALITY IMPACT ASSESSMENT

7.1 Under the Equality Act 2010, Section 149, a public authority must, in the exercise of its functions, have due regard to the need to—

- eliminate discrimination, harassment, victimisation and any other conduct that is prohibited by or under this Act;
- advance equality of opportunity between persons who share a relevant protected characteristic and persons who do not share it;
- foster good relations between persons who share a relevant protected characteristic and persons who do not share it.

7.2 Reading Borough Council has paid due regard to the so-called Public Sector Equality Duty throughout the development and delivery of the Healthy Weight Implementation Plan. The impact of decommissioning services in support of this Plan is being considered as part of a wider health equality impact assessment for the Reading Public Health budget as a whole. The Healthy Weight Implementation Plan will continue to be developed with an awareness of inequalities of health identified through robust local data sets.

8. LEGAL IMPLICATIONS

8.1 There are no legal implications arising at this stage.

9. FINANCIAL IMPLICATIONS

9.1 The engagement associated with the Healthy Weight Action Plan development has been met using existing resource and will not in itself require additional capital or revenue investment.

9.2 The Council's Wellbeing Team will consider engagement feedback and the recommendations through the task and finish group in delivering the Health Weight Implementation Plan. It will be an imperative that this plan drives the efficient use of resources and identifies clear health benefits on investment so as to protect a sustainable local health and care system. This will involve recognising the breadth of influences on obesity, and so maximising the use of resources across different partner agencies, in terms of work on the delivery of shared priority agendas.

10. BACKGROUND PAPERS

Joint Strategic Needs Assessment for Reading
Reading's Health and Wellbeing Strategy 2017-20

Appendix A - Healthy Weight Strategy – Action Plan Phase 2, Council-led and partner programmes.

The table below details actions in progress and planned that contribute to the healthy weight agenda. The action plan has been developed through a multi-agency Healthy Weight Strategy Implementation group formed following the January Health and Wellbeing Board to help shape and agree the developed delivery plan below.

What will be done – the task	Tier of service	Who will do it	By when	Outcomes the difference it will make	Milestones.	National indicators
Support 'Walk Leader Volunteers' to lead sustainable local group walks for the local community. To encourage inactive and less active people to engage in a regular walks programme.	1 (prevention)	Wellbeing Team and Leisure Team	By March 2017	A larger pool of trained walk leaders will increase local capacity to deliver health walks to people who have low physical activity levels. More people choose to walk for leisure and active travel. Ongoing administrative support of the programme will ensure that walk leaders have a point of contact and that encouraged to continue leading walks. Opportunities for more volunteers to join training days nationally to be identified.	41 walk leaders have been trained. Total of 925 participants have made 8577 visits in 18 months. Increase from 4 to 12 weekly / monthly walks now taking place. Completed	1.16 - % of people using outdoor space for exercise/health reasons.
To offer MECC training to the local voluntary and community sector	1	Wellbeing Team	From June 2018	To increase knowledge, skills and confidence to make appropriate use of opportunities to raise the issue of healthy lifestyle choices and signpost to sources of support.	Train the Trainer MECC programme will be developed. 2 MECC training sessions delivered and online module available to staff. Investigation of STP funding to deliver further sessions.	2.13i Percentage of physically active and inactive adults – active adults.

What will be done – the task	Tier of service	Who will do it	By when	Outcomes the difference it will make	Milestones.	National indicators
To create a Reading Services Guide page to be a central online resource for local heathy weight programmes and self-help information.	1	Wellbeing Team.	March-August 2017	To have a central online location where people can find information about weight management, healthy eating and physical activity and local services. Including those commissioned by RBC, the voluntary sector, and commercial enterprises	Weight management page created on Reading Services Guide – completed. Promotional plan will be developed to raise awareness of page. Site analytics monitored bi-annually to ascertain use.	Potentially all PHOF indicators highlighted in this section relating to healthy weight, healthy eating and physical activity.
To ensure delivery of the National Child Measurement Programme (NCMP) See 0-19 programme targets below.	1	School nurses commissioned by Wellbeing Team as part of the 0-19 (25) programme	Ongoing	Weight and height measurements offered to all children attending state funded primary school children who are in Reception Year (age 5) and Year 6 (aged 10,11) in accordance with national NCMP guidance.	>95% uptake in Reception and Y6. Local information about healthy eating, healthy weight and physical activity programmes are offered to parents of overweight or obese children with feedback letters. On target for uptake. Revision of signposting opportunities based on changes in service provision required Autumn 2018.	2.13ii Percentage of physically active and inactive adults – active adults.

What will be done – the task	Tier of service	Who will do it	By when	Outcomes the difference it will make	Milestones.	National indicators
To build links with Neighbourhood Initiatives Team - working in areas of social deprivation provide / share information and seek opportunities to promote healthy weight via managed databases, community centres, networking meetings / events, faith sector links, community newsletters etc.	1	Neighbourhood Initiatives Team working with Wellbeing Team	Ongoing	People who are living in socially deprived areas and not accessing mainstream sources of information and support relating to healthy weight are reached through community networks, befriending services and personal contact based on trust (within the context of a community development approach).	Healthy weight programme and other healthy living-related issues to feature in NI team's work plans. HW is featured in community articles / newsletters, social media platforms, local poster and leaflet sites and on local community notice boards. Work with Reading's neighbourhood network (peer-led networking support group for Reading's community sector) to ensure healthy weight is a regular feature in their newsletter. Over 12 months, NI team work with Wellbeing to ensure that presentations are made to community centre management committees / trustees / community associations with a view to seeking local pledges, which are then tracked and revisited to monitor progress within 6 months. Seek opportunities for NI team training and provision of information / resources to empower staff to facilitate health behaviour change related to healthy weight. Making Every Contact Count training received March 2018.	Potentially all PHOF indicators highlighted in this section relating to healthy weight, healthy eating and physical activity.

What will be done – the task	Tier of service	Who will do it	By when	Outcomes the difference it will make	Milestones.	National indicators
A Local Cycling & Walking Infrastructure Plan will be developed identifying measures to support increases in journeys undertaken by active modes and setting out the long-term strategy for delivery	1	Transport & other internal and external stakeholders	2017/18	More people encouraged to consider cycling and walking for local journeys, including commuting trips and journeys to school.	Technical support to develop strategy expected to be drawn down from June 2018 Feedback on draft network of routes and list of schemes (Autumn 2018) The Plan is expected to be adopted in spring 2019 as part of our fourth Local Transport Plan	2.13 Percentage of physically active and inactive adults – active adults. Increase in the number of people accessing the town centre by bike or on foot Increase in the number of children travelling to school by active modes

What will be done – the task	Tier of service	Who will do it	By when	Outcomes the difference it will make	Milestones.	National indicators
To encourage people to consider walking and cycling for local journeys through the delivery of supporting initiatives, such as those delivered through EMPOWER, including: -Training & education (e.g. cycle training) -Travel advice & marketing campaigns -Advice on the development of school & workplace travel plans	1	Transport	Ongoing	More people will be encouraged to consider cycling and walking for local journeys, including commuting trips and journeys to school.	Bikeability scheme exceeded number of funded places in 2017/18 with over 1400 children receiving some form of Bikeability training The Heights School and Moorlands Primary School are expected to be awarded their Modeshift STARS Bronze Award for encouraging sustainable travel to school in June 2018. Further schools will also be encouraged to take part to ensure their travel plans remain up-to-date and sustainable travel encouraged. EMPOWER – complete	2.13 Percentage of physically active and inactive adults – active adults Increase in the number of people accessing the town centre by bike or on foot Increase in the number of children travelling to school by active modes

What will be done – the task	Tier of service	Who will do it	By when	Outcomes the difference it will make	Milestones.	National indicators
The delivery of a new National Cycle Network route NCN 422, connecting Newbury to Ascot via Reading	1	Transport	Spring 2018	The route will serve key destinations, including business parks, schools, other local facilities/services and wider cycle routes.	Cycle network completed (exp. Summer 2018).	Increase in the number of people walking and cycling for local journeys
Input into the development of the new leisure services contract to provide increase healthy lifestyle programme options for customers.	1	Leisure & Recreation Service / Environment & Neighbourhood Services / Wellbeing team	August 2018	Leisure services are integrally linked with programmes for weight management and other public health services. Leisure centres actively support healthy weight by offering healthy eating options, weight management programmes and activities to engage the inactive.	Leisure centres offer a range of activities targeting underserved, disengaged or inactive groups to: - provide information on healthy weight and physical activity. - encourage regular participation in physical activity and healthy weight programmes through a regular programme of targeted activities. - Work in partnership with providers of other commissioned healthy weight programmes to increase bi-directional referrals. - Support healthy catering and vending machines in leisure centres. Contract out to tender.	Potentially all PHOF indicators highlighted in this section relating to healthy weight, healthy eating and physical activity.

What will be done – the task	Tier of service	Who will do it	By when	Outcomes the difference it will make	Milestones.	National indicators
Sportivate – To deliver 5 sport programmes in 2017 to engage young people: • Cycle Racing • Soccercise • Teen SwimFit • Trampoline Fit • Gymnastics	1	Leisure services	Projects will be delivered throughout the year with the cycle project	Sportivate is a Lottery funded programme that gives more young people the chance to discover a sport that they love.	To deliver 6 blocks of 6 Sessions Completion Target: 34 Females and 20 Males aged 11 – 25 years Project underway	1.16 - % of people using outdoor space for exercise/health reasons.

What will be done – the task	Tier of service	Who will do it	By when	Outcomes the difference it will make	Milestones.	National indicators
Health and Wellbeing is a key driver behind the £1.77m HLF Reading Abbey Revealed project. The building conservation work will be accompanied by a scalable programme of activities linked to healthy weight and increased physical activity Participate in the Happy Museum affiliate scheme to develop targeted future programmes that contribute to Healthier lifestyles and Wellbeing. Initiate 'Waking with the Ancestors' project – Submit Esmee Fairbairn funding application	1	Reading Museum Service	Within the scope of Audience Development Plan 2017 - 2020 Funding application for 'Walking with the Ancestors' project submitted March/April 2017 (3 year project)	The historic Reading Abbey quarter will be re-opened to the public, providing a tranquil outdoor shared space suitable for outdoor activity including walking. Happy Museum affiliation will sustain the Museum Service focus on programmes with Health and Wellbeing outcomes. Encourage more people to walk for leisure, take part & take notice	•Self-guided trails around the Reading Abbey Quarter – aiming for 5,000 people to have accessed •Specialist guided tours – aim to run a minimum of 50 tours days each year and at least 250 people taking up a place on the tour day each time. •Dedicated tours around the Abbey Quarter – aim to run a minimum of 15 tours each year and at least 75 families take a tour each year Reading Museum has organised 62 specialist guided tours with 474 visitors and 14 tours around the Abbey Quarter with 135 visitors. Each tour involves approximately 1 hour of walking. Esmee Fairburn Bid unsuccessful but future opportunities will be sought. Happy Museum affiliation informs partnership working with the MERL (Museum of English Rural Life) under our Arts Council National Portfolio Organisation status in which health & wellbeing is a central strand of the investment. The NPO project start-up was in April 2018 and is a 4 year programme.	Percentage of physically active and inactive adults – active adults. % of people using outdoor space for exercise/health reasons.

What will be done – the task	Tier of service	Who will do it	By when	Outcomes the difference it will make	Milestones.	National indicators
To utilise the national workplace challenge to encourage local workforces to be more active	1	GBA, with support from Wellbeing team	Ongoing	Reduced absenteeism in the local workforce Staff are encouraged to lead more active lifestyles.	10% annual increase in the number of staff registered for the workplace challenge. Year on year increase in participation (awaiting final figures) and Reading Borough Council received award for 'most CO2 saved' through Active Travel. Lunchtime and out of hours exercise classes for staff being trialled at RBC sites including Yoga, Pilates and Circuit training.	2.13i Percentage of physically active and inactive adults – active adults.

What will be done – the task	Tier of service	Who will do it	By when	Outcomes the difference it will make	Milestones.	National indicators
To commission and implement an accessible tier 2 lifestyle adult weight management service that aligns with NICE guidance for overweight and obese adults aged 16+ as an integral part of the weight management service in Reading. To target access to the service in line with local Joint Strategic Needs Assessments To monitor and evaluate the delivery and outcomes of the service to the stated objectives.	2	Wellbeing Team	New contract to commenced June / July 2017.	To contribute to halting the continued rise in unhealthy weight prevalence in adults.	Achieve at least 70% completion rate for those starting a course. At least 35% of those completing the course achieve 5% weight loss At least 50% of participants are achieving 150 minutes of physical activity each week by the end of the course. Programme to be decommissioned Sept 2018.	2.06i - % of children aged 4-5 classified as overweight or obese.

What will be done – the task	Tier of service	Who will do it	By when	Outcomes the difference it will make	Milestones.	National indicators
Commission and implement a school / community based Tier 2 children's healthy lifestyle and weight management programme in line with NICE guidance as an integral part of the weight management service in Reading. To target access to the service in line with local Joint Strategic Needs Assessments To monitor and evaluate the delivery and outcomes of the service in line with the stated objectives To pilot a legacy pack for schools who host the Tier 2 programme to encourage schools to continue supporting the principles of the course beyond the 10-week intervention.	2	Wellbeing Team	Currently mid-contract for tier 2 service. Legacy pack developed for implementation from Sept 2017.	Helping to halt the continued rise in unhealthy weight prevalence in children and young people in Reading. A sustainable, 'whole family approach' to healthy eating and physical activity. Will be available to local families.	Of those attending the course, at least: 50% not already eating 5 a day increase fruit and vegetable intake. 50% reduce sugary snacks and drinks. 50% reduce sedentary behaviour <2hrs a day. 50% achieve an improvement in the shuttle run challenge. Legacy pack introduced to schools Sept 2017 – positive feedback received from schools. Programme to be decommissioned Sept 2018.	2.06ii - % of children aged 10-11 years classified as overweight or obese.

What will be done – the task	Tier of service	Who will do it	By when	Outcomes the difference it will make	Milestones.	National indicators
To promote breast feeding, healthy eating and physical activity via the Reading the 0-19/25s service To provide breastfeeding peer support to mothers in Reading Take proactive steps to raise awareness in schools of priority Public Health messages especially around healthy life-styles	1-2	Wellbeing Team/Children's Services/Breastfeeding Network	From April 2018	More babies are fed breast milk, through an increase in breastfeeding initiation and prevalence. More children and young people are a healthy weight, through a reduction in the number of children who are overweight and obese at 4-5 years and 10-11 years	62% of infants are being breastfed at 6-8 weeks. Breastfeeding Network's Reading peer support contract ended in May 2018, and the Council received no bids when a post May 18 service was put out to tender. New mothers are now encouraged to contact their midwives and health visitors for face to face breastfeeding support. They are also encouraged to use the national breast feeding helpline and other online resources on breastfeeding. 93% uptake of NCMP in Y6 49% uptake of NCMP in YR (progress to 31st March 2018 which is on target to complete by end of summer term) School Nursing service are sharing local and national public health information, campaigns and signposting to other services via their Facebook and Instagram pages.	2.06i - % of children aged 4-5 classified as overweight or obese.

What will be done – the task	Tier of service	Who will do it	By when	Outcomes the difference it will make	Milestones.	National indicators
Healthy weight support for troubled families. Healthy Weight Strategy will continue to be supported through the Troubled Families Programme in Reading.	1	Troubled families and Wellbeing teams.	Apr 2018	TF team are aware of healthy weight issues, have access to training and resources to signpost families to healthy weight information and support.	TF team identify weight issues in their assessment framework. Troubled Families will encourage through Early Help Teams the HWS. This is currently being done through paperwork and guidance. This will be developed to include opportunities for families and resources for staff. Explore opportunities within Children's Social Care with respect to the HWS. To support the HWS with Troubled Families Data. Data provided.	2.06i - % of children aged 4-5 classified as overweight or obese. 2.06ii - % of children aged 10-11 years classified as overweight or obese.

What will be done – the task	Tier of service	Who will do it	By when	Outcomes the difference it will make	Milestones.	National indicators
Libraries supporting Healthy Weight	1	Library services / Leisure / Wellbeing	Ongoing from September 2017	Families are aware of library self-help resources for weight management. Families are engaged with leisure services and community programmes that support physical activity and healthy weight.	Healthy lifestyle promotional sessions held in libraries highlight resources and offer a range of activities including: Reading Sport and Leisure mini health checks. Eat 4 Health / Let's Get Going promotions. Information on local walking and cycling initiatives. Change 4 Life. 3 promotional sessions held in Reading libraries highlighting sugary drinks, Change 4 Life, Eat 4 Health and Lets Get Going and local leisure opportunities. Very positive engagement from parents and interest in local programmes.	Potentially all PHOF indicators highlighted in this section relating to healthy weight, healthy eating and physical activity.

What will be done – the task	Tier of service	Who will do it	By when	Outcomes the difference it will make	Milestones.	National indicators
Inclusion of policies to promote Healthy Weight in Reading's Planning Policies.	1	Planning	Ongoing	Planning policies promote an environment that encourages walking, cycling and public transport use whilst limiting car use. Policies also prioritise open space for sport and recreation, leisure facilities and improved air quality. Dominance of smaller centres by fast food takeaways will be avoided, where possible.	Developments will be accessible by walking, cycling and public transport. The public realm will be designed to create a sense of place and safe environments to incentivise walking. Access to open space for sport and recreation is prioritised. Development will avoid overprovision of parking in order to incentivise active or public transport instead of private car use. Development must mitigate the effects of poor air quality that discourage outdoor activity. Major transport projects will help to limit car use and encourage walking and cycling, as well as improve air quality. Work is undertaken to limit Fast food takeaway usage. Consultation exercises to date have received positive feedback from residents regarding 'walkability' and 'green space' elements of the proposals.	Percentage of physically active and inactive adults – active adults. % of people using outdoor space for exercise/health reasons.

What will be done – the task	Tier of service	Who will do it	By when	Outcomes the difference it will make	Milestones.	National indicators
Family Information Service/SEND Local Offer – Leisure activities available for children & Young People with SEND	1	LA, Voluntary & Community Groups	Ongoing	• The SEND Local Offer provides information on social activities available to children & young people with SEND, including sport and leisure activities. There are many community and voluntary organisation offering active leisure activities to meet the needs of children with additional needs. Link to the page on the 'Local Offer' - http://servicesguide.reading.gov.uk/kb5/reading/directory/family.action?familychannel=3-11 • The Family Information Service – also provide information on universal activities including sport and leisure for all children to promote and encourage children to take up these opportunities – link to page - http://servicesguide.reading.gov.uk/kb5/reading/directory/family.page?familychannel=8	The 'Local offer' is promoted to families who have a child or young person with SEND and feedback from parents, young people and activity providers is evaluated. Families with a child or young person with SEND have access to comprehensive information on the physical activity options available There are now 165 services listed under the Special Needs Activities section of the Local Offer, sub categories include Clubs & Groups, Days Out, Holiday Clubs, Sports & Leisure, Supported Holiday and the Great Outdoors. These are all widely promoted to parent carers through the SEND Local Offer website, Local Offer-Disc Newsletter, Facebook and regular email updates. We are working closely with schools (SENCO's), community and voluntary organisations to promote activities.	% of people using outdoor space for exercise/health reasons. 2.06i - % of children aged 4-5 classified as overweight or obese. 2.06ii - % of children aged 10-11 years classified as overweight or obese.

READING HEALTH AND WELLBEING BOARD

DATE OF MEETING:	13 July 2018	**AGENDA ITEM:**	**15**
REPORT TITLE:	Director of Public Health Annual Report		
REPORT AUTHOR:	Marion Gibbon	**TEL:**	0118 937 4538
JOB TITLE:	Consultant in Public Health	**E-MAIL:**	marion.gibbon@reading.gov.uk
ORGANISATION:	Reading Borough Council		

1. PURPOSE OF PAPER

To share the Strategic Director of Public Health's Annual Report ***"Creating the Right Environments for Health"*** with the Health and Wellbeing Board.

It is a requirement for all Directors of **Public Health** to produce an annual independent **report** on the health of their local population. The annual report is the Strategic DPH's independent professional statement about the health of local communities, based on sound epidemiological evidence, and interpreted objectively in their role as an independent advocate for the health of the population and system leader for its improvement and protection.

2. REPORT SUMMARY

Since public health moved back into local government in 2013, we have reconnected with many of our valued colleagues in planning, leisure and sports development, parks and recreation, housing and highways (amongst others) to create place-based strategies and deliver actions which bind together these wider determinants of health with our local priorities.

"Creating the Right Environments for Health" aims to reconnect professions, communities and landowners and highlight opportunities for them to work together to support the public's health through creating and maintaining accessible high quality green spaces and natural environments. The report provides information and evidence that can support placed-based strategies to realise the potential of green and natural spaces for the health and wellbeing of local residents and communities and showcases examples of how local communities are already using the natural environment to stay healthy or improve their health and wellbeing.

3. RECOMMENDATION(S)

The Board is asked to read and note the DPH Annual Report and its conclusions and to share widely within their respective organisations and local communities.

"Creating the Right Environments for Health" recommends that;

1. Local authorities and other agencies should continue to encourage community initiatives that make the most of natural space available, with the aim of improving mental health, increasing physical activity and strengthening communities.
2. Existing green space should be improved and any new developments should include high quality green spaces. The use of professional design and arrangements to ensure the

ongoing management of natural environments should be considered if spaces are to be sustainable.

3. Opportunities to increase active transport should be considered when designing new green spaces and in the improvement of existing space.
4. Planning guidance for new developments should specifically consider the use of green and blue space to improve the health and wellbeing of residents and others using the space.
5. Local Authorities and their public health teams should foster new relationships with organisations aiming to improve the natural environment and its use.

4. IMPLICATIONS

Bearing in mind the above recommendations Reading Borough Council aims to implement the following more specific recommendations:

1. Reading Borough Council will use the massive opportunity it has with regard to its new leisure developments to drive engagement and promote community resilience and cohesiveness into its future plans.
2. Reading Borough Council will continue to improve its green spaces and ensure that they are safe for everyone.
3. Reading Borough Council will ensure all new developments incorporate considerations of how they will improve the health and wellbeing of residents and others, including provision of and links to green spaces where opportunities allow.

Reading Borough Council and partners would also like to mention the ongoing work that is being undertaken which supports the recommendations made in the Strategic Director of Public Health's Annual Public Health Report:

- Relevant policies for the protection and enhancement of green space in our new draft Local Plan;
- Ongoing investment in improving parks and open-spaces and an annual tree planting programme;
- Our work around sustainable / active travel (high levels of patronage on public transport, for example, and supported by ongoing major investment in dedicated bus lanes and cycleways);
- Establishment of Prospect Park as the operational base for the Play Service targeting families and young people;
- Green Flag gardens at Forbury and Caversham Court plus the re-opening of the Abbey Ruins to the public.

5. FINANCIAL DETAILS / VALUE FOR MONEY

N/A

6. LEGAL IMPLICATIONS

N/A

7. RISKS

N/A

8. POTENTIAL IMPACTS

The Annual Public Health Report of the Strategic Director of Public Health aligns with the priorities of the Health and Wellbeing Strategy priorities of:

- Supporting people to make healthy lifestyle choices
- Reducing loneliness and social isolation
- Promoting positive mental health and wellbeing in children and young people

Furthermore, it aligns with Reading Borough Council's Corporate Priority of

- Keeping the town clean, safe, green and active.

9. CONSULTATION

This is an independent report by the Strategic Director of Public Health

10. IMPLEMENTATION

The recommendations of this annual report will be implemented through feeding into the work of the Health and Wellbeing Strategy and the contribution it makes to the Corporate Priorities of Reading Borough Council.

11. APPENDICES

DPH Annual Report

12. BACKGROUND DOCUMENTS

N/A

Creating the Right Environments for Health

The Annual Report from the Director of Public Health

Reading

July 2018

Reading Borough Council
Working better with you

FOREWORD

We are shaped by our environment more than we may realise. Public health through the ages has always understood that environmental factors, from poor housing, lack of sanitation and poor air quality have an important role to play in determining our health; both as immediate threats to life and limb; and as long-term factors creating long-term exposure to potential harms. Other disciplines - and indeed many of our established arts - have sought refuge and inspiration in nature; however, it has taken some time for public health and medicine to identify the evidence base supporting what many of us had long felt; that nature and greenspace is good for us!

This report is intended for a wide audience. Since public health moved back into local government in 2013, we have reconnected with many of our valued colleagues in planning, leisure and sports development, parks and recreation, housing and highways (amongst others) to create place-based strategies and deliver actions which bind together these wider determinants of health with our local priorities. I hope that this report reaches a wide and diverse audience, most importantly to residents and to their representatives such as Councillors and GPs, who are poised to respond to the recommendations laid out herein.

With ever increasing demands for new housing in the South-East of England, and the need to improve and increase infrastructure; so the natural environment can come under pressure and its intrinsic values may be overlooked. Berkshire is as a whole, a green and pleasant place. From the areas of outstanding natural beauty of the North Wessex Downs; to the Green Flag accredited parks of Slough, communities live close by or surrounded by attractive green space. Rivers and waterways play an important part in our communities too – from the Thames at Windsor through to the reclaimed recreational parks and lakes of Dinton Pastures; these provide nature and people with nourishment, peace and pleasure. The new town planners who gave birth to Bracknell in the late 1940s planned a town where greenspace and recreation was a defining generator of the town's layout; and in Reading, the Thames side open spaces at Richfield Avenue and at King's Meadow provide homes to two huge community events; the Reading Festival and Reading Pride respectively.

Berkshire's natural environment can be seen to provide opportunity for peace and tranquillity; gentle and boisterous play; sport, competition and spectacle; natural habitats and preservation of wildlife; and attractive places to walk; cycle and live amongst. That our communities are still able to live amongst and use a variety of natural environments freely for our recreation is testament to many who have fought for their preservation and enhancement. Improvement in and widening access to green and blue space must be a public health ambition in itself, and this report provides the evidence base to build that ambition.

I truly hope that this report reconnects professions; communities and landowners who all have a duty to support the public's health through creating the right environments for health to thrive and benefit us all through the beauty of natural and green spaces.

Darrell Gale FFPH MSc BA (Hons)
Acting Strategic Director of Public Health for Berkshire

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ABOUT THIS REPORT

This report was developed and produced on behalf of the Acting Director of Public Health by Shared Public Health Services for Berkshire, and authored and coordinated by Dr Steffan Glaze (Foundation Doctor).

This report is the joint effort of all Consultant-led Public Health teams in Berkshire to produce the statutory annual report of the Director of Public Health both as a pan-Berkshire document, celebrating the history of shared working across the six Unitary Authorities; and also as a unique report for each individual authority.

Case studies were provided by a variety of individuals from local authority public health teams or other groups, such as voluntary organisations who are acknowledged below and with their contributions.

Finally, we acknowledge Judith Wright who was Interim Strategic Director of Public Health for Berkshire from April-December 2017, who conceived of the topic and encouraged us all to find the right environments for health.

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INTRODUCTION –

The Wider Determinants of Health

There are many factors, or determinants, that come together to affect our health. There are some we cannot change – chiefly, our genes. Of the modifiable factors, some are individual and personal choices such as taking up smoking or choosing to exercise. On a population level, there are the wider determinants of health: a diverse range of economic, environmental and social factors that affect people's health and influence their choices and lifestyles. Difficult to quantify, many of these determinants are shaped by national and local government policies, our environment and the distribution of wealth - things not quickly changed. They include:

- Income and social status
- Educational attainment
- Quality of housing
- Community and social networks
- Activity – the way we live

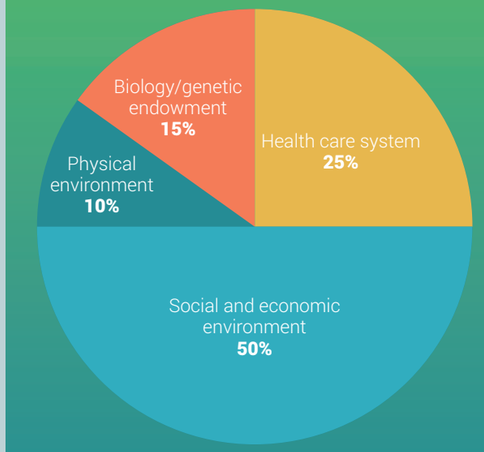
It is generally agreed that these wider determinants of health overall have a more significant impact on the health of individuals that direct interventions in health care. Estimates vary, but it seems that health care contributes less than 25% of our overall health, with these wider determinants contributing to the majority.

Health is a state of complete physical, mental and social well-being and not merely the absence of disease or infirmity

World Health Organisation, 1948

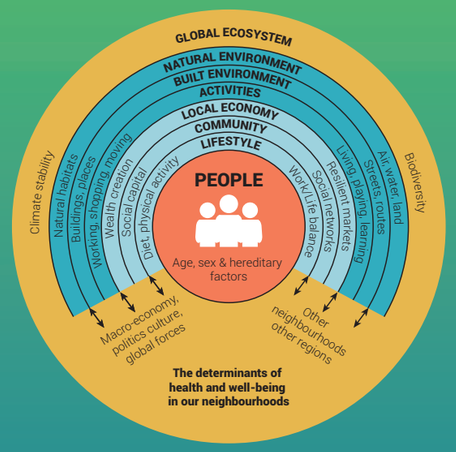
Public health, as a responsibility of local authority, has the opportunity to influence these determinants for the improvement of the health and wellbeing of the population it serves. The benefits may not be quickly realised, but are potentially vast and wide reaching, and could reduce the inequalities in our society and improve health and wellbeing for all of us.

[1] Estimated impact of determinants on health status of the population



Source: Canadian Institute for Advanced Reseach, Health Canada, Population and Public Health Branch AB/NWT 2002

[2] Barton and Grant, "A health map for the local human habitat", 2006



The health map: Barton and Grant 2006 developed from a concept by Dahigren and Whitehead 1991

This report will focus on one of the wider determinants of health – the natural environment – and how this could be used to improve our health. We will begin by describing the natural environment and its relationship to other determinants of health, then go on to examine particular health dimensions in this context. Finally, we will consider the challenges – and opportunities – to the natural environment that we can adjust to improve the wellbeing of our communities and from these build recommendations to act on.

Throughout the report, you will find case reports and research. We want to make effective changes, such that investments made will reap benefits for our communities. The research is included to discuss the scientific factual evidence available, and local case studies highlight the ways in which local communities are already using the natural environment to stay healthy or improve their health.

RESEARCH

Most of the research described in this report comes from scientific journals. Researchers conduct their studies, and then publish their results only after a body of other scientists have reviewed their work for accuracy. It can be difficult to get evidence on a population scale because there are so many things that can contribute to health and wellbeing, making it hard to measure the amount caused by a single aspect. The studies selected are considered to be of good quality, but reflect only a small proportion of the data available.

CASE STUDY

All of the case studies are examples of the work going on in this local authority in line with the theme of the report. We are pleased to highlight a variety of council, voluntary and national initiatives that are contributing to improving our health.

THE NATURAL ENVIRONMENT

The natural environment can encompass many parts of our surroundings. We often think of wide open fields, quiet forests or flowing rivers as the truly natural environment, but our urban environments can include natural elements. Often termed 'green space', this includes many things, from sports fields to decorative gardens. The natural environment can also encompass 'blue spaces' such as rivers and lakes, which are features of our area that can enable exercise, time in nature, leisure and relaxation. There is evidence that this natural environment has an influence on health in a variety of ways.

The ways in which the natural environment can improve health are complex and intertwined with many other factors. There are broad themes that have appeared from the research in this field, namely [3]:

- Stress reduction
  - It has been known for a long time that spending time in nature can have restorative effects, through relaxation.
- Improved environmental quality
  - Green spaces are more likely to be biologically diverse, and contribute to improving air quality and reducing the effect of heat concentration in cities.
- Greater social cohesion
  - Areas of natural environment are places that people can socialise and congregate, places of pride in the community and as a result improve the cohesion of neighbourhoods.
- Increased physical activity
  - Green spaces are appealing to visit, and typically need to be walked, cycled or played in to appreciate them.

We will see throughout this report how scientific research has found evidence from an individual to a population level that green spaces and the natural environment can have positive effects on our health and wellbeing. Although the exact mechanism isn't clear, there is still the opportunity to increase the availability, quality and use of natural elements in our communities.

Policy

The Department for Communities and Local Government published a consultation paper [4] in 2010 on planning policy and shaping healthy environments. Within the paper, the government defined a wide range of green spaces.

- parks and gardens – including urban parks, country parks and formal gardens
- natural and semi-natural urban green spaces – including woodlands, urban forestry, grasslands, common land, wetlands, areas of open and running water, wastelands, derelict open land and rock areas
- green corridors – including canal and river banks, cycle ways and rights of way
- outdoors sports facilities (with natural or artificial surfaces, either publicly or privately owned) – including tennis courts, bowling greens, sport pitches, athletics tracks, playing fields and other outdoor spoors areas
- amenity green space – including informal recreation spaces, green space in and around housing, domestic gardens and town or village greens
- provision for children and teenagers – including play areas, adventure playgrounds, skate parks, basketball courts and other informal areas
- allotments, community gardens, city (urban) farms and land used for permaculture
- cemeteries and churchyards
- accessible countryside in urban fringe areas
- civic spaces, including civic and market squares
- landscape around buildings – including street trees

RESEARCH

At an individual patient level, in 1983 R Ulrich [5] found that a view over green space could quicken someone's recovery from surgery in a suburban hospital in Pennsylvania, USA. This study compared similar people who had the same operation, but what differed between the two groups compared was the view from their window - either a brick wall or trees. Those with the green view had statistically significant lower length of stays and lower use of painkillers. This early evidence showed that there may be a restorative effect to simply viewing greenery and natural environments.

Looking at the population level, a study in the Netherlands [6] examined the electronic GP records of over 340,000 patients, and measured their illness by how often they saw their GP for various health problems. This was then compared with the percent of green space in a radius around their postcode based on satellite imaging. The analysis showed that over half the health problems were less common among the patients who lived in areas with more green space, even when correcting for potential confounding factors such as age and socioeconomic status. The correlation was strongest for anxiety and depression, children under 12 and those aged 46-65. They found that an extra 1% of green space in a person's area was as beneficial to overall health as being a year younger.

How can we measure Green space?

How can we define how 'green' our neighbourhoods are? There are many ways this is measured in scientific study, the two most common being:

- Satellite imaging – by looking at photographs taken from space, scientists can calculate what percent of an area is covered by plants. This is relatively easy to derive, and data is available for much of Europe. However, it does not account for the quality of the green space, e.g. for access or for food production, or how much we can actually access or use that greenery, as any plants on roofs, within private land, or in the middle of a roundabout would be included.
- Mapping – analysing maps can reveal the different land types in an area, from arable to housing. Counting how much of an area is covered by accessible green space can be used to measure the amount of natural environment in a neighbourhood. This method will miss small areas, such as verges and paths, which contribute to green routes but are not large enough to be documented on most maps.

Although effective at developing a measure of how green an area is, neither of these methods account for how easy the space is for people to access, how much that space is used or the quality of it. This aspect of the natural environment can be heavily influenced by the community who use it and live near it, such that we can all have a part to play in making the most of green spaces in our area.

Resources

A variety of resources are available for us to find and use green space in our area.

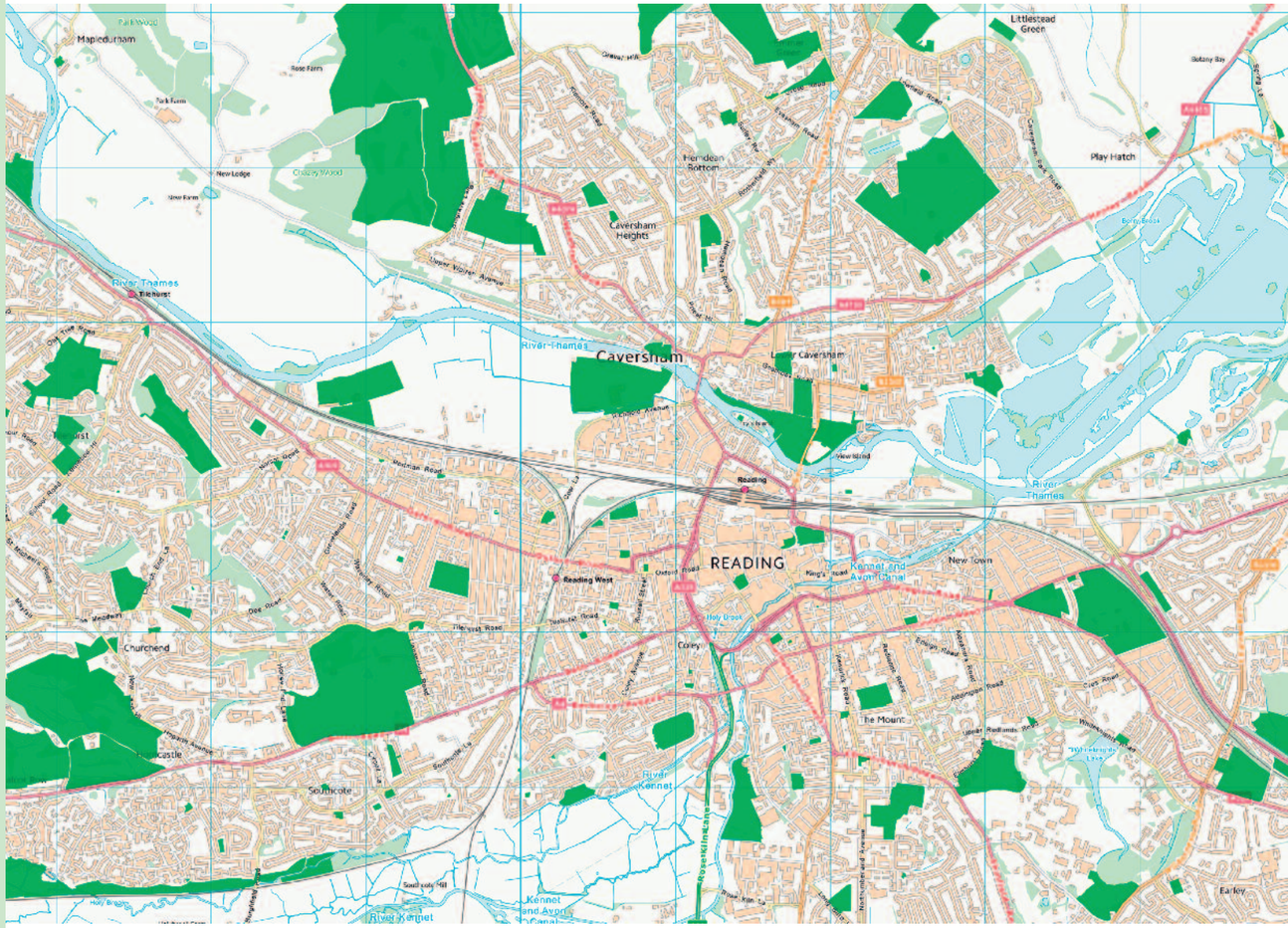
WOODLANDS TRUST WEBSITE

The Woodlands Trust, the UK's largest conservation charity, has an online database of the woods they manage. Using your postcode, you can find more about the woodland in your area.

OS GREENSPACE

The Ordnance Survey has assessed their own data about land use in the United Kingdom to produce an interactive map which can be used to see where green spaces are, what they are used for and how they can be accessed.

Reading Borough Council keeps online records of all the green spaces they manage, which includes details about facilities and opening times. You can find this resource at the following address:
http://www.reading.gov.uk/outdoors



Source: © Ordnance Survey OpenData (2018)

HEALTH OUTCOMES AND BEHAVIOURS –

Profiles

The following section describes some of the key health outcomes and behaviours on which there is a firm evidence base for the effect of green space or the natural environment. The relevance of these to our communities is demonstrated by data about the current health and wellbeing of the local communities in a summary graphic. You will also find original research evidence and a case study from your local area.

Mental Health

Mental health is essential for our overall health and wellbeing, and changes in policies and the NHS is increasingly recognising this. The 2011 report from the Department of Health 'No Health Without Mental Health' identifies some key facts about the national picture:

- mental illness is the single largest cause of disability in the UK
- at least one in four people will experience a mental health problem at some point in their life and one in six adults have a mental health problem at any one time
- the costs of mental health problems to the economy in England have recently been estimated at a massive £105 billion, and treatment costs are expected to double in the next 20 years

How could natural environments contribute to changing this picture? It is hard to identify exactly the mechanisms for these benefits, but a variety of evidence is available. It has been shown that exposure to natural environments can reduce stress, anxiety, blood pressure and anger. Over longer periods of time, those who live in greener areas are more likely to report good mental health and wellbeing.

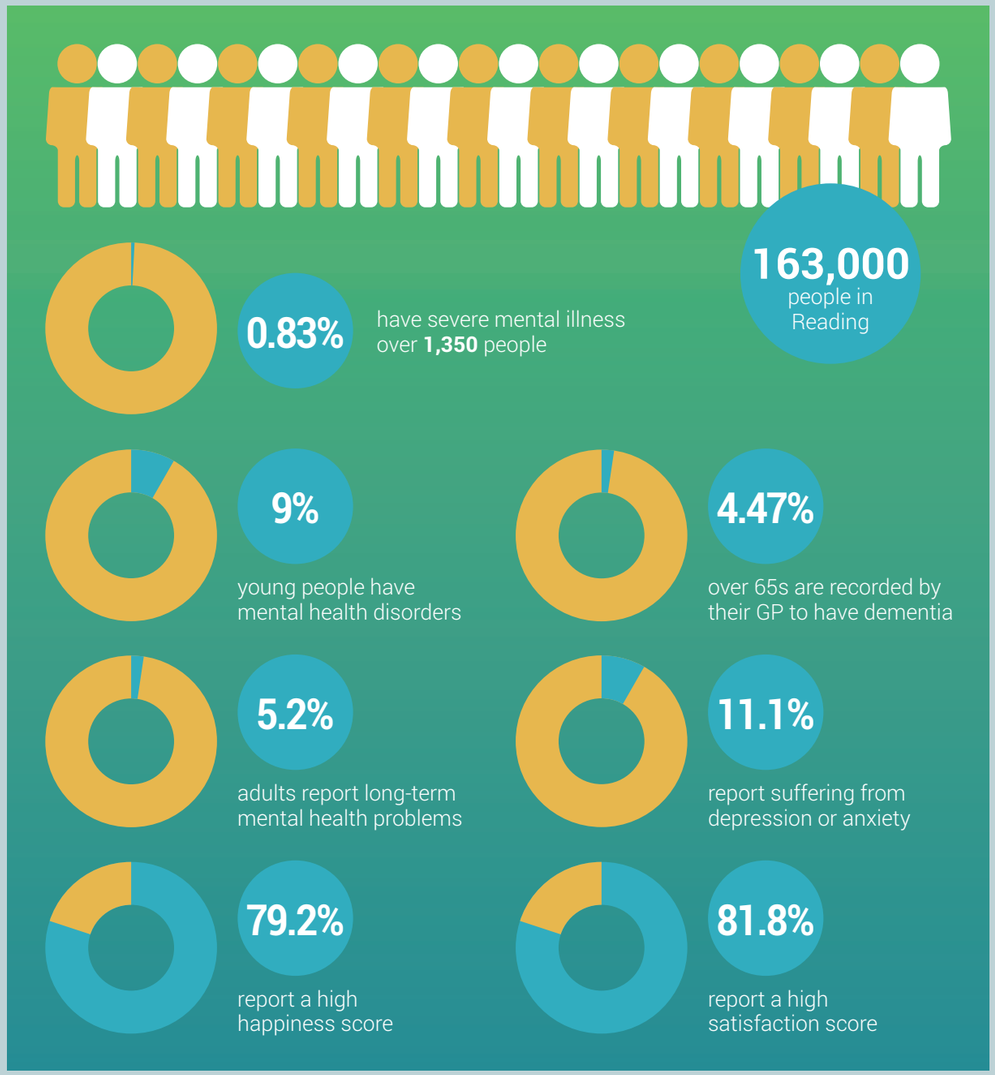
Mental health is not just the absence of mental disorder. It is defined as a state of well-being in which every individual realises his or her own potential, can cope with the normal stresses of life, can work productively and fruitfully, and is able to make a contribution to her or his community.

World Health Organisation definition

National policies and initiatives recognise the benefits of spending time in green spaces on mental health. For example, Mind's Ecominds scheme found 7 of 10 people experienced significant increases in mental wellbeing by the end of an ecotherapy project [7]. It helped people find full-time employment, with potential savings of around £5,700 for each person in terms of government spend.

IN OUR AREA

There are currently estimated to be around 163,000 people [8] in Reading: 0.83% have severe mental illness – over 1,350 people. An estimated 9% of young people have mental health disorders, and 4.47% of over 65s are recorded by their GP to have dementia. Responding to a GP Survey, 5.2% of adults report long-term mental health problems, and 11.1% report suffering from depression or anxiety. In terms of self-reported well-being, 79.2% report a high happiness score and 81.8% a high satisfaction score. [9] [10]



RESEARCH

Evidence for the effect of green space on mental health looks at both the short-term, temporary effects and long term benefits. Contact with nature can improve emotional state, reduce self-reported anger, fatigue, anxiety, sadness and increase feelings of energy. [11]

Hartig et al [12] tested whether natural environments were more relaxing and restorative than purely urban surroundings, by giving subjects difficult tasks. They measured blood pressure and reported mood throughout, and found that being in nature was associated with quicker returns to normal levels of blood pressure and mood after stress – evidence that being in nature can improve your physical and mental wellbeing in times of stress.

A study by Alcock et al [13] looked at people who moved to greener areas during the years of an annual survey of their mental health. Moving from a less to more green area was associated with improvements in reported mental health.

CASE STUDY: RIDGELINE THERAPEUTIC GARDEN

By Graham Johnson, Chair of Trustees at the Ridgeline Trust

Clients are referred to Ridgeline's services through Reading or Wokingham Borough Councils or via GPs or personal referrals. We cater for all people with experience of a range of physical and mental disabilities, as well as other special needs such as learning difficulties or dementia. Our lead Horticultural Therapist assesses each client's individual needs and aspirations, develops a personal programme for each one, and monitors their progress to ensure optimum building of their skills, confidence and well-being. Currently there are 18 client gardeners supported by about 12 volunteers.

What is our impact?

Whatever their problems and difficulties, our gardeners can expect to gain social and physical benefits, including a sense of community, friendship, confidence-building and opportunities for meaningful communication and physical exertion through active engagement outdoors. Being part of a gardening team which is working towards shared aims helps our clients and volunteers to create and enjoy a sense of belonging, camaraderie and achievement, all of which are found to promote positive mental health and well-being. Examples of the specific benefits follow.

- Physical benefits: Physical activity is associated with good health and the reduction of risk factors such as heart disease. It has also been shown to be useful in reducing anxiety and helping with depression, as well as in stimulating those with Alzheimer's or dementia.
- Psychological benefits: Caring for the garden and plants, watching these grow and flourish, and being part of a group effort allows individuals to attribute success to their contributions, thereby improving their self-esteem.
- Benefits from the environment: The garden environment offers the chance to escape from the indoors to a natural outdoor setting that is calm and restful.
- Benefits from communication and social interaction: The horticultural activities, craft work, and cookery done in group settings allow clients and volunteers to enjoy collaborative working, and the popular tea breaks and lunch times provide the opportunity to engage in and develop their social and communication skills.

You can find more details on our website:
www.ridgelinetrust.org.uk

Children and Young People

Every child deserves the best start in life to give them the opportunity to thrive in life. Pregnancy and upbringing impacts our physical and mental health during childhood and through to adulthood. Enabling good maternal health can allow a safe delivery and good growth of the foetus, preventing potential poor outcomes from low birth weight or prematurity. The development of a baby's brain and immune system begins in the womb, and continues as they grow.

Green spaces may alter the environmental stimuli we are exposed to, and through this change whether we develop inflammatory diseases such as asthma. They can encourage us to be more active or to connect with our community, which can improve cognitive development. Exposure to the natural environment appears to have an impact on the development of our microbiome – the vast number of microorganisms that co-inhabit the human body. This microbiome may have an impact on the formation of our immune system, and as such the prevalence of allergies and long-term inflammatory diseases – including asthma. There is also evidence that street trees can improve the air quality in urban areas by absorbing some of the particulate matter from pollution, as well as reducing the 'heat island' effect generated by the concentration of hard surfaces and taller buildings [14].

Together with the improvements in mental health through spending time in nature, green spaces can contribute to a positive development for children, especially for play. The natural environment can improve our environment and change our behaviour to help us grow well. A healthy community which is using the green space available for both formal and informal play to increase a child's chance for the best start in life can set them off on the way to greater health and wellbeing.

RESEARCH

Dadvand et al [15] studied a group of 2,593 primary school children in 36 schools in Barcelona, Spain. Using repeat measures of memory and inattentiveness as an indicator of cognitive development, they compared this with exposure to green space. They measured the 'greenness' around the children's homes, their route to school and the school itself from satellite data that measures the percent of an area covered by plants. They found greater progress in the children in greener schools and home environments, partly explained by a reduced exposure to air pollution.

An American study [16] examined the association between birth outcomes and residential greenness. Looking at 64,705 births in Vancouver, Canada (1999-2002), they examined the density of vegetation within 100m of participants' homes, their birth outcomes and other aspects of their environment. They found that, independent of air pollution, noise, neighbourhood walkability and proximity to a park, increasing residential greenness was associated with beneficial birth outcomes including higher term birth weight and reduction of likelihood of prematurity.

IN OUR AREA

Looking at the most recent data for the health of children in Reading, we see 6.4% of infants born at a low weight. There were 21,767 attendances to Accident and Emergency by those under 18 years old, and 61 hospital stays last year to treat asthma. At 4-5 years of age 9.6% of children are obese, which increases to 18.5% at age 10-11.

In terms of being ready for school, 80.3% of children meet the expected level at the phonics screening check and 70.4% had achieved a good level of development at the end of reception year. Looking ahead, 55.7% of pupils at Key Stage 2 met the expected standard in reading, writing and maths; 52.1% of teenagers achieved five A*-C grades at GCSE. [17] [18] [19]

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Looking ahead

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just over **52%**

of teenagers achieved five A*-C grades at GCSE

CASE STUDY: A DOSE OF NATURE

By Natalie Ganpatsingh,
Director of Nature Nurture CIC

Nestled on a hilltop in Berkshire is a beautiful nature reserve called 'Lousehill Copse'. Winding paths meander through oaks and hazel and a woodland pond invites a mindful moment away from the hustle and bustle of the town. The keen listener might hear the chirp of the goldcrest. Bluebells, celandines and primroses abound.

This ancient woodland is in the residential area of Tilehurst, tucked away between three housing estates including Dee Park. Urban nature spaces like these; our parks, woodlands and waterways, provide spaces for communities to get active, play, learn, relax and experience the restorative effects of nature. They are places where people of all ages and backgrounds can explore and have fun, together, for free. Lousehill Copse is situated within an ethnically diverse area of deprivation. Anti-social behaviour such as fly tipping and drug use is prevalent. Many of the pathways are overgrown and inaccessible.

Nature Nurture CIC is an award winning company on a mission to connect urban communities with the nature on their doorstep. Over the last 6 years, this Reading-based community organisation has been delivering a range of nature-based health interventions across Reading. They believe that by connecting communities with nature, not only do we improve health outcomes, but we also increase the quality of our green spaces, which in turn generates more visits. By integrating conservation activities, they improve habitats which then increases biodiversity. It turns out that participating in physical activity in environments with plenty of natural features is even better for our health than indoors. It's a win-win for people and nature. Thanks to funding from The Health Lottery, Tesco and Catalyst Housing, they have been able to deliver an ongoing family-orientated programme with the Dee Park community.

The Nature Nurture team are trained across a variety of areas: Forest School, Earth Education, John Muir Award, Environmental Education, Creative Arts and School Gardening, as well as by partner organisations delivering dance, yoga and drumming. The key to their success in community engagement is their fun, accessible and inclusive approach. This area of town of West Reading and Tilehurst is slowly overcoming a poor reputation (mostly unwarranted) for crime and anti-social behaviour. To boost community pride and a sense of ownership of these urban green spaces, they created a brand around 'The Wild West', to inspire a sense of adventure.

Their most popular event is the Family Wild Day. Delivered in various parks and woodlands across Reading, these events typically attract 150 - 500 people, with activities on offer such as bug hunting, pond dipping, den building, wild art, woodland yoga and wild walks. Family Wild Days provide opportunities for interaction between a broad range of ages, race and social status - making the most of what we have - local, free...and communal. They recently developed the 'Wild Workout' which features a range of friendly woodland creatures, encouraging simple physical activity workouts, without the need for specialist instructors, equipment or clothing. They encourage people to embed local nature connection into their everyday lives, so all activities are simple to replicate on their own future self-led adventures. A parent who attended a Family Wild Day at Lousehill Copse said that she had lived in the adjacent road for 10 years and never set foot in the woodland until the event and reported 3 months later that spending time there had become a frequent part of her family's life.

The monthly Wild Child Adventure Club at Lousehill Copse combines Forest School inspired activities with actual conservation work, such as clearing pathways and rebuilding bridges. Children as young as three join in the hazel coppicing. This is delivered in partnership with The Conservation Volunteers and Catalyst Housing and is another way for parents and their children to reap the benefits of spending time in nature, together. The Wild Wednesday After School Club connects children from Ranikhet Academy to the copse and to ensure they reach the families who stand to benefit the most, they liaise with the school's Family Development Worker.

Thanks to grants, everything Nature Nurture provides is free to participants as they want to make their programmes accessible to all and promote the sense of nature being free.

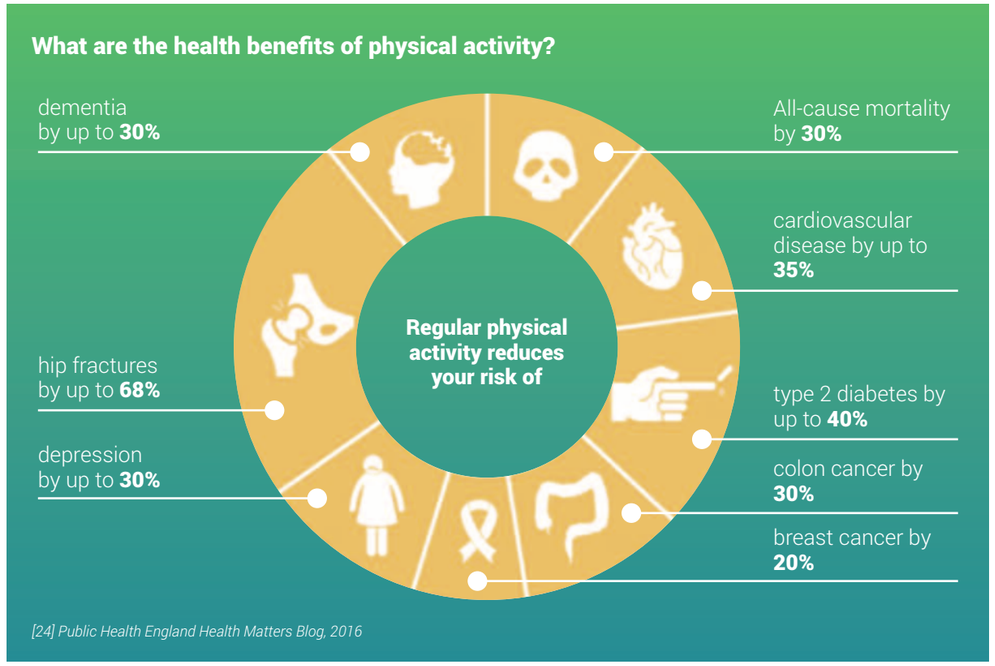
To find out more, visit **www.nature-nurture.co.uk**

Physical Activity

Being active can have wide reaching benefits to our health. It has been shown to reduce the risk of coronary heart disease, stroke, type 2 diabetes. It can help maintain a healthy weight, improve self-esteem and reduce depression and anxiety. Physical inactivity contributes to 1 in 6 deaths [20] , estimates suggest that an inactive person is likely to spend 37% more time in the hospital and visit the doctor 5.5% more often than an active person [21]. The Department for Environment, Food and Rural Affairs estimates that the health system could save £2.1 billion per year if everyone had sufficient access to green space and its benefits. [22]

We also know our environment can shape our behaviour, so there is the opportunity to design our neighbourhoods and towns with activity in mind. The links between access to green space and levels of physical activity are well-established in research, which shows higher levels of physical activity in areas with more green space [23]. Careful planning of towns can enable active travel – i.e. walking or cycling as a mode of transport – through making distances achievable and creating safe and aesthetically pleasing routes to travel on. Those who walk or cycle to their place of work are more likely to meet their physical activity needs. If more of us were active, we could significantly improve the health and wellbeing of our communities. The potential benefits are not limited to health – reducing journeys made by car will decrease carbon emissions, air pollution and traffic, and encouraging walking for shopping can boost our local economy.

Accessible, quality green spaces also allow sports and play to increase leisure time activity. Supporting local sports clubs with facilities, giving spaces for community groups and the provision of playgrounds can all enable people at all ages to be more active. We can harness the natural environment to increase physical activity in our community, and be healthier as a result.



POLICY

Chief Medical Officer Recommendations [25]:

1. Adults should aim to be active daily. Over a week, activity should add up to at least 150 minutes (2½ hours) of moderate intensity activity in bouts of ten minutes or more – one way to approach this is to do 30 minutes on at least five days a week.
2. Alternatively, comparable benefits can be achieved through 75 minutes of vigorous intensity activity spread across the week or a combination of moderate and vigorous intensity activity.
3. Adults should also undertake physical activity to improve muscle strength on at least two days a week.
4. All adults should minimise the amount of time spent being sedentary (sitting) for extended periods.

RESEARCH

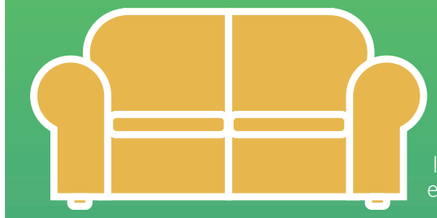
Analysis of the Danish National Health Survey [26] was able to assess self-reported distances to green spaces, BMI and exercise habits. It revealed that those who reported living over 1km, compared with less than 300m, to green space were more likely to be obese and less likely to exercise. Although based on self-reporting which may be biased, this study highlights the potential benefit of encouraging physical exercise through proximity to green space.

A study [27] in Bristol, UK, used data from the 2005 Bristol Quality of Life in your Neighbourhood survey of 6,821 adults and matched it with a mapping database of neighbourhood and green space information. After statistical analysis, they found that the amount of use reduced with increased distance from the green space, and those living near a formal park were most likely to achieve the recommended amounts of physical activity and were less likely to be overweight.

IN OUR AREA

In Reading, current data shows 65.8% of adults (18-65) report meeting the physical activity guidelines set out by the Chief Medical Officer, yet 19.2% of adults complete less than 30 minutes exercise per week [28]. Just over half (53.6%) of adults do any walking at least 5 times per week. 71% of 15 year olds are sedentary for over seven hours per day on average. A study by NHS Digital using an accelerometer found however that only 6% of men and 4% of women met the required levels of activity [29].

Over half of Reading's adults are overweight or obese (55.3%), and this starts in childhood – 32.9% of Year 6 children are overweight or obese. 8,568/4.7% have diabetes, 26,261/11.2% people are living with high blood pressure and 4,271/1.8% suffer from heart disease. 108 people were admitted to hospital last year having broken their hip. [30] [31]



19% Completing less than 30 min exercise per week

55% Overweight or obese

66% Performed the recommended physical activity (based on self-reported surveys)

But only **6%** of men **4%** of women meet the recommended activity levels when objectively measured with an accelerometer

Source: Health Survey for England 2008

If people were more active, what could we reduce?

26,261 (11.2%) with high blood pressure

8,568 (4.7%) with diabetes

4,271 (1.8%) with heart disease

108 admissions for hip fractures

CASE STUDY: READING WALKS

By Luke Lloyd, Programme Manager at the Leisure and Recreation Service, Reading Borough Council

There is considerable evidence to show that walking has many benefits to a person's physical, social and mental wellbeing and can help to reduce risk of diseases such as cancer and coronary heart disease.

Walking has been described as a 'near perfect exercise' particularly to those who get little or no exercise or live in areas of poor health, As well as the health benefits it also offers people safe access to their local parks and green space.

Walking For Health enables local organisations to set up and run local, volunteer led health walks. Reading Walks has been running for a number of years and aims to enhance the quality of life of residents in Reading by offering them community based led walks, run by our volunteer walk leaders.

The main objectives of the walking for health programme are:

- Engage with older and isolated people in the community.
- Increase people's physical activity levels
- Increase independence.
- Discovery of people's local community and green space and decrease social isolation.
- Reduce health inequalities and enhance quality of life for people in Reading

With administrative support from Reading Sport and Leisure, volunteers now lead 5 regular walks in the area. Over 300 people have been involved, walking a total of 171 hours between them this year.

Communities and Health Inequalities

The wider determinants of health, as described in the introduction, have an important role in shaping our health and wellbeing. They were a key focus of the Marmot Review [32], which examined the health of our nation and identified a number of inequalities across our society – those of a lower socio-economic class have a lower life expectancy, a higher frequency of many diseases and poorer mental health. The mechanisms between a lower socio-economic class and poorer health are complex, but can include low quality housing, less healthy diets and lower educational achievement.

Green spaces have been shown to reduce these health inequalities, as the benefits of the natural environment may have a stronger effect for those in lower socio-economic groups. This may be in part due to smaller personal gardens and less aesthetic features in neighbourhoods, but there are often more barriers to the use of green spaces as well – such as crime, traffic and social isolation, which itself has been shown to be associated with increased mortality [33].

An important task of public health is to ensure improvements to health occur throughout society, and inequalities in our area are reduced. Improving green spaces in particular areas of deprivation or using initiatives that reduce isolation and loneliness might be one of the means for us to eliminate health inequalities in our area and improve our communities.

POLICY

The Marmot Review [32] of 2010 is a key piece of work that identifies many of the health inequalities in our society and gives recommendations for change. Policy Objective E, 'Create and develop healthy and sustainable places and communities' has a number of aims for the improvement and development of green spaces across the social gradient.

PRIORITY OBJECTIVES:

- Develop common policies to reduce the scale and impact of climate change and health inequalities
- Improve community capital and reduce social isolation across the social gradient

RECOMMENDATIONS:

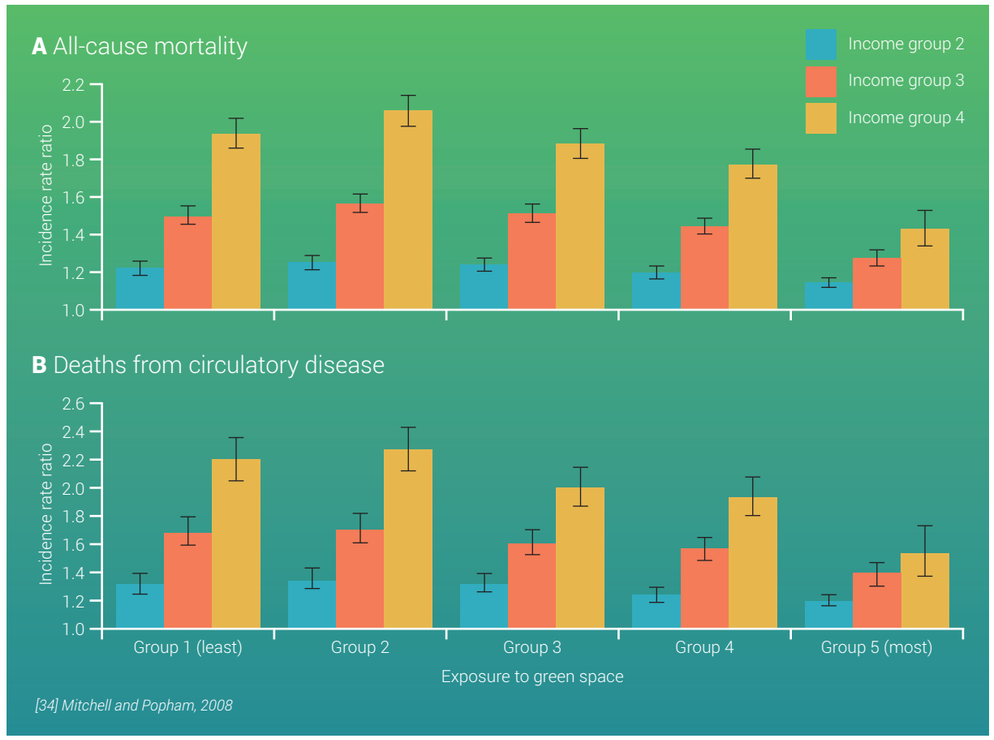
- E1: Prioritise policies and interventions that both reduce health inequalities and mitigate climate change, by:
  - Improving active travel across the social gradient
  - Improving good quality open and green spaces available across the social gradient
- E2: Fully integrate the planning, transport, housing, environmental and health systems to address the social determinants of health in each locality.
- E3: Support locally developed and evidence-based community regeneration programmes that:
  - Remove barriers to community participation and action
  - Reduce social isolation.

RESEARCH

Mitchell and Popham [34] compared different socio-economic groups and the influence of green spaces on their health. Looking at people of working age in groups of increasing income and comparing them with the same groups in areas of increasing green space, they found that the difference in different health outcomes was reduced in areas with more green space. This can be seen in the graph below by the reducing size of the bars as you move left, which is areas of higher green space.

National data from the Monitor of Engagement with the Natural Environment survey, undertaken by Natural England from 2013 to 2015 [35] found that 12% of children had not visited the natural environment in the previous year, and these children were more likely to be of Black and Ethnic Minority origin or of a lower socio-economic class.

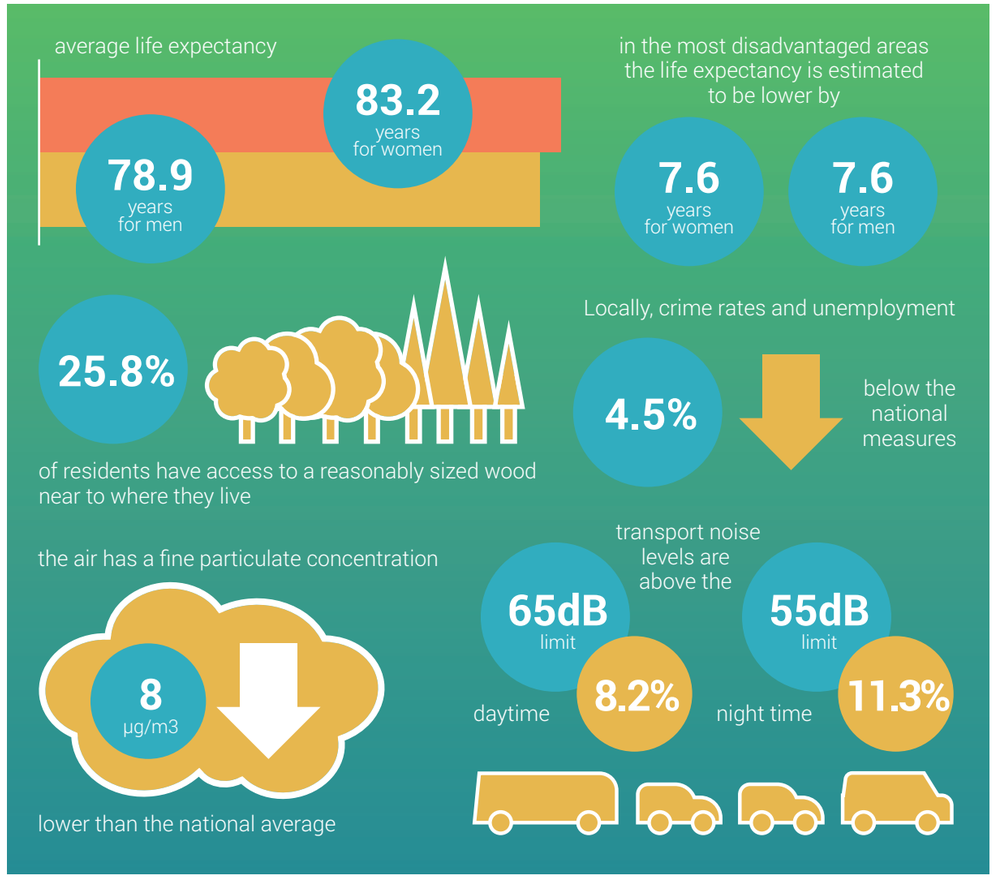
A study [36] in Chicago, USA, looked at the surrounding greenness of 98 publically owned apartment blocks. Residents were randomly assigned to any of the blocks. An examination of police data showed that there were fewer crime reports from apartment blocks with greener surrounding areas when compared to those with less green surroundings.



[34] Mitchell and Popham, 2008

IN OUR AREA

The latest data for Reading shows the average life expectancy is 83.2 years for women and 78.9 for men. However, in the most disadvantaged areas the life expectancy is estimated to be lower by 7.6 years for women and men, compared to the least disadvantaged areas. There are lots of ways to measure the potential causes – they are often the wider determinants of health discussed earlier in the report. Locally, unemployment (4.5%) is below the national rate but crime is slightly more common. In terms of pollution, the air has a fine particulate concentration of 8µg/m3 (lower than the national average), but transport noise levels are above the 65dB limit in daytime for 8.2% of residents, rising to 11.3% for the night time 55dB limit. In terms of personal isolation, only 45.2% of adult social care users have as much social contact as they would like. Only 25.8% of residents have access to a reasonably sized wood near to where they live. [37]



CASE STUDY: SOUTHCOTE GROWALLOT

By Sharon Fitton, Project Coordinator at Food4Families

Food4families is a community programme, run by World Education Berkshire (also known as RISC), a registered charity in Reading and located in some of Readings most deprived areas. Its main aims are to enable local communities to manage land in their own neighbourhoods for the sustainable growing of food for their own consumption, encourage healthier eating and lifestyle habits and develop understanding of the broader environmental, cultural and economic aspects of sustainable food production.

Since its conception in 2009 it has developed a network of community based food-growing projects including educational work with schools, Community Gardens, Vegetable Patches and Cookery Classes.

In 2011 Food4families, in partnership with Jubilee People's Millions and local residents, transformed a patch of derelict wasteland behind the Florian Garden flats in Southcote, Reading, into a community space where local people can grow and share crops. Run entirely by volunteers and managed by a committee, with support from Food4families tutors, the plot has a number of beds, an orchard, polytunnel, tool shed, log cabin, gazebo, lean-to, pond, compost heaps and rain water butts.

The allotment is fruit of the immense work done by all the members, volunteers and tutors over the years, transforming what was a waste ground full of fly-tipped rubble into an oasis-like, peaceful, award-winning garden, providing fresh organic food for the community.

The project brings together different parts of the local community and beyond, and this diversity works towards producing cheap, healthy, fresh food via a common love of gardening, and creates a safe environment for vulnerable adults and children.

People of all ages and backgrounds are welcome and valued, whether for their experience or their youthful enthusiasm. Workshops, learning sessions, corporate volunteer days, open days and stalls are also run regularly throughout the year.

The primary beneficiaries are Southcote residents living in flats with no outdoor space, who gain access to land where they can garden and socialise. We also work with other local organisations, professional or voluntary, which may benefit from using the community allotment. There is a strong focus on local residents, BME communities and groups on low incomes.

Everything grown is distributed out amongst those who attend with the surplus being given away for a donation to local residents in Coronation Square.

Our own and others' experience and research demonstrates that urban community food growing projects provide a unique mix of skills development, dietary improvements, socializing and physical activity that improves participants' well-being, enhances the local environment and builds community capacity.

Evidence collected by The University of Reading researcher during a 2016 study of the project found:

- 66% of people attending regular gardening sessions report a general improvement in their emotional well being.
- 88% of people attending regular gardening sessions report knowing more people in their neighbourhood.
- 89% of people who reported being interested in and more able to influence what is happening with the outside space in their neighbourhood.
- 57% of people involved attending food growing sessions report eating more fruit and vegetables.
- 35% of people attending regular gardening sessions report personal fitness has improved
- An improvement in health related quality of life for residents with treatable/ long term health conditions and disabilities; 5% of participants reported poor mental or physical health
- Those participating will gain skills and knowledge from our gardening and growing activities linked to improved access to fresh food and an improved diet
- Residents gain confidence from new social contacts in their neighbourhood and reduce their isolation from others.
- A positive change in self-confidence and self-esteem for individuals and their families
- Improved links and contacts between third sector and formal health/ care service providers

For more information contact:

Sharon Fitton, F4F project coordinator - Email **sharon@risc.org.uk**
Ring **01189 586692**

OPPORTUNITIES AND CHALLENGES

New Developments and Regeneration

The planning of our local area can influence our health behaviours. Quality, easily accessible green space can enable us to exercise, accessibility to services allows walking and there can be opportunities for social engagement.

With local pressures on housing and the demand for new homes to be built in our area, there are both opportunities and challenges to the amount of quality green space. As urbanised areas already become increasingly built up, there is the need to use green areas on the peripheries of towns to provide enough quality accommodation for our population, often against the wishes of some residents. Although green views can be lost, the majority of these developments take place on private land which is not generally accessible by the public. With careful planning, new developments on previously private land could actually result in more publically accessible green space.

A variety of national policies and frameworks exist to assist local authorities concerning the provision of green spaces. These take the form of general advice through to specific quantifications of how much should be provided and for what purpose. These policies are often used by planning authorities to develop local policies that are relevant to the local situation.

To deliver safe, quality homes and neighbourhoods for all groups in our community it is important to find ways to balance the loss of green areas, the need for more housing and the opportunity to develop new green spaces and use investments to benefit the wider community. By engaging with the planning process and ensuring health and wellbeing of residents is considered in planning, we have the opportunity to develop new assets to improve our neighbourhoods.

POLICY

The Six Acres Standard [38] is a commonly used set of measures to guide local planners as to the amount of recreational space that should be in a community. It was developed by the National Playing Fields Association (NPFA, operating name Fields in Trust), and has existed in various forms since the 1930s with a specific recent update in 2008. It aims to inform policy that will result in the protection, improvement and green spaces focused on sport and play. Many Local Authorities include the standard in their open spaces policies.

Fields in Trust recommended benchmark guidelines - formal outdoor space [38]

Open space typology	Quantity guideline (hectares per 1000 population)	Walking guideline (walking distance: metres from dwellings)	Quality guideline
Playing pitches	1.2	1200m	• Quality appropriate to the intended level of performance, designed to appropriate technical standards • Located where they are of most value to the community to be served • Sufficiently diverse recreational use for the whole community • Appropriately landscaped • Maintained safely and to the highest possible condition with available finance • Positively managed taking account of the need for repair and replacement over time as necessary • Provision of appropriate ancillary facilities and equipment • Provision of footpaths • Designed so as to be free of the fear of harm or crime • Local authorities can set their own quality benchmark standards for playing pitches, taking into the account the level of play, topography, necessary safety margins and optimal orientation • Local authorities can set their own quality benchmark standards for play areas using the Childrens' Play Council Quality assessment tool
All outdoor sports	1.6	1200m	
Equipped/ designated play areas	0.25	LAPs -100m LEAPs - 400m NEAPs - 1000m	
Other outdoor provision (MUGAs and skateboard parks)	0.3	700m	

The National Planning Policy Framework [39] features a number of policies relating to green and open spaces. They include:

- Promoting healthy communities, through access to high quality open spaces and opportunities for sport and recreation
- Protection for existing facilities and the 'Local Green Space' designation, which can be used to afford special protection for green areas of particular local importance due to their use or features
- Protection of green belt land and the need to positively enhance beneficial use of the land through increasing access, biodiversity of improvement of damaged land

INCREASING ACCESS

Another way we can maximise the benefits of green space in our area is to make best use of existing spaces. This can be through improving the quality of already available spaces, opening previously private areas and finding new ways to encourage their use.

Access to green spaces can be increased by removing the barriers to their use. These can vary for different groups, and are not restricted to their quantity or closeness to home. Personal concerns for safety, the quality of the spaces, the weather or poor transport infrastructure can prevent people using green spaces.

Local authorities can work to remove these barriers, alongside the wide range of other organisations who aim to improve the natural environment, encourage people to use it and increase healthy behaviours. Finding new ways to collaborate and strengthening existing links can allow us to make the most of the potential benefits for the green spaces already in our area.

RESEARCH

Volunteering with the Wildlife Trusts [40] improved peoples' mental wellbeing in 6-12 weeks in a study looking at 139 people, some of which were referred by healthcare providers, who volunteered with the Wildlife Trusts as they took part in nature conservation volunteering activities. 95% of participants with low self-reported wellbeing at the start of the project reported an improvement in 6 weeks, this level increased further over the following 6 weeks. Participants reported significantly enhanced feelings of positivity, increased general health and pro-environmental behaviour, higher levels of physical activity and more contact with green space at 12 weeks.

An Australian study [41] combined an audit about public open spaces in Perth with over 1,800 personal interviews. After statistical analysis, they found that those with very good access to large, attractive open spaces were 50% more likely to report high levels of walking, when compared with those do not have access to quality public spaces. This is evidence that the proximity and quality of spaces increases their use.

POLICY

A briefing [42] from the UCL Institute of Health Equity and Public Health England suggests some ways to increase access to green spaces:

1. Create new areas of green space and improve the quality of existing green spaces.
2. Increase accessibility of green spaces and improve engagement with local people.
3. Increasing the use of good quality green space for all social groups.

The Accessible Natural Greenspace Standard (ANGSt) was developed by Natural England to aim to quantify the need for local, useable space near communities. The standards state:

'All people should have accessible natural green space:

- of at least two hectares in size, no more than 300m (five minutes' walk) from home
- at least one accessible 20 hectare site within 2km of home
- one accessible 100 hectare site within 5km of home
- one accessible 500 hectare site within 10km of home'

These criteria account for the need for immediately local smaller spaces, as well as larger areas for sports and walking and are a means by which we can measure the depth and breadth of green spaces around us. Applying the standards to our area might enable us to find particular spaces that could be opened for residents for the widest benefit.

CASE STUDY: GREEN FLAG CAMPUS AT THE UNIVERSITY OF READING

By The University of Reading

READING VOTED BEST UNIVERSITY GREEN SPACE IN THE UK

Release Date 11 October 2017

The University of Reading's Whiteknights campus has been voted among the top ten most popular green spaces in the UK.

Whiteknights, which is made up of 130 hectares of beautiful parkland, was voted for out of almost 1,800 green spaces entered into the 2017 Green Flag People's Choice Award and is the only university campus in the top 10.

The University received its seventh Green Flag Award earlier this year in recognition of its well-maintained and well-managed campus.

All Green Flag Award-winning parks and green spaces were entered into the annual poll, and the public were asked to vote for their favourite. The Green Flag Award scheme is the benchmark standard for parks and green spaces in the UK and is run by Keep Britain Tidy.

The Whiteknights campus includes a lake, woodlands and the widely enjoyed Harris Garden.

Steve Boon, Facilities Maintenance Director at the University, said: "We are delighted to have been voted in the top ten green spaces in the UK, and hugely proud to be the only university campus on that list. Our beautiful Whiteknights campus plays a huge part in attracting students and staff to the University of Reading.

"The grounds and maintenance teams work extremely hard to keep the campus looking good all year round, so I would like to thank them for their hard work and dedication, which has helped us gain this fantastic recognition."

The campus includes public rights of way and is used by local residents as well as staff and students of the university.

CONCLUSIONS

Green spaces can fundamentally define the spaces in which people live and work. The natural environment can have wide ranging health benefits for individuals and our communities and therefore have an important role to play in helping to reduce health inequalities.

Green spaces are free at the point of use and are an accessible asset for all communities, including those who may not be willing or able to pay to use other public or private facilities. It should be noted that green spaces are assets of value in their own right and are often valued for their relatively undeveloped and unspoilt nature. The quality of such spaces and their benefit to communities depends upon appropriate design and management of them.

We have examined how there is clear evidence for a range of improvements to health and wellbeing, including but not limited to:

- Mental health
- Pregnancy
- Childhood development
- Reduction in cardiovascular disease
- Increasing physical activity
- Reducing health inequalities
- Improving cohesion in communities

We have been able to showcase the wide range of success stories from the local authority and other organisations that are increasing our health and wellbeing by using the natural environment.

We also considered the current health of our population, particularly in the areas that could be improved by green spaces.

There are opportunities and challenges to using green spaces, and we have also considered some of the limitations to achieving these benefits and a few of the ways we might make more use of the assets in our area.

RECOMMENDATIONS

1. Local authorities and other agencies should continue to encourage community initiatives that make the most of natural space available, with the aim of improving mental health, increasing physical activity and strengthening communities.
2. Existing green space should be improved and any new developments should include high quality green spaces. The use of professional design and arrangements to ensure the ongoing management of natural environments should be considered if spaces are to be sustainable.
3. Opportunities to increase active transport should be considered when designing new green spaces and in the improvement of existing space.
4. Planning guidance for new developments should specifically consider the use of green and blue space to improve the health and wellbeing of residents and others using the space.
5. Local Authorities and their public health teams should foster new relationships with organisations aiming to improve the natural environment and its use.

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Reading
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READING HEALTH AND WELLBEING BOARD

DATE OF MEETING:	**13 JULY 2018**	**AGENDA ITEM:**	**16**
REPORT TITLE:	**COVER REPORT FOR READING HOMELESS HEALTH NEEDS AUDIT**		
REPORT AUTHOR:	**VERENA HUTCHESON**	**TEL:**	**0118 937 4136**
JOB TITLE:	**HOMELESSNESS AND HOUSING PATHWAYS MANAGER**	**E-MAIL:**	**Verena.hutcheson@reading.gov.uk**
ORGANISATION:	**READING BOROUGH COUNCIL**		

1. PURPOSE OF REPORT AND EXECUTIVE SUMMARY

1.1 Throughout January and February 2017, over a five week period, partners from Reading's Homelessness Forum commissioned and undertook a Homeless Health Needs Audit in Reading. The Audit included completion of questionnaires with 150 individuals who were single or part of a couple without dependent children and who were homeless - for example those who were rough sleeping, sofa surfing, living within supported accommodation, refuges or in Bed and Breakfast. The aims of the Audit were to listen to and take account of single homeless people's views on their health; provide an evidence base and fill in any information/evidence gaps; contribute to Reading's Joint Strategic Needs Assessment (JSNA); consider what is currently working well within services, with a view that this could inform improvements; and develop a case for change for homeless people in Reading.

The findings of the Homeless Health Needs Audit are intended to be a research piece that can inform improvement and service development across sectors where key issues from respondents have been highlighted and management within sector services are invited to set out their responses to these findings and develop subsequent action plans.

1.2 Appendix 1 - *Reading Homeless Health Needs Audit: A report based on findings of a Homelessness Forum partnership project into the physical, mental and sexual health needs of Reading's single homeless population.*

2. RECOMMENDED ACTION

2.1 That partners that represented at the Health and Wellbeing Board note the Reading Homeless Health Needs Audit report research to inform improvement and service development within their area and across housing, health and social care sectors.

2.2 That management and commissioners within and across housing, health and social care sector services develop responses to the Audit's findings and report back to the Board plans to address highlighted issues and barriers for those who are single, or part of a couple without dependent children experiencing homelessness.

3. POLICY CONTEXT

3.1 The Homeless Health Needs Audit and associated toolkit was first developed by Homeless Link, in partnership with the Department of Health and nine pilot areas across England, in 2010. In 2015, with funding from Public Health England, it was updated to take into account changes to local commissioning environments and other relevant reforms impacting on homelessness and health.

Homeless Link established that people who become homeless have some of the highest and costliest health needs in a local community, but those needs are often overlooked when healthcare and social care services are planned and commissioned. Homeless Link advise that addressing health inequalities is a statutory requirement for the NHS, including local bodies such as Health and Wellbeing Boards, public health teams and Clinical Commissioning Groups. They advise that improving the evidence base around homeless people's health and the services they use is of vital importance in achieving this aim.

The Homeless Health Needs Audit itself provides a framework for gathering and using information to access local need and improve healthcare services using the direct experiences of people who single, or part of a couple without dependent children and that are homeless. In gathering local data, Audits across 27 local authority areas have aimed to do the following:

- Increase the evidence available about the health needs of people who are homeless and the wider determinants of their health
- Bring statutory and voluntary services together to develop responses to local priorities and address gaps in services
- Give people experiencing homelessness a stronger voice in local commissioning processes
- Help commissioners understand the effectiveness of their services

4. THE PROPOSAL

4.1 Current Position

Audit data has been collated and a report has been prepared that analyses and presents this research for housing, health and social care services.

4.2 Options Proposed

That Audit data is considered and utilised by housing, health and social care management and commissioning services to develop action plans that address highlighted issues and barriers.

5. CONTRIBUTION TO READING'S HEALTH AND WELLBEING STRATEGIC AIMS

5.1 The proposals within this cover report contribute to the following of Reading Health and Wellbeing's Strategy priorities:

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

6. COMMUNITY & STAKEHOLDER ENGAGEMENT

6.1 To ensure that the Audit had the widest possible input and impact it was conducted in partnership with agencies across statutory and voluntary sectors. The partnership was formed as a sub-group of Reading's Homelessness Forum. Details of all partners involved are included within the body of the report. 23 volunteers and staff across sectors were involved in completing Audits with individuals. All staff and volunteers were fully trained and had the full support of staff within the Homelessness Support (Pathways) Services team.

7. EQUALITY IMPACT ASSESSMENT

7.1 Not applicable

8. LEGAL IMPLICATIONS

8.1 Not applicable

9. FINANCIAL IMPLICATIONS

9.1 Not applicable

10. BACKGROUND PAPERS

10.1 None

Reading Homeless Health Needs Audit

A report based on findings of a Homelessness Forum partnership project into the physical, mental and sexual health needs of Reading's single homeless population

September 2017

Icons have been resourced from www.flaticon.com and www.piktochart.com

Contents

Executive Summary

Throughout January and February 2017, over a five week period, partners from Reading's Homelessness Forum commissioned and undertook a Homeless Health Needs Audit in Reading.

The Audit completed questionnaires with 150 individuals who were single or part of a couple without dependent children, who were homeless - for example, those who were rough sleeping, sofa surfing, living within supported accommodation, refuges or in Bed and Breakfast.

The aims of the Audit were to listen to and take account of single homeless people's views on their health; provide an evidence base and fill in any information/evidence gaps; contribute to Reading's Joint Strategic Needs Assessment (JSNA); consider what is currently working well within services, with a view that this could inform improvements and develop a case for change for homeless people in Reading.

The findings of the Audit and this report are intended to be a research piece that can inform improvement and service development across sectors. Key issues from respondents have been highlighted and management within sector services are invited to set out their responses to these findings and develop subsequent action plans.

The report is set out under the following headings:

- Statements of health
- Physical and mental health
- Smoking, drug and alcohol use
- Access to health services
- Focus on rough sleepers' health needs
- Prevention opportunities

Key findings from the report show that respondents have particular concerns about their mental health and the support they receive to manage their mental health needs. 80% of respondents reported having a mental health problem with many stating that their homelessness was a contributing factor to their mental health problems; that they had difficulty accessing mental health services (waiting times, inconsistency; concurrent substance misuse issues); that they would rather have face-to-face support and that specialist trauma services would be beneficial.

Regarding the physical health needs of respondents, the top three longer-term needs concurred with the national picture as (1) joint aches or problems with bones/muscles; (2) heart problems or chronic breathing problems and (3) dental/teeth problems. A third of respondents reported problems with their teeth/mouth. Several respondents stated that they had not received treatment for dental health problems in the last 12 months primarily due to fear of examination; not being able to get an appointment and not feeling motivated to get treatment.

A significantly high proportion of respondents were smokers. Alcohol and drug misuse amongst Reading's respondents was in line with other health need audits across the country with drug use at 43% and alcohol misuse at 30% and the use of NPSs being minimal. Over half of respondents stated that they were using drugs and/or alcohol as a means to cope with mental health or past trauma.

Compared to other health need audits, Reading's respondents had a slightly lower GP registration rate and significantly lower registration refusals. This can be attributed to Reading having a well-used Walk-In Centre facility. Those within supported

accommodation were more likely to be accessing primary health care and less likely to be refused access to services.

Over a third of respondents stated they had accessed A&E at least once in the last year; with just under a third admitted to hospital from A&E. Those most prolifically using A&E and ambulance services were primarily living in supported accommodation and had multiple and longstanding health issues. Only one was sleeping rough. All but one respondent accessing A&E identified as having depression and anxiety as well as at least one other mental health diagnosis - primarily Personality Disorder and a dual diagnosis (alcohol/drug misuse and a mental health diagnosis). Respondents stated that they valued having appointments with a regular and familiar GP; were frustrated with not being able to get an appointment with a GP in a timely way; sometimes felt disbelieved and judged when presenting with symptoms at A&E and felt that discharge staff could do more in establishing a patient's housing situation.

Sexual health checks and confidence about accessing sexual health advice were higher than in other Audit areas. Reports of HIV, TB and Hepatitis B and C were very low. Uptake of the Hepatitis B vaccination was significantly higher than other local authority areas. Respondents who had recently been in custody stated that they considered their health and wellbeing needs had not been addressed whilst in custody in preparedness for their release.

There were several examples of responses from those who partook to highlight the following positive experiences of health care and support in Reading: availability and accessibility of Reading's Walk-In Centre; accessibility of in-reach services provided by the Health Outreach Liaison Team (HOLT); peer support services for those with substance misuse issues and high levels of respondents knowing how to access contraception and advice about sexual health.

Respondents showed that they would like to see improvements in the following areas:

- Obtaining GP appointments and wanting consistency of support from the same GP.
- Access to accommodation and a feeling of home to improve overall mental health and well-being.
- How mental health support is obtained, delivered and it's availability.
- Access to more support, including peer support and specialist trauma support, for mental health and/or substance misuse.
- Attitudes of health care staff towards those who have physical and/or mental health issues alongside substance misuse issues; wanting to feel believed, not judged, and given time by professionals.
- Feeling able and comfortable in accessing dental health services.

The Council's Housing Needs team currently commission several homelessness support services in Reading to meet the needs of those who are single and homeless. From September 2018, these services will be recommissioned, in line with local best practice and national recommendations, to create immediate and emergency responses to those who are homeless or sleeping rough; housing and support offers to address the differing needs of single homeless people and services that pre-empt and prevent homelessness. Since June 2017, the Council and St. Mungo's have set-up a two year Housing First pilot as an innovative approach to housing and supporting those who have complex and entrenched behaviours where traditional models of supported accommodation have proved to be ineffective. Housing First works with the principle that individuals do not need to engage with treatment services as a precursor to accessing accommodation, where such conditions can be a barrier. This model will house 8 - 10 Reading individuals who will be supported by a full-time Housing First Worker.

Partner Organisations

To ensure that the Audit had the widest possible input and impact it was conducted in partnership with agencies across statutory and voluntary sectors. The partnership was formed as a sub-group of Reading's Homelessness Forum.

The Homeless Health Needs Audit Project Group was formed with the following partners to provide steer, direction and operational support to the process:

- Ability Housing Association
- Berkshire Healthcare Foundation Trust - including Adult Mental Health Services, Thames Valley Diversion and Liaison Team, Health Outreach Liaison Team (HOLT) and Royal Berkshire Hospital (RBH)
- Berkshire Women's Aid (BWA)
- Bournemouth Churches Housing Association (BCHA)
- Churches in Reading Drop In Centre (CIRDIC)
- Christian Community Action (CCA)
- Community Rehabilitation Companies and National Probation Service
- Elizabeth Fry Charity
- FAITH Christian Group
- Healthwatch Reading
- IRIS Drug and Alcohol Service, Reading
- Launchpad Reading
- NHS South Reading Clinical Commissioning Group (CCG)
- PACT Charity
- Patient Voice Reading
- Public Health England
- Providence Chapel
- Reading Borough Council - including the Homelessness Support (Pathways) Services Team, Adult Social Care Commissioning and Public Health Reading
- Reading Voluntary Action (RVA)
- Riverside
- St. Giles Trust
- St. Mungo's
- The Mustard Tree
- The Passage
- The Salvation Army
- YMCA Reading

The partnership was led by Reading Borough Council's Homelessness Support (Pathways) Services Team. Terms of Reference for the Project Group are attached as an appendix.

Acknowledgements

Thank you to all Audit respondents for their honesty and time in providing a voice to those with lived experience of homelessness and health needs in Reading.

Special thanks to local voluntary sector partners for their input from a non-statutory perspective - this has been very valuable in shaping the Audit and challenging perceptions, as well as supporting with completions of questionnaires.

We are immensely grateful to all volunteers, across sectors, who undertook essential training to assist with the Audit and who dedicated their time during the day and in the evenings to complete questionnaires with participants.

Thank you to Healthwatch Reading for supporting the Audit with their expertise and supplementing the Audit with additional qualitative focus group data, provided in a separate report.

Nationwide provided five pound denominations of vouchers to incentivise the project. This financial support enabled the Audit to reach further groups and those who we may not otherwise have been able to engage with. Thank you to Sascha Chennell for organising the provision of vouchers for the project.

Homeless Link enabled Reading to access the Homeless Health Needs Audit template and toolkit. Thank you to Debra Hertzberg for her advice on designing the questionnaire and to Sarah Gorton for attending the Homelessness Forum initially to explain and promote the Audit project to Reading partners.

Thank you to commissioned homeless and housing support services in Reading who invested a significant amount of staff time and effort into completing the Audit with their clients.

Finally, thank you to Homelessness Forum members for supporting the Audit and making it happen and to the Homelessness Support (Pathways) Services Team for designing and providing volunteer training and for inputting, analysing and presenting the data contained within this report.

Objectives of the Audit

The Homeless Health Needs Audit is a framework designed by Homeless Link for gathering and using information about health inequalities that single homeless individuals may be experiencing, by asking partners to complete a questionnaire with those affected. The information gathered is then analysed to inform lead partners – housing, health, commissioners - about changes that can be made to services, service delivery and partnerships to improve the health of homeless individuals and their access to services within the local area.

Reading's Homeless Health Needs Audit 2017 was commissioned by Reading's Homelessness Forum and the findings aim to develop an understanding of the health and wellbeing of those who are homeless in Reading. The aim is to offer commissioners and service providers, across all sectors, a better understanding of the health conditions that homeless individuals face and to make recommendations on how to improve partnerships and services.

The objectives of the Audit are:

- To listen to, take account of and record the views of single homeless regarding their health needs using relevant evidence gathering procedures by giving people experiencing homelessness a stronger voice in local commissioning processes
- To provide an evidence base on the health needs of single homeless people by building a comprehensive dataset on Reading's local homeless population to fill in any information or evidence gaps.
- To contribute to Reading's Joint Strategic Needs Assessment (JSNA).
- To demonstrate the value of homelessness services in contributing to the health agenda and vice versa – identifying what we are doing well and where improvements could be made by helping commissioners to understand the effectiveness of their services
- To improve service access and delivery for single homeless individuals in Reading and ultimately improve their overall health.
- To develop a case for change by considering the development of new services; service remodelling; new or better partnerships and systems, or additional training for targeting and engaging single homeless individuals.
- To bring statutory and voluntary sector services together to develop responses to local priorities and look to address gaps in services.

The Audit does not aim to and cannot provide answers to all questions sectors, services and commissioners might have about single homeless individuals and their health needs. It provides an evidence base; however, there will still inevitably be some gaps in information and evidence that arise from the data explored. The main areas of focus for the Audit are:

- Access to health services
- Physical health
- Mental health
- Drug and alcohol use
- Prevention: Vaccinations and screening

Background Information

Single homelessness and rough sleeping in Reading

In January 2017 the Department for Communities and Local Government (DCLG) published autumn figures for rough sleeping across England. The figures provided a snapshot of the number of people every local authority estimates or counts to be sleeping rough on any one given night.

A total of 4,134 people were counted or estimated to be sleeping rough on a 'typical night' in 2016. This was a 16% increase since 2015. People sleeping rough has more than doubled over the last two years. This is an increase of 134% since 2010 when this centralised and mandatory methodology for local authorities estimating and counting those rough sleeping began[1].

In 2016 Reading saw an increase in rough sleeper numbers on a 'typical' night of 22 individuals, up from 16 in 2015. The number of people known to rough sleep on occasions, for example those who have some sofa surfing options with friends and family and then spend some time rough sleeping, has increased in Reading over the last five years too.[2]

There are many reasons why there have been increases in single homelessness numbers across England in the last few years including:

- The impact of welfare reform, such as the application of under-occupation charges; benefit sanctions and those aged under 35 only being entitled to a rate of Local Housing Allowance (LHA) that meets the cost of a room in a shared house.
- From April 2017 those aged 18 - 21 who are claiming Universal Credit are no longer entitled to financial help with housing costs unless deemed vulnerable or unable to live with parents.
- Increases in European nationals and unsuccessful asylum seeker applications where people have no recourse to public funds.
- A reduction in local authority funding from central government which has impacted upon the commissioning and delivery of non-statutory single homeless accommodation and related support services.
- Difficulties with move-on from supported accommodation into longer term accommodation. This is primarily due to availability and affordability where market rents, significantly in the South East, exceed Local Housing Allowance rate entitlements.
- Thriving day and night time economies in towns and cities like Reading in the South East which can attract those wanting to access on-street donations through begging to fund day-to-day cycles of Class A drug and alcohol misuse. In less lucrative areas, this cohort may otherwise choose to access supported accommodation or reconnect to their area of origin rather than sleep rough to maximise their begging opportunities.

Reading does not have access to data that accounts for numbers of homeless individuals who are staying with various friends and/or relatives on an ad-hoc basis - this is often referred to as 'sofa-surfing'. CRISIS refers to 'hidden homelessness'[3] where people have no fixed address and tend to 'sofa surf' amongst friends and relatives, but rarely enter into

[1] Homeless Link (2016) *2016 Rough Sleeping Count*. Accessed at http://www.homeless.org.uk/sites/default/files/site-attachments/Homeless%20Link%20-%20analysis%20of%20rough%20sleeping%20statistics%20for%20England%202016.pdf on 22/08/17.

[2] Please note that since this report was authored, further data has been released regarding rough sleeping numbers. In January 2018, figures for 2017 for Reading were released where Reading saw an increase in numbers from 22 to 31 rough sleepers found during an official annual count.

[3] Fitzpatrick, S. et al. (2017) *The Homelessness Monitor: England 2017*, CRISIS, London.

rough sleeping. These individuals are rarely seen by street outreach teams or housing advice officers within local authorities. Where such services are commissioned, like in Reading, some are supported by floating support teams into the private rented sector where it is appropriate and affordable to do so. For the purposes of the Audit, the partnership group recognised the importance of representing these groups and housing circumstances within responses gathered. This is outlined further within the *Methodology and Response Sources* section.

It is worth noting in this section that Reading Borough Council commissions several homelessness support services for those with a local connection to Reading, including 217 supported accommodation bed spaces; a rough sleeper outreach team and a floating support service to prevent homelessness.

Reading's voluntary and faith sector community provide several services for those who are homeless or vulnerably housed including a night shelter throughout January and February and several groups and outreach functions for meeting the basic needs of these individuals.

Homelessness and health

It is widely recognised and has been demonstrated by Homeless Link Homeless Health Needs Audit responses from across several local authority areas since 2010 that homeless people experience specific and multiple health problems, that not only contribute towards the cause of homelessness, but that can also exacerbate their homeless situation.

Those who experience homelessness can also experience the detrimental effect that is has upon their physical and mental health wellbeing. A report by CRISIS in 2011 determined that the average age of death of a male who is sleeping rough is 47 and for women this is 43. The report concludes that those sleeping rough are nine times more likely to commit suicide[4].

Homelessness and in particular rough sleeping is an independent factor for premature mortality and chronic homelessness is an associated marker for tri-morbidity. Tri-morbidity is the combination of physical ill health with mental health and substance misuse, complex health needs and premature death. Tri-morbidity often has roots in histories of complex trauma, including high levels of child neglect and abuse, that impact upon developmental trajectories and subsequently an individual's adult mental health and well-being.

There are several factors that can mean that homelessness and in particular, but not exclusively, rough sleeping itself makes it difficult to access health care services because homeless people:

- Can be prevented from registering with a GP because they are unable to provide proof of their address or identity.
- Can find it difficult to make and keep appointments due to inflexible booking procedures and a lack of phone number or safe address for arranged appointments to be sent to or take place in.
- Can perceive or experience stigmatisation and discrimination because they are homeless which can deter them from accessing healthcare or can cause them to disengage with healthcare services before their health needs can be met.
- Can be chaotic in their nature and therefore are more likely to access acute healthcare services disproportionately to the general population. Data from the London Pathway in 2016 detailed that homeless people attend A&E up to six times

[4] CRISIS (2011) *Homelessness: A Silent Killer - a research briefing on mortality amongst homeless people*, CRISIS, London.

as often as the general population; are admitted four times as often and, once admitted, tend to stay three times as long in hospital[5].

Rough sleepers have a lower life expectancy and greater health and support needs compared to the general population and this puts pressure on and increases costs for other public services.

Homelessness and healthcare provision in Reading

Reading Walk-in Health Centre[6]
The Walk-in Centre is open seven days a week, 365 days a year from 8:00 am until 8:00 pm where people can see a nurse practitioner as a walk-in patient. Patients do not have to be registered at the Centre to see a GP or nurse and being seen at the Centre does not automatically mean a patient has been registered. Individuals can choose to register with the Centre if preferred. Referral to a GP will be at the discretion of a nurse practitioner rather than at the request of the patient and referrals to a GP are only made if medically necessary.

Waiting times can be anything from five minutes up to four hours - a number system is used, but urgent cases are seen out of turn. This decision is made by a nurse practitioner having assessed waiting patient's presenting needs.

For unregistered walk-in patients staff at the Centre do not have access to a patient's medical records and therefore there are limitations on prescriptions that can be provided. Where patients are registered with other GP surgeries, a record of contact and treatment is sent back to this surgery for their records, unless otherwise requested. For unregistered walk-in patients specialist referrals will not be made.

The Centre does have an upper capacity limit and therefore patients may be directed towards their GP, a pharmacist, 111 services or A&E where appropriate.

Homeless Outreach Liaison Team (HOLT)[7]
The HOLT is a unique service commissioned in Reading that specifically targets working with those who are homeless, living in a hostel or where people are having difficulties accessing mainstream health services. The team comprises two specialist workers in physical and mental health needs.

HOLT conducts outreach clinics for initial assessments and treatment at the following locations:

- **Every Monday**, 11am to 1.30pm, at the Churches in Reading Drop In Centre (CIRDIC), 1 Berkeley Avenue, Reading, RG1 6JT.
- **Every Tuesday**, 7am to 9am, in partnership with St Mungo's, Reading, to offer help to anyone found sleeping rough.
- **Between Tuesday and Friday**, a number of clinics on a referral basis at different locations including approved premises, Launchpad and 1st Stage supported accommodation.

Generally the service is open Monday to Friday, 9am - 5pm.

[5] Urban Village Medical Practice (2016) *Manchester Homeless Health Needs Audit 2016,* Urban Village Medical Practice, Manchester.
[6] NHS (2017) *Reading Walk-In Centre*. Accessed at http://readingwalkinhealthcentre.nhs.uk/ on 20/09/17.
[7] Berkshire Healthcare Foundation Trust (2017) *Health Outreach Liaison Team.* Accessed at https://www.berkshirehealthcare.nhs.uk/our-services/adult-healthcare/health-outreach-liaison-team-holt/ on 20/09/17.

Referrals and appointments are not needed, but can be made by health care and other support services where appropriate and requested. If health needs cannot be met by the team at these clinics then clients are supported to access the right service such as registering with a local GP, dentist or optician.

Methodology and response sources

The Audit Tool

The Homeless Health Needs Audit aims to offer a practical way to improve the health of people who are homeless at a local level and across sectors. The Audit was first developed in partnership with the Department of Health and nine pilot areas in 2010. In 2015, with funding from Public Health England, the tool was updated to take into account changes in local commissioning environments and other relevant reforms impacting on homelessness and health[8]. The Audit is designed, with accompanying guidance, to be used by anyone with an interest in the health of homeless individuals, including those with responsibility for improving health and wellbeing and reducing health inequalities.

Project Sub-Group

A sub-group of the Homelessness Forum, comprising partners outlined in the *Partner Organisations* section, was formed and met prior to the Audit taking place in July, October and December 2016 and then after the Audit in June 2017 to discuss and analyse the data and findings.

The sub-group ensured that the questionnaire was adapted to meet the purposes of members and sectors; that adequate training and preparation was undertaken for questionnaires to be completed comprehensively and sensitively and that guidance was provided on how to sufficiently signpost any safeguarding concerns or other needs raised with interviewers throughout the Audit process. Terms of Reference were devised in line with aims outlined in the *Objectives of the Audit* section.

Definition of homelessness for the purposes of the Audit

The definition of homelessness for the purposes of the Audit was as recommended by Homeless Link. The Audit was designed to only include single people, or individuals that formed part of a couple without dependents, who were:

- Aged 18 or over
- Living on the street - Consistently, regularly or occasionally
- 'Sofa surfing' with friends or family
- Squatting
- In bed and breakfast, hostel or other temporary accommodation including refuges, supported accommodation currently referred to in Reading as the Homelessness Pathway or any temporary night shelter

The Audit in Reading

Reading's Homeless Health Needs Audit was undertaken between 23 January and 24 February 2017. The project sub-group agreed to undertake the Audit during the second month that Reading's night shelter, established and co-ordinated by FAITH Christian Group, was open. This is because FAITH was a key partner in assisting with the completion of questionnaires and capturing views from those who were rough sleeping.

[8] Homeless Link (2014) *Homeless Health Needs Audit: Better planning to improve the health of people who are homeless in your area,* London, Homeless Link.

Sample size and representation

A sample size minimum of 50 - 75 participants is set by Homeless Link to ensure a valid comparable and substantial dataset. The project sub-group were aiming for at least 100 participants ensuring that respondents were representative in terms of age, gender, ethnicity, sexuality and type of accommodation currently occupied. It was recognised that different groups amongst those experiencing homelessness would likely have different needs and varying access to health services and how important it would be to capture these in the Audit. Reading's Audit exceeded expectations with 150 responses in total and respondents were representative across the groups detailed above.

The Audit Questionnaire

The Audit uses a standard set of questions developed by Homeless Link. Some questions were omitted where the sub-group considered them not to be as relevant to Reading as to the national picture and some additional questions/changes were made in conjunction with partners, including Public Health England, Reading West Berkshire CCG and homelessness and health sector partners. Questions asked covered basic demographic information, access to primary care, acute and support services along with wider questions on physical and mental health wellbeing.

It was a decision by the project sub-group to go through the full version of the questionnaire as a collective; discuss and agree which questions were necessary, which questions should be removed and what additional questions would be beneficial. The aim was to keep the questionnaire as short as possible.

A copy of the full version of the questionnaire was taken to NHS South Reading CCG's GP Management Executive meeting for advice on phrasing, questions being asked, suitability for complex respondents and to identify any possible gaps. The draft questionnaire was also considered by residents at Willow House and peer mentors at IRIS drug and alcohol support to gain feedback on preferred incentives; preferred approach for asking questions and any questions that needed clarifying to inform the staff and volunteer training.

Alterations suggested were to:

- Categorise respondent living circumstances by determining whether an individual is rough sleeping, in B&B, in supported (Pathway) accommodation etc.
- Establish the length of time a respondent had spent in their current living circumstances
- Include more in-depth questions regarding access to dental services
- Consider attitudes of health services staff towards respondents
- Reduce the length of the questionnaire to ensure there was a relative balance between a reasonable amount of time taken to complete it and maintain the respondent interest and capturing as much useful data as possible

From a Homeless Link standardisation position and striking a balance between excessive length and data capture, not all suggested amendments were made; however, as many as feasibly possible were incorporated.

All questionnaires were completed by trained staff and volunteers with respondents in a one-to-one setting on paper copies. Responses were to be inputted into an on-line survey tool provided by Homeless Link at a later date by RBC staff. It was agreed by the partnership group that the questionnaire should not be completed by participants independently, but with the assistance of staff or volunteers. Appendices from Homeless Link's Homeless Health Needs Audit Toolkit were used to ensure that the completion process was ethical and that respondents understood why the Audit was taking place; that the questionnaire data would be anonymous and how the local authority planned to use the anonymised data.

Homeless Link advised that it would take approximately 30 – 40 minutes to complete the full questionnaire, with core questions taking around 15 – 20 minutes. Completion of core questions was key to be able to compare data at local and national levels. The shortened, core question version of the questionnaire provided an option to capture the views of individuals who might find it difficult to engage, without them having to commit to the full questionnaire; thus giving us a broader and more representative sample when it comes to those with more complex needs. In reality, the full questionnaire took around 30 minutes to complete, although some were much shorter and other participants were particularly keen to express their feelings about their needs at length.

Questionnaires were completed in the following locations over a timetable of five weeks to ensure representation, equality of access and equal opportunities to respond:

- Alana House
- B&B placements
- BWA refuge premises
- CIRDIC Day Centre
- Elizabeth Fry Approved Premises
- FAITH Soup Run (St. Mary's Church)
- Homelessness Support (Pathways) supported accommodation across all stages
- Reading Churches Bed for the Night (various church locations)
- Reading YMCA
- St. Leonard's Approved Premises

A copy of the questionnaire can be found in Appendix 2.

Volunteer and staff training

Three two-hour training sessions were held by the RBC Homelessness Support (Pathways) Services Team for volunteers and supported accommodation services staff in the afternoons and evenings of 11th and 12th January 2017.

A total of 23 volunteers and Homelessness Support (Pathways) Services staff attended these sessions and were given a copy of the completion timetable and locations to sign up to. The plan was for each session to have a representative from RBC; coupled with a volunteer from Patient Voice, Healthwatch, Launchpad or IRIS. Completions by Bed for the Night volunteers, Launchpad and Ability staff were carried out without RBC present. It was compulsory for anyone completing questionnaires with participants to undertake the training session.

The project sub-group agreed that the training should include the following:

- Safeguarding - including how to identify and report any immediate concerns
- Boundaries
- Familiarisation with the Homeless Link Audit Toolkit and available resources
- Skills practice - including a sense of how it feels to be asked the Audit questions
- Signposting to other services
- An opportunity to discuss any concerns and any other useful resources

Support was provided for volunteers via:

- The Audit Toolkit with extensive explanatory notes and advice for questionnaire completers
- Training sessions for volunteers
- A resource sheet devised by the Homelessness Support (Pathways) Services team that detailed drop in times and contact details for all relevant support services in Reading. Participants were able to take this away.

- A tick sheet/script to prompt volunteers/staff to introduce the Audit and thank the participant for their time; cover confidentiality; check that the participant had not completed the Audit previously; explain, provide and document the incentive and signpost to support where required.
- Hard copies of the Reading Streetlife Guide aimed at single homeless individuals http://www.reading.gov.uk/media/5417/Street-guide/pdf/RBC_Street_Guide_2016_v5.pdf
- The Homelessness Support (Pathways) Services Team as a point of contact for advice at any time including the opportunity to reflect with and report back any concerns or worries having completed questionnaires with complex individuals.

Anonymity and incentivising the Audit

Nationwide Building Society donated funds to purchase five pound vouchers from a supermarket chain to incentivise participation. The project sub-group decided to keep track of vouchers issued and avoid duplication as much as possible, by asking volunteers and staff conducting the questionnaires to document the names, location and last four digits of the voucher barcode. These lists were returned to RBC to collate a list of completions and identify any duplication. Questionnaires were still anonymous as names could not be connected to the completed questionnaires. Duplication was minimised and was not significant enough to skew any findings.

Data Analysis

Homeless Link was initially able to provide access to Lime Survey for inputting data and the use of on-line analysis tools. However, Homeless Link undertook a server change midway through Reading inputting the questionnaire data. This meant that the Lime Survey tool and analysis was unavailable for a substantial amount of time. Whilst a workaround was found using Microsoft Excel, the issue with Lime Survey at Homeless Link was never resolved and therefore, the analysis was undertaken without the aid of Homeless Link's on-line analysis tools. This delayed and extended feedback and report writing timeframes.

Data comparison

In most instances, the data captured in Reading has been compared with a summary of 27 Homeless Health Needs Audits completed across England, which has an overall sample size of 3,355. Some information has had to be compressed due to small numbers and some data was not available for comparison.

Findings and data dissemination

The project sub-group agreed not to attempt coinciding with sector and service commissioning cycles, for example, for data to feed into the NHS's commissioning cycles the Audit would need to have been completed by January 2017. It was decided that January - February, whilst the night shelter was operational, would be the best time to carry out the Audit where data quality and opportunity for collation would take precedence.

Data will be fed into Reading's Joint Strategic Needs Assessment (JSNA) and a report and the Health and Well-being Partnership Board for the Board to determine whether to develop and monitor an Action Plan within this strategic group.

The project sub-group suggested that the report should also be disseminated to and discussed at the following groups and forums:

- Reading Carers Steering Group
- Older People's Partnership
- Access and Disabilities Steering Group
- Physical Disability and Sensory Needs Partnership

- Learning Disabilities Partnership Board
- Reading Voluntary Sector Wellbeing Forum
- Mental Health Well-being Strategy Group

Barriers to and limitations of the Audit data

As this was the first time the Homeless Health Needs Audit was undertaken in Reading, the tool and concept was new to partners and the following barriers and limitations were identified during the process of its use and analysis. These will be used to inform any future or similar projects. They will also be fed back to Homeless Link to contribute to the overall development of the Audit tool:

- The server change issue at Homeless Link, which has not been resolved to date, resulted in additional work to input, analyse and present the Audit data.
- There were notably more responses from those living in supported accommodation where (a) there was more opportunity to complete them as respondents had accommodation available to them; (b) there was more resource available from supported housing providers to complete questionnaires and (c) the Homelessness Support (Pathways) Services team who commission supported accommodation services were leading on the Audit and therefore partner interest was weighted towards the support sector.
- There was some duplication of results as returns were anonymous. However, this was minimised by asking respondents to sign to say they had not completed the survey previously and ensuring that interviewers were kept informed about those who had already responded. Whilst mitigated as far as possible, this method was not infallible so duplication was inevitable where an incentive was offered. Offering an incentive did result in some individuals providing false names or disingenuous answers so that the voucher could be obtained. This was not significant enough to discount the sample data.
- Responses could vary depending on the skill and experience of those completing questionnaires with respondents. Although this was mitigated as far as possible through training sessions with all staff and volunteers, not all volunteers and staff were used to working within the homelessness sector and/or undertaking primary research with members of the public.
- By using Homeless Link's Audit tool the breadth of research was limited to single people only. Several partners expressed how beneficial it would be to undertake a similar piece of work with homeless families and households with dependents.
- Within Stage 1 supported accommodation environments, where individuals were more complex and likely to have recently come from rough sleeping or custodial environments, the Audit was undertaken by RBC staff and partner volunteers. Within Stage 2 supported accommodation environments where individuals were likely to have been further along their journey of independence the Audit was completed by key working staff and support workers known to respondents. There was some debate within the project sub-group about whether people would be more honest in their responses with unknown staff and volunteers, or with known support workers. The sub-group's conclusion was that it would be entirely respondent dependent and that this could not be mitigated. Anecdotal feedback from staff and volunteers is that most people appeared to be genuine about their needs.
- Some concerns were raised by the project sub-group about people spending their incentive vouchers on alcohol if they were donated by a supermarket. With the amount being five pounds the project sub-group felt that if residents and service users are to take part, there should be no restriction on how or what they spend their incentive upon.
- There was some duplication of resources by completing the questionnaire on paper and then inputting this online. It would have been more efficient use of time to

input the questionnaires directly online. However, mobile internet connections can be unreliable and using a laptop or screen can be impersonal and create an unnecessary physical barrier between interviewer and respondent.

- There was some suggestion from the sub-group that respondents, where possible, might like to complete the questionnaire themselves and that answers given might be more honest. However, the Audit questionnaire has not been developed by Homeless Link in a Plain English way and it might not be very 'readable' or as 'user friendly' without training and toolkit guidance. It was also important to have all core questions answered to ensure that responses were valid and comparable. Having a trained volunteer or staff member ensured this.
- The *Information for Respondents* sheet from the Audit toolkit was translated into written Polish by Reading Borough Council. However, if the respondent's understanding of English was too limited to understand the Audit questions, they would not be able to partake in the Audit. However, anecdotal feedback from interviewers was that no-one was prevented from completing a questionnaire on the basis of language being a barrier. Homeless Link was not able to provide the questionnaire in other languages.
- Gathering quantitative data through the Audit has unearthed more questions and scope for further research. Partners have requested further clarification on some of the data that unfortunately this 2017 Audit cannot provide.

Who took part in Reading's Homeless Health Needs Audit?

Gender

	Reading	England
Male:	69%	71%
Female:	30%	29%
Not known:	1%	-

Sexuality

	Reading	England
Heterosexual:	88%	93%
Gay/lesbian:	<3%	4%
Bisexual:	6%	3%
Not known:	3-5%	1%

Age

	Reading	England
Under 18:	0%	4%
18 to 25:	18%	28%
26 to 35:	31%	22%
36 to 45:	27%	23%
46 to 55:	19%	16%
56 to 65:	3-5%	6%
66 and over:	3%	2%

Migration and Ethnicity

	Reading	England
UK resident:	95%	93%
White ethnic group:	81%	89%

Physical Health problems

78% of participants in both Reading and England reported physical health problems

53% of participants in Reading had long-term physical health problems, compared to 44%in England

Current sleeping situation

	Reading	England
Hostel or supported accommodation:	69%	69%
Emergency or temporary accommodation:	12%	6%
Sofa surfing or squatting:	7%	9%
Rough sleeping:	11%	9%
Other:	<3%	1%

Mental Health problems

81% of participants in Reading reported mental health problems, compared to 86% in England

Analysis of who took part in Reading's Homeless Health Needs Audit

The demography of the Audit has been compared to the Homeless Health Needs Audit data collated from 27 other English local authority Audit partnerships with an overall sample size of 3,355; census data and information known about single homeless populations.

Gender

Reading's Audit data is consistent with others across England. In Reading between a third and a quarter of individuals accessing supported accommodation and known to be sleeping rough are female. This data is consistent with and representative of what is known about single homeless individuals in Reading.

Sexuality

A report by Homeless Link[9] identified that those who identify as LGBTQ+ (Lesbian, Gay, Bisexual, Transgender, Queer and +)[10] are disproportionately more likely to be homeless or insecurely housed than their non-LGBTQ+ peers and are at higher risk of substance use and mental health issues due to discrimination, lack of acceptance and abuse. Additionally they may face multiple discrimination and they may present with specific needs if they are at risk of being homeless. Statistics show that 1.7% of the UK population identifies as lesbian, gay or bisexual. For younger adults aged 16 - 24 this rises to 3.3%. Young people identifying as LGBTQ+ are more likely to find themselves homeless than their non LGBTQ+ peers, comprising 24% of the youth homelessness population with approximately 4% of individuals using services for people experiencing homelessness identifying as being lesbian, gay, bisexual or transgender.

Reading's Audit data seems to be over-representative of those who were lesbian, gay or bisexual respondents at just under 9% of the sample, when compared to Audit data across England and the UK population. However, as identified from the data published by Homeless Link those accessing homelessness services and members of the youth homeless population are more likely to identify as LGBTQ+ so Reading's data is congruent with this.

The 'not known' figure of 3 - 5% for Reading could be attributed to interviewers unfamiliar with primary research and working with this particular cohort not feeling comfortable asking this question.

Age

Data from Reading's Audit is consistent with the overall English picture in that approximately 50% of respondents are under the age of 35; approximately 45% being aged 36 - 65 and a marginal percentage over the age of 66.

The Local Housing Authority and Children's Social Care departments have duties under the Housing Act 1996 and the Children's Act 1989 to ensure that no-one aged 16 or 17 are sleeping rough. In Reading this is enabled by a joint working protocol between the two agencies. Although the Audit in Reading specified those aged 18 or over, this was with a

[9] Homeless Link (2017) *Supporting LGBTQ+ people in homelessness services: An introduction for frontline staff*, London, Homeless Link.

[10] Queer has historically been used as a slur, however the word has now been reclaimed by the community to take away its power as an insult. However, this term should only be used by those who identify as queer. "Q" can also refer to questioning however, and is indicative of the fact that definitions and terminology are fluid and can change. + is anyone who may not feel they quite fit into any of the aforementioned definitions e.g. asexual or intersex people (Taken from Homeless Link (2017)).

view that no 16 or 17 year old should be included in the Audit where duties should be met by statutory authorities.

Migration and ethnicity

Information taken from Reading's Joint Strategic Needs Assessment (JSNA)[11] states that census data from 2011 shows 75% of Reading's population is from a White ethnic group, compared to 86% in England overall. Therefore the difference in data of 81% for Reading's Audit and 89% across English Audits is still proportionate to census data from 2011. Recent data returns from local authorities have shown an increase in black and ethnic groups presenting as homeless and this has been reflected in the Audit data.

Current sleeping situation

As stated under *Barriers to and limitations of the Audit data* section of this report, for Reading's Audit there were notably more responses from those living in supported accommodation where (a) there was more opportunity to complete them as respondents had accommodation available to them; (b) there was more resource available from supported housing providers to complete questionnaires and (c) the Homelessness Pathway team who commission supported accommodation services were leading on the Audit and therefore partner interest was weighted towards the support sector. This is consistent with how other boroughs and areas have conducted their Audit - however, by conducting the Audit at the same time as the night shelter was operational Reading was able to get more representation from those rough sleeping who were within this temporary provision.

Primary reasons for homelessness

The following primary reasons for homelessness were given by respondents, attributing to 45% overall:

(1) Parents or care givers no longer able or willing to accommodate (23)
(2) Homeless upon leaving custody (20)
(3) Non-violent relationship breakdown with partner (13)
(4) Unemployment (12)

Homelessness upon leaving custody and health needs is explored further under the section *Prevention Opportunities - Immunisations, sexual health screening and those leaving custody*.

[11] Reading Borough Council (2017) *Joint Strategic Needs Assessment - Migration*. Accessed at: http://www.reading.gov.uk/jsna/migration on 5 September 2017.

Initial anecdotal themes from the Audit project sub-group staff and volunteers

The months immediately after completion of the Audit in Reading, prior to any initial analysis of data, project sub-group members involved in completing questionnaires with respondents collated some intuitive and anecdotal thoughts on the responses received. Interestingly, these have since been supported by the data collated. The project sub-group felt it was important to share these initial thoughts within this report and these are detailed as follows:

Homelessness

- People surveyed felt strongly that their homelessness played a big part in their poor physical and mental well-being where they felt that a settled and permanent home would improve both.

Access to healthcare services

- Interviewers felt that, having explored this with respondents, there were fewer issues for respondents in accessing primary care services than anticipated.
- Many respondents stated they have dental problems, but were not accessing dental services.
- Most respondents were having regular sexual health checks and there was a general confidence and knowledge amongst respondents about where to access free contraception and advice about sexual health concerns.
- Several respondents highlighted waiting times to access mental health services and their GP as a problem for them.
- There were several positive statements about IRIS drug and alcohol support services and key workers within supported housing services.

Smoking, drug and alcohol use

- Most respondents were smokers, tending to use rolling tobacco as this is cheaper and often smoking without the use of filters.
- Hardly any respondents stated that they were using New Psychoactive Substances (formerly known as legal highs) where Class A drug use and/or alcohol misuse were most prevalent.
- The Homelessness Support (Pathways) Services team particularly felt that not as many people respondents stated that they were IV drug users as expected, although several heroin and crack users were identified. This may be because the question about IV use was not well placed within the design of the questionnaire.
- There were several respondents using drugs who have a mental health need (dual diagnosis) who were not accessing mental health services.
- That the main method of support for mental health and substance misuse (dual diagnosis) was medication with there being fewer uptakes of counselling, alternative therapies or peer support programmes.
- Younger respondents were tending to use cannabis and not identifying this as a ‘drug problem’.

Mental health

- It seemed, as interviewers, that more respondents expressed concerns about their mental health, than concerns about their physical health - even where it appeared that respondents had several physical and mental health issues. Interviewers observed that people seemed to feel less in control of and that they had fewer options or solutions around their mental health.

Data findings and analysis

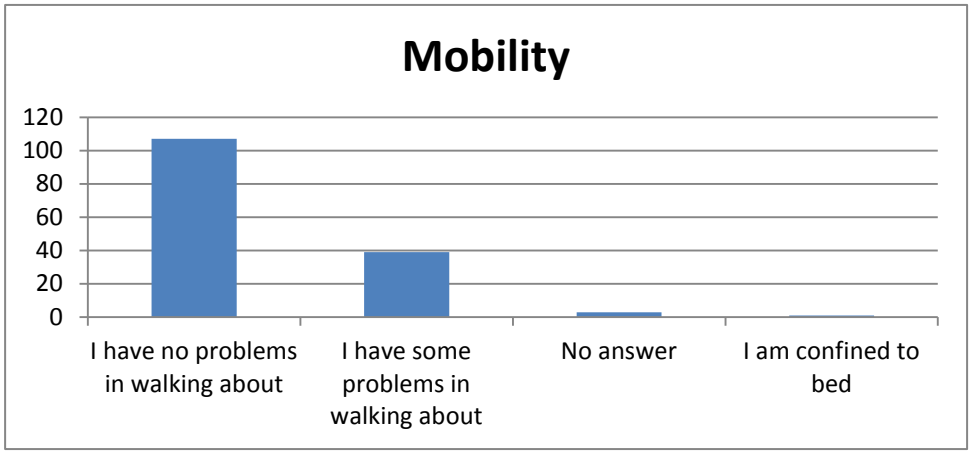
The following section provides a pictorial summary, an analysis of the Audit's main findings and some key messages from respondents, as follows:

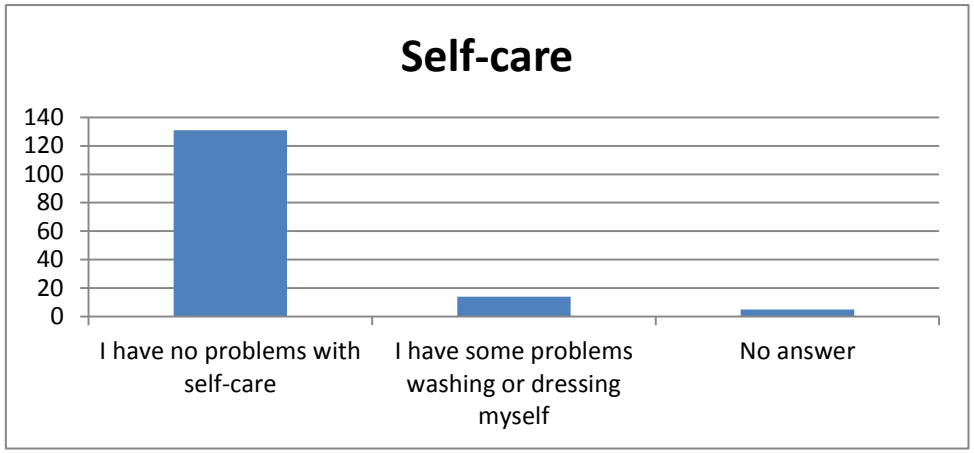
- **Statements about health**
- **Physical health**
- **Mental health**
- **Smoking, drug and alcohol use**
- **Access to health services** - including primary and secondary care service use and accessing support and treatment
- **Focus on rough sleepers' health needs -** including access to primary and secondary healthcare services
- **Prevention opportunities** - Immunisations, sexual health screening and those leaving custody

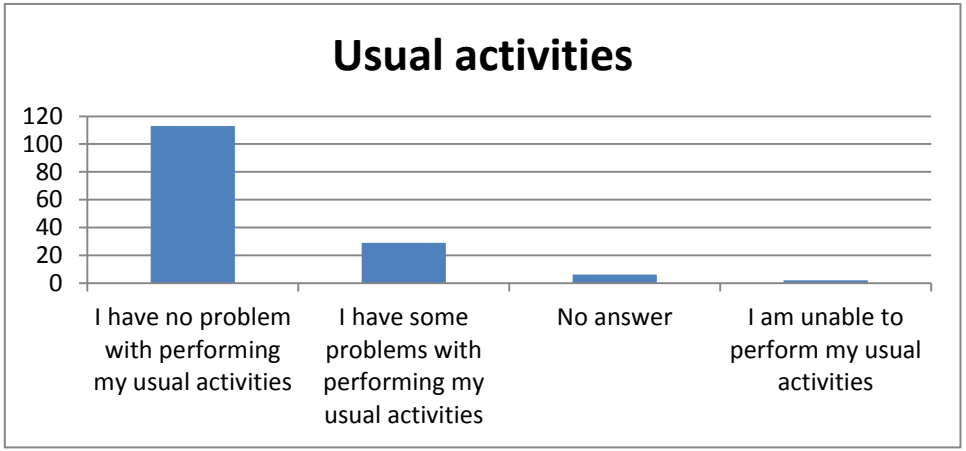
Statements about health

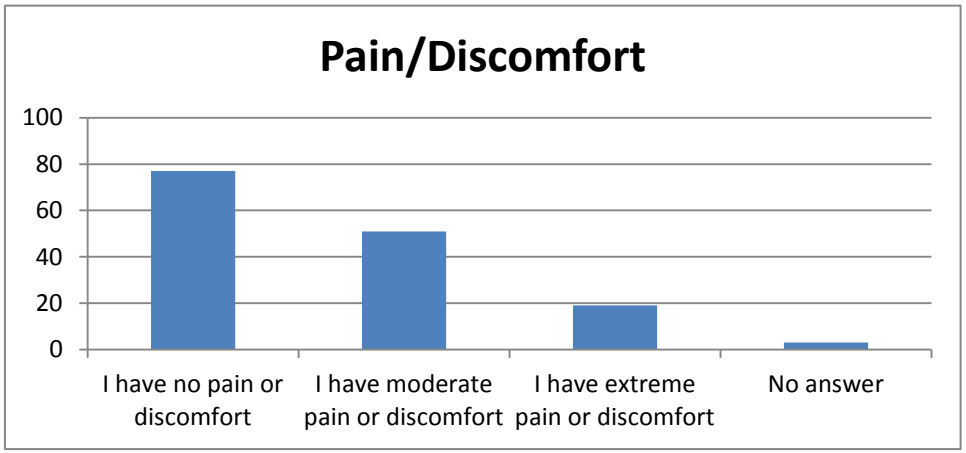
As part of the Audit, respondents were asked to rate how they felt, day-to-day about their mobility, self-care, undertaking 'usual' activities, pain/discomfort and anxiety/depression on a scale of 'not a problem' up to being an 'extreme problem'.

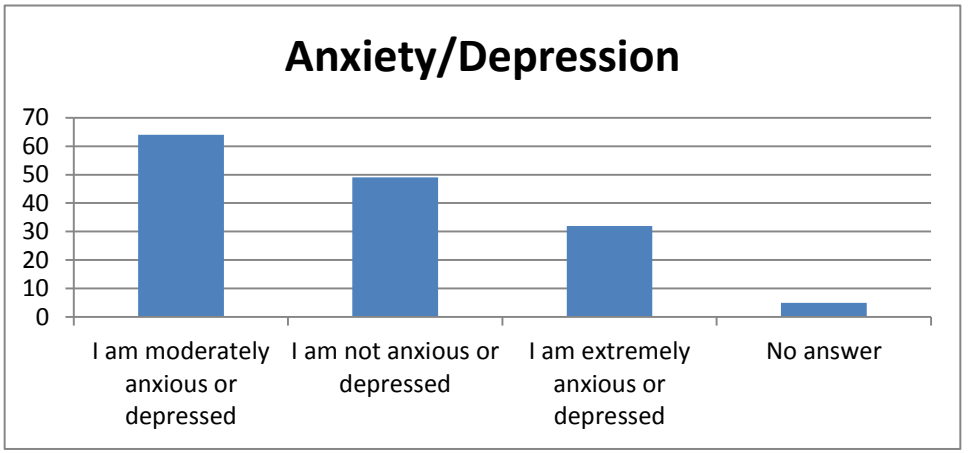
These broad findings are detailed below and support the initial thoughts of the project sub-group that respondents had particular concerns about managing their mental health needs where a majority felt moderately or extremely anxious and/or depressed on a day-to-day basis.








Pain/Discomfort
100
80
60
40
20
0
I have no pain or discomfort
I have moderate pain or discomfort
I have extreme pain or discomfort
No answer

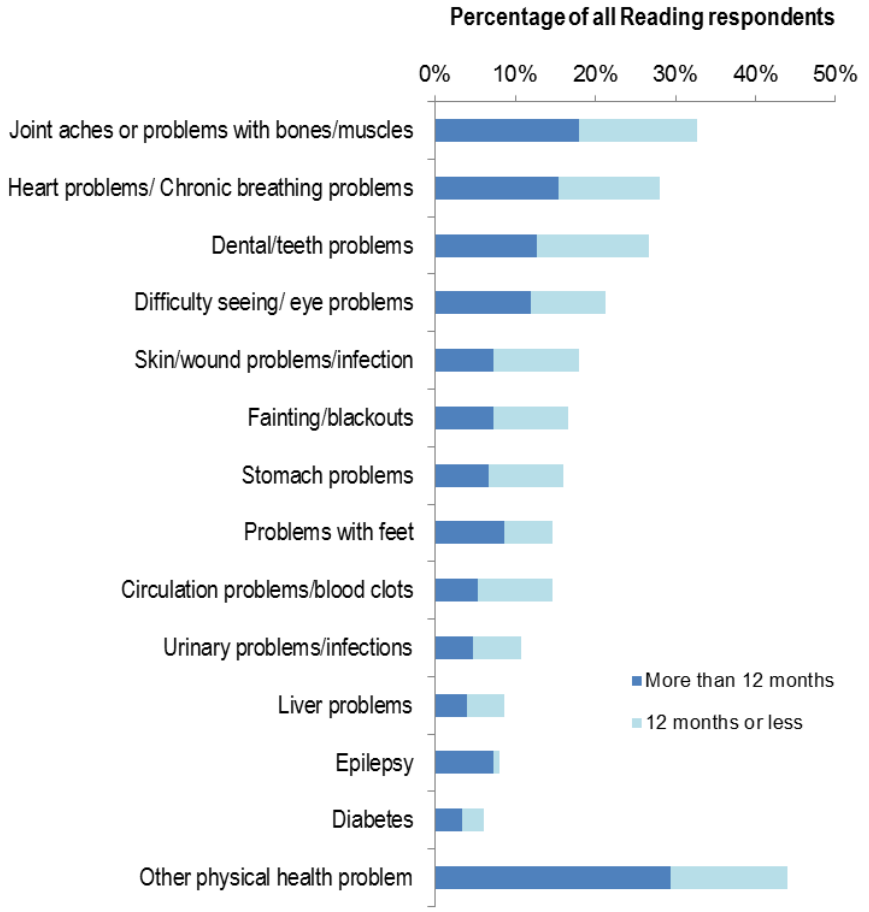

Anxiety/Depression
70
60
50
40
30
20
10
0
I am moderately anxious or depressed
I am not anxious or depressed
I am extremely anxious or depressed
No answer

Physical health: Summary

78% of respondents in Reading reported a physical health problem, which was congruent with other Homeless Health Needs Audits in England.

53% of respondents in Reading reported a long term physical health problem (on-going for 12+ months), compared to 44% in the other England Health Needs Audits.

Summary for Reading respondents	Physical Health Problems	Long-term Physical Health Problems
Gender		
Male:	79%	57%
Female:	76%	44%
Age		
18 to 25	70%	56%
26 to 35:	72%	43%
36 to 45:	83%	50%
46 to 55:	83%	59%
56 to 65:	100%	100%
66 and over:	100%	100%
Currently sleeping		
Hostel or supported acc:	70%	60%
Emergency or temporary acc:	72%	47%
Sofa surfing/squatting:	83%	55%
Rough sleeping:	83%	28%
Own home:	100%	60%
Other:	100%	-



Physical health: Analysis of findings

Long-term physical health problems

Nearly 10% more respondents in Reading reported long term physical health problems (on-going for 12+ months) than other Audit respondents across England.

This could be attributed to a number of factors, including that Reading's homeless population:

- Have poorer physical health generally due to their living situations
- Have better access to primary healthcare services to enable diagnosis
- Reported symptoms rather than diagnosis when answering this Audit question

Top three identified physical health diagnoses

An analysis of the top three recent and longer-term physical health diagnoses identified by homeless people in Reading corresponded exactly with the national picture for single homeless people Audited in England. These were:

(1) Joint aches or problems with bones/muscles
(2) Heart problems or chronic breathing problems
(3) Dental/teeth problems

Gender and physical health

Male respondents reported higher levels of physical health problems and longer term physical health problems than females with female respondents in Reading reporting long-term physical health problems in line with the national Audit representation.

In Reading and nationally, single homelessness tends to be divided into between a quarter to one third being female and three quarters to two thirds being male[12]. Single homelessness and rough sleeping is dominated by men. In Reading and in line with good practice responses to rough sleeping, female rough sleepers are viewed as acutely vulnerable when rough sleeping and therefore, are often prioritised for vacancies within supported accommodation. This may account for why females contributed to fewer of the 'top three' long term conditions associated with homelessness.

Age and physical health

There is clear correlation between a respondent's age and an increase in reports of recent and longer term physical health problems reported by respondents.

Current sleeping situation and physical health

Those accommodated in supported accommodation or sofa surfing reported higher levels of long term physical health needs than those rough sleeping or in emergency or temporary accommodation (night shelters, approved premises, refuges or B&B); however the opposite was true of physical health problems overall.

It would be anticipated that those rough sleeping or in very temporary/less secure accommodation would report having more physical health needs, but perhaps with less diagnoses. Those accessing supported accommodation or sofa surfing may be more likely to engage with primary healthcare services and support services generally in addressing physical health needs, where continued and regular engagement with primary healthcare services could mean a more forthcoming diagnosis.

[12] Homeless Link (2017) *Supporting women who are homeless: Briefing for homelessness services*, London, Homeless Link.

Dental problems

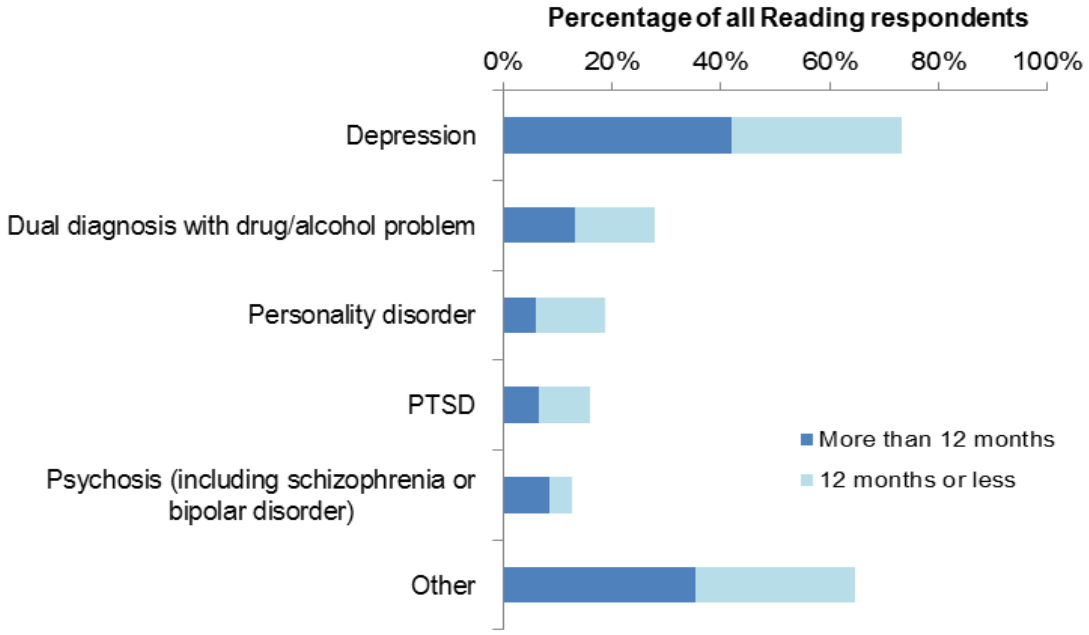
A third of respondents, 49 out of 150, stated that they had problems with their teeth or mouth. Only 14 of those reporting problems stated that they were receiving treatment for these problems. Those accessing treatment were primarily receiving it from dental surgeries.

Mental health: Summary

81% of respondents in Reading reported a mental health problem, compared to 86% across Homeless Health Needs Audits in England.

55% of Reading respondents felt that they had or were using alcohol or drugs to cope with mental health problems.

Summary for Reading respondents	Mental Health Problems
Gender	
Male:	79%
Female:	87%
Age	
18 to 25	89%
26 to 35:	78%
36 to 45:	83%
46 to 55:	76%
56 to 65:	100%
66 and over:	67%
Currently sleeping	
Hostel or supported acc:	85%
Emergency or temporary acc:	72%
Sofa surfing/squatting:	82%
Rough sleeping:	71%
Own home:	80%
Other:	67%



Mental Health: Analysis of findings

In line with feedback from other Homeless Health Needs Audits in England, single homeless respondents in Reading reporting a mental health problem exceeded 80%, with females and those aged 18 - 25 identifying themselves as having the highest levels of mental health problems.

Overwhelmingly Reading respondents reported a diagnosis of anxiety (88 out of 150) and/or depression (110 out of 150) as their main mental health problem. 44 respondents advised that they had a dual diagnosis with a drug and/or alcohol problem.

28 out of 150 advised that they had been diagnosed with Personality Disorder; 24 with Post Traumatic Stress Disorder (PTSD) and 19 with psychosis. Other identified mental health problems, with no significant trends were Obsessive Compulsive Disorder (OCD), agoraphobia and Sensory Integration Disorder (SID).

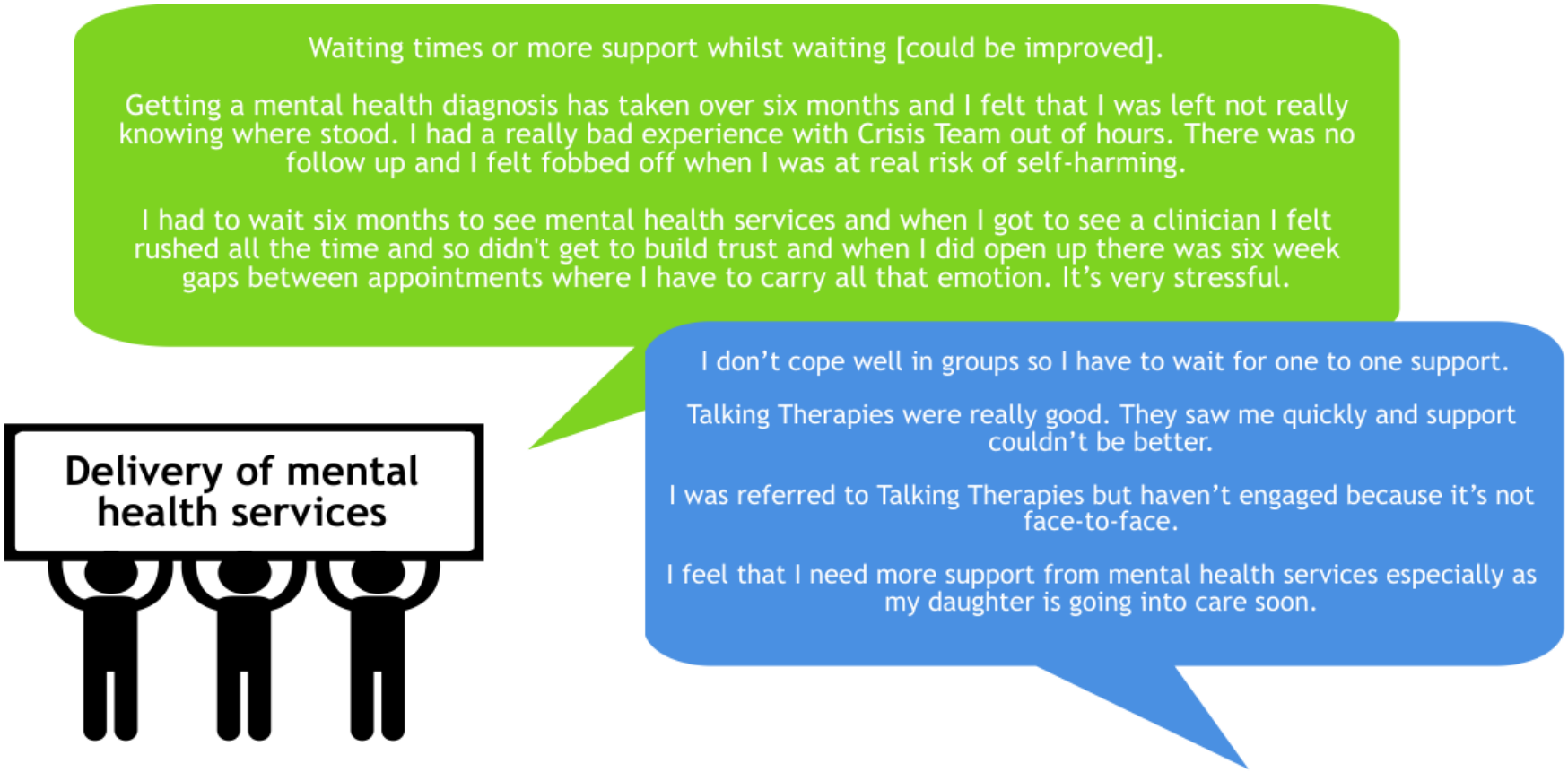
There seemed to be no significance in the levels of mental health problems within different housing situations, with those accommodated within supported housing having the highest diagnosis rate.

Women and mental health
Female respondents identified with a much higher level of mental health problems than male respondents. This is congruent with research from St. Mungo's[13] and Homeless Link around the exceptional and gender specific trauma and feelings of stigmatisation that homeless women can associate with.

[13] St. Mungo's (2014) *Rebuilding Shattered Lives: The Final Report*, London, St. Mungo's.

Key messages from respondents: Delivery of mental health services

- Within the section that asked *"What could be improved within health care services in Reading?"* over a third of 80 individuals who responded to this question contributed that they had experienced difficulties in accessing mental health services and this had made them doubt the effectiveness of how mental health services are delivered.
- Some respondents advised that their experience of accessing services had been difficult in terms of navigating the system and having to explain their feelings on the telephone rather than face-to-face.
- Some respondents outlined their personal barriers in accessing services were that as a homeless person they had no accommodation to be assessed in at point of referral and a feeling that their substance misuse was preventing them from receiving support with their mental health.



Key messages from respondents: Delivery of mental health services

- Nearly a quarter of those that responded to the question *"What could be improved within health care services in Reading?"* advised that they felt waiting times to access services are long; that times between appointments feel uncertain and appointments and contact with the Crisis Team can feel rushed.
- There was some positive feedback about experiences of Talking Therapies. A third of respondents who answered the same question about what could be improved felt that they needed regular face to face/one to one support and specialist trauma services for their mental health support to be most effective for them.
- Respondents clearly linked poor mental health to their housing situation and being homeless.

Smoking, alcohol and drug use: Summary

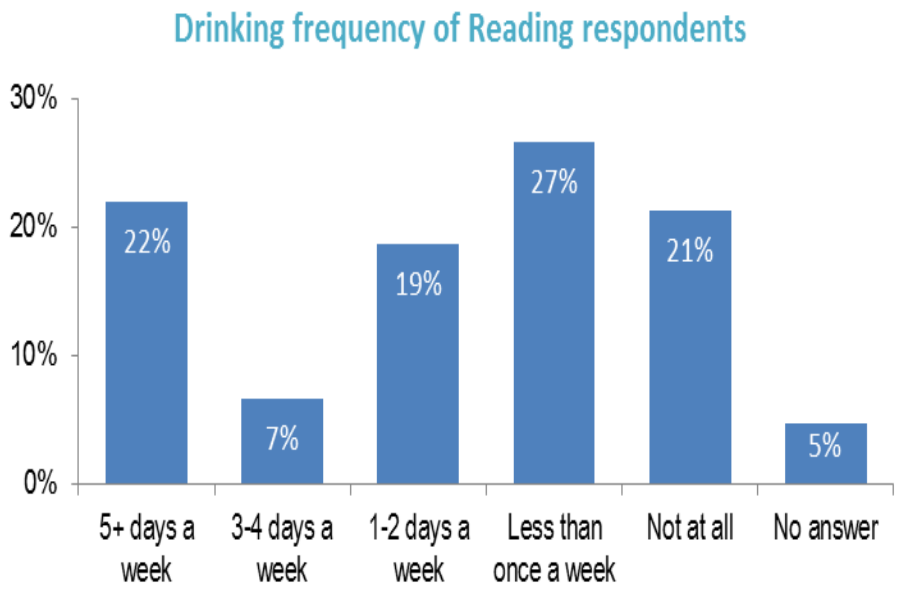
Current smoker
Reading: 84%
England: 78%

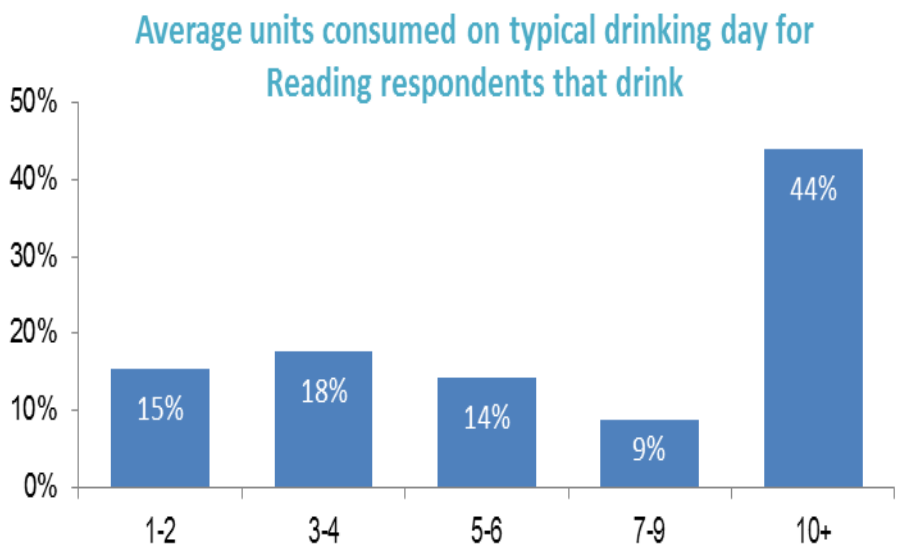
Alcohol problem
Reading: 30%
England: 27%

Drug problem or in recovery
Reading: 43%
England: 41%

22% of respondents in Reading reported that they drink alcohol five or more days a week.

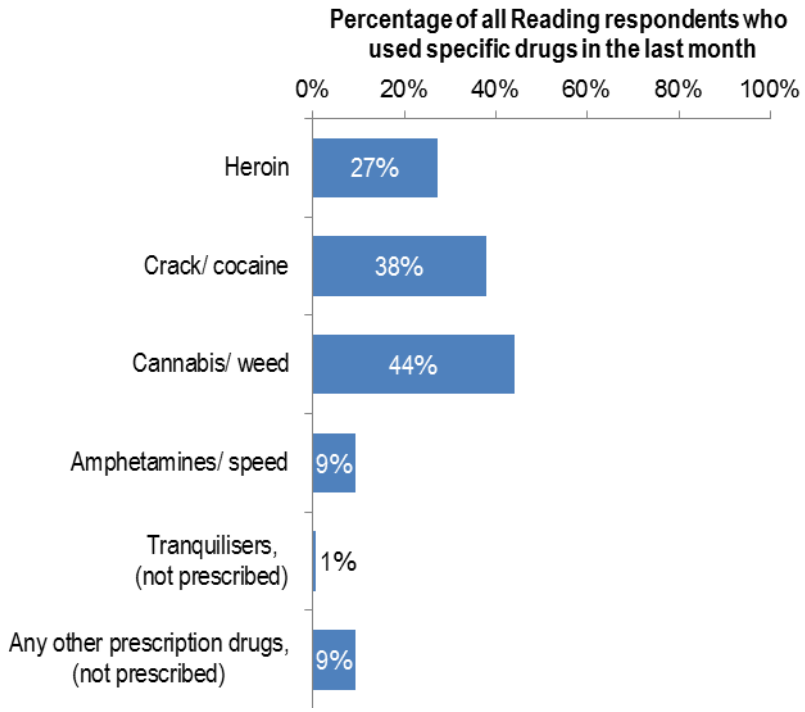
44% of those drinking alcohol in Reading consumed 10 or more units on a typical drinking day.





Summary for Reading respondents	Currently smokes	Alcohol problem	Drug problem or in recovery*
Gender			
Male:	85%	34%	50%
Female:	82%	20%	24%
Age			
18 to 25	85%	7%	15%
26 to 35:	83%	41%	54%
36 to 45:	95%	28%	63%
46 to 55:	83%	34%	34%
56 to 65:	60%	40%	0%
66 and over:	33%	33%	0%
Currently sleeping			
Hostel or supported acc:	83%	33%	43%
Emergency or temporary acc:	89%	17%	56%
Sofa surfing/squatting:	82%	27%	36%
Rough sleeping:	82%	35%	29%
Own home:	80%	20%	40%
Other:	100%	33%	67%

* an additional 14% of respondents stated that they used drugs, but did not report a 'drug problem'



23% of Reading respondents take Methadone, Subutex or other substitute drugs.

12% of these are not prescribed for the person taking them.

Smoking, drug and alcohol use: Analysis of findings

Smoking

126 out of 150 identified as smoking cigarettes, e-cigarettes, cigars or a pipe. Anecdotally, most were smoking rolling tobacco without filters as the cheapest way to fund this.

Data from 2015 published by the Office of National Statistics (ONS)[14] showed that of all adults in the UK, 17.2% smoked. Smoking is identified by the World Health Organisation (WHO) as the biggest health inequality and local data shows that the prevalence among the single homeless population in Reading is high at 84%, even when compared to other Homeless Health Needs Audits in England where 78% of respondents were smokers.

Reading's Audit data shows that there is little differentiation between the number of men and women smoking amongst Reading's homeless population. It is prevalent across genders.

Alcohol misuse

Alcohol Concern UK[15] states that there are an estimated 595,000 dependent drinkers (0.9% of the UK population), where only 17% are currently accessing treatment. Alcohol misuse is the biggest risk factor for death, ill-health and disability among 15-49 year-olds in the UK, and the fifth biggest risk factor across all ages. 7% of adults in England regularly drink over the Chief Medical Officer's low-risk guidelines and 2.5 million people report drinking over 14 units on their heaviest drinking days.

Comparing this to the homeless population generally, and to Reading's homeless population specifically, it is clear that alcohol misuse and binge drinking are prevalent among single homeless people. 29% could be determined as dependent drinkers (compared to 0.9% UK estimates) and 44% who could be considered to exceed Chief Medical Officer's low-risk guidelines (compared to 7% UK estimates).

Reading Borough Council's *Drug and alcohol misuse needs assessment*[16] from 2016 identifies that 30,000 Reading residents are drinking to hazardous levels and 4,500 are drinking to harmful levels. Reading has high rates of alcohol-specific mortality and mortality from chronic liver disease in both men and women.

Homeless Health Needs Audit data for Reading shows that alcohol misuse is more prevalent amongst: homeless men than women; amongst those aged 26 and over and those who are rough sleeping.

[14] Office of National Statistics (ONS) (2015) *Adult smoking habits in the UK: 2015*, London, ONS.
[15] Alcohol Concern (2017) *Alcohol Statistics* at https://www.alcoholconcern.org.uk/alcohol-statistics, accessed on 6 September 2017.
[16] Reading Borough Council (2016) *Drug and alcohol misuse needs assessment* at http://www.reading.gov.uk/media/4501/Item-15-Appendix/pdf/Item_15_Appendix.pdf, accessed on 6 September 2017.

Drug misuse

According to a report by the Home Office[17] in 2015/16 3% of adults aged 16 - 59 had taken Class A drugs in the last year, the equivalent of just under 1 million people.

3.3% of people across England and Wales identified as being a frequent drug user, with young adults aged 16 - 24 more likely to frequently use drugs than the wider age group. Cannabis was the drug most commonly used across England, with 37% of cannabis users being classed as frequent users. The Home Office's report highlighted a decrease in the use of ecstasy and powder cocaine and low prevalence of New Psychoactive Substances (NPS) with 0.7% of adults aged 16 - 59 having used NPSs in the last 12 months.

Key findings from the Home Office report showed that young people are more likely to take drugs than older people; men are more likely to take drugs than women and people living in urban areas reported higher levels of drug use than those living in rural areas.

The data from Reading's Audit shows that drug misuse within Reading's homeless cohort is predominantly affecting those aged 26 - 45 which differs from national findings for the whole population of England and Wales. However, where Class A intravenous drug use is more prevalent amongst those who are homeless and heroin and crack cocaine are more addictive, leading to longer term use, the age range for Class A drug misuse is representative.

Data from Reading's 2016 Joint Strategic Needs Assessment (JSNA) shows that Reading has a higher rate of opiate and/or crack cocaine users per 1,000 of the population at 11.7% compared to the rest of England and Wales at 8.4%. The rate of injecting drugs in Reading is twice as high as the England average at 4.98%. This is has been reflected in the Homeless Health Needs Audit data.

Reading's Audit showed that cannabis use was most prevalent amongst those aged 18 - 25; that men were more likely to be misusing drugs than women and that the use of NPSs was minimal which is synonymous with the Home Office findings from 2015/16. Reading's Audit findings showed that the group most likely to have a drug problem or be recovering from a drug problem are those in temporary accommodation or supported accommodation, rather than those who are sofa surfing or rough sleeping. However, as stated in the section of the report titled *Barriers to and limitations of the Audit* the Audit sample does over-represent those living in supported accommodation, rather than individuals who are sofa surfing or sleeping rough. Those who rough sleep and sofa surf have more chaotic and complex lives and are harder to reach. Therefore, communicating about the availability of the Audit and then arranging to complete questionnaires with these individuals proves to be more difficult. For this Audit, less people who were sofa surfing and rough sleeping were represented in the Audit sample. Information from Reading's Street Outreach Team suggests that Class A drug use amongst those who are rough sleeping is prevalent. Often those who are rough sleeping will not disclose details regarding drug and alcohol use until they are within accommodation where they have a built up a trusted relationship with a support professional.

Drug and alcohol use and mental health

82 out of 150 respondents (55%) identified with using drugs and/or alcohol as a means to cope with mental health or trauma.

[17] Home Office (2016) *Drug Misuse: Findings from the 2015/16 Crime Survey for England and Wales, second edition*

Access to health services: Summary

Primary healthcare registration and service use

Registered with GP
Reading: 86%
England: 92%

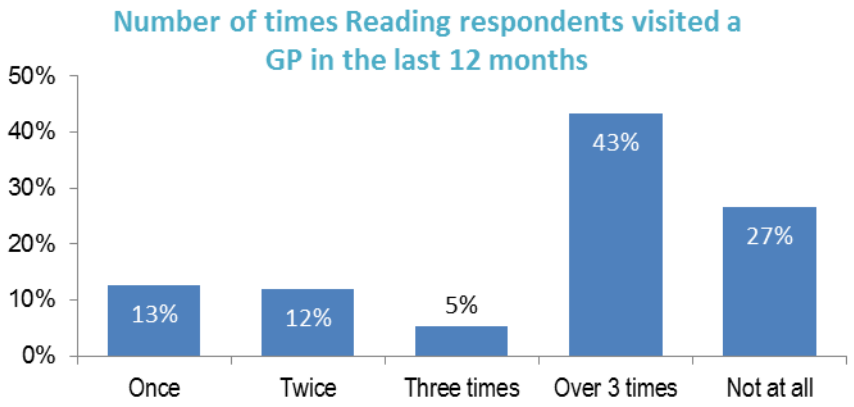
Registered with dentist
Reading: 49%
England: 58%

Refused registration to GP or dentist in last 12 months
Reading: 9% England: 18%

Summary for Reading respondents	Registered with GP or homeless health care	Registered with dentist	Refused registration
Gender			
Male:	82%	40%	9%
Female:	96%	69%	11%
Age			
18 to 25	89%	59%	19%
26 to 35:	83%	41%	4%
36 to 45:	88%	43%	13%
46 to 55:	86%	66%	7%
56 to 65:	80%	20%	0%
66 and over:	100%	67%	0%
Currently sleeping			
Hostel or supported acc:	91%	56%	8%
Emergency or temporary acc:	50%	33%	0%
Sofa surfing/squatting:	91%	55%	18%
Rough sleeping:	88%	29%	18%
Own home:	100%	40%	20%
Other:	100%	33%	0%

73% of Reading respondents had visited a GP in the last 12 months.

43% had seen a GP over 3 times in the last 12 months.



Secondary healthcare service use

In the last 12 months:

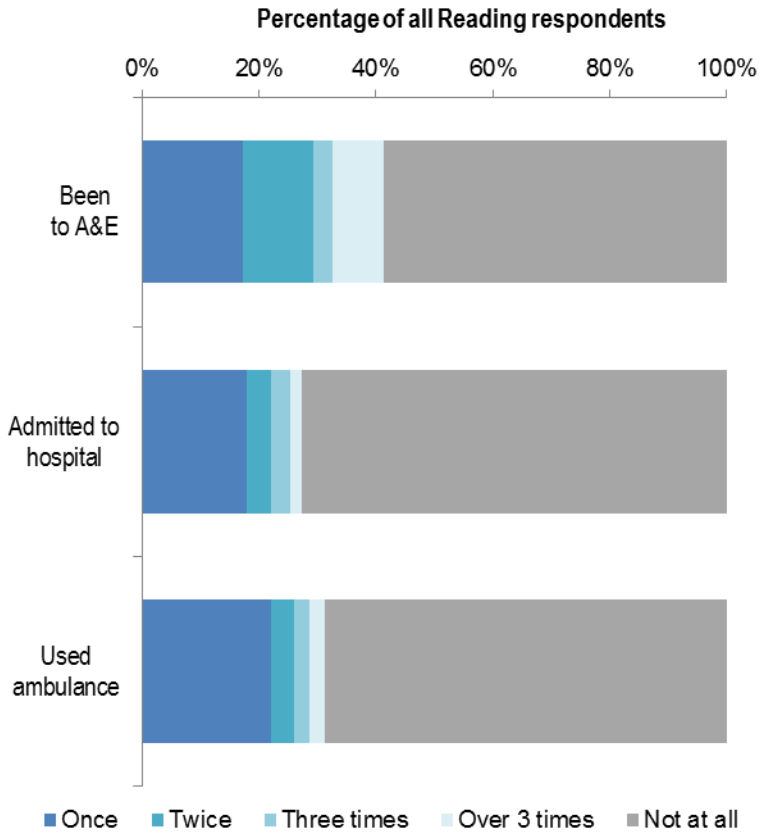
Been to A&E
Reading: 41%

Been admitted to hospital
Reading: 27%

Used an ambulance
Reading: 31%

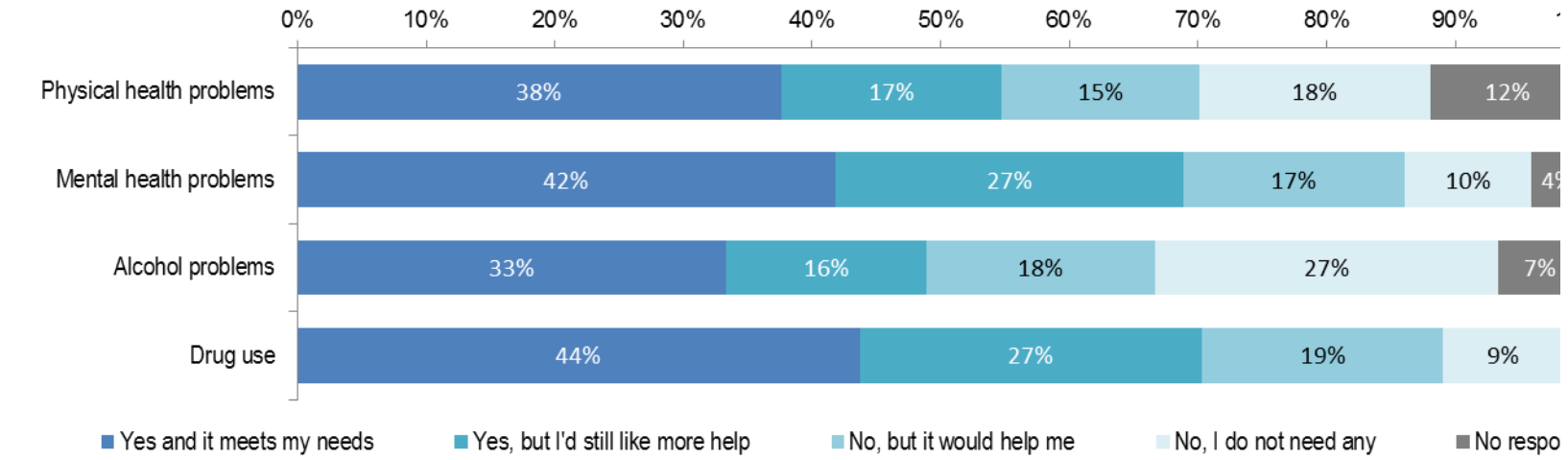
Summary for Reading respondents	Been to A&E	Been admitted to hospital	Used an ambulance
Gender			
Male:	38%	28%	26%
Female:	47%	27%	42%
Age			
18 to 25	63%	30%	41%
26 to 35:	39%	20%	30%
36 to 45:	25%	33%	25%
46 to 55:	41%	31%	31%
56 to 65:	60%	20%	20%
66 and over:	67%	33%	67%
Currently sleeping			
Hostel or supported acc:	46%	29%	30%
Emergency or temporary acc:	22%	11%	17%
Sofa surfing/squatting:	45%	27%	36%
Rough sleeping:	18%	29%	29%
Own home:	80%	20%	80%
Other:	67%	67%	67%

Number of times Reading respondents have used health services in the last 12 months



Support and treatment

96% of respondents in Reading identified that they had a physical health, mental health, alcohol or drug problem. These respondents were asked if they received support or treatment to help with these problems and whether this met their needs.



Access to health services: Analysis of findings

Primary healthcare registration and service use

Reading's Audit has shown a slightly lower figure for GP registrations than other Audits in England at 86% and just under half of respondents were registered with a dentist, although Public Health England advised that people have not been required to be registered with a dentist since 2006.

Registrations with GPs amongst the Audit population may be lower due to the Walk-in Centre facility in the borough as detailed under the *Homelessness and healthcare provision in Reading* section. Qualitative feedback from respondents shows that the Walk-in Centre is clearly valued and frequently used by this particular population in Reading. Anecdotal information from Reading's Street Outreach Team is that it is easier to facilitate their clients in attending the Walk-in Centre on an ad-hoc basis than facilitating clients to a planned future appointment with a registered GP.

Women respondents were more likely to be registered and accessing GP and dental health services than men.

73% of Reading respondents had visited a GP in the last 12 months and 43% had engaged with a GP more than three times. 9% of respondents stated that they had been refused registration to primary healthcare services in the last 12 months; half the statistic of the experiences of homeless people Audited across England. Again, these statistics can likely be attributed to Reading's Walk-in Centre facility and/or the number of respondents who were living in supported accommodation where access to primary healthcare is an essential part of commissioned support planning.

There was clear correlation between fewer respondents living in commissioned supported accommodation services being refused access to services. This is possibly due to having an allocated and accessible advocate/key worker who is able to navigate systems where those sleeping rough or sofa surfing/squatting may be less likely to have this level of support due to having a more chaotic and less engaged lifestyle.

Audit reports from other counties across England, show that some GP practices are reluctant to register people who they consider to be transient. Additionally, homeless people will often present with a complex picture of comorbidity and social issues (physical issues, mental health issues and difficulties with substances misuse) which can be more difficult and/or time intensive for GP services to deal with effectively.

Secondary healthcare service use

Audit responses from Reading showed that the following homeless cohorts are more likely to use an ambulance and attend A&E:

- Women
- Those aged 18 - 25 or aged 66 and over
- Those living in supported accommodation (including those who stated they are living in their own home which is supported accommodation) or sofa surfing/squatting. This could be because supported housing providers and individuals who are living with/having contact with others are more likely to have their welfare monitored, resulting in encouragement to access emergency services.

According to Reading's Audit data, those sleeping rough were more likely to be admitted to hospital once emergency services had been accessed.

The most prevalent reason respondents gave for visiting A&E, using an ambulance and being admitted to hospital was relating to a physical health problem or condition.

Dental healthcare services

There are no figures available for homeless people's actual usage of dental services, but there is evidence that some homeless people may be using less appropriate and more costly A&E services instead to meet their dental health needs (Hill and Rimington 2011)[18].

In Reading 32 out of 150 respondents, over 20%, stated that there had been one or more occasions in the last 12 months that they had needed treatment for dental problems but that it had not been received. The primary reasons for this being fear of dental exams/treatment; not being able to get an appointment or not accessing services due to a lack of motivation or physical barriers such as transport links.

Only three individuals identified that they had been refused access to dental treatment in the last 12 months.

A&E and hospital admissions: Most prolific users

63 out of 150 respondents advised that they had accessed A&E at least once in the last 12 months. Five respondents stated that they had accessed A&E due to mental health problems.

18 respondents advised that they had accessed A&E three or more times in the last 12 months; 8 of these 18 respondents advised that they had used an ambulance three or more times in the last 12 months.

41 respondents advised that they had been admitted to hospital at least once in the last 12 months. Five respondents were admitted to hospital due to mental health problems.

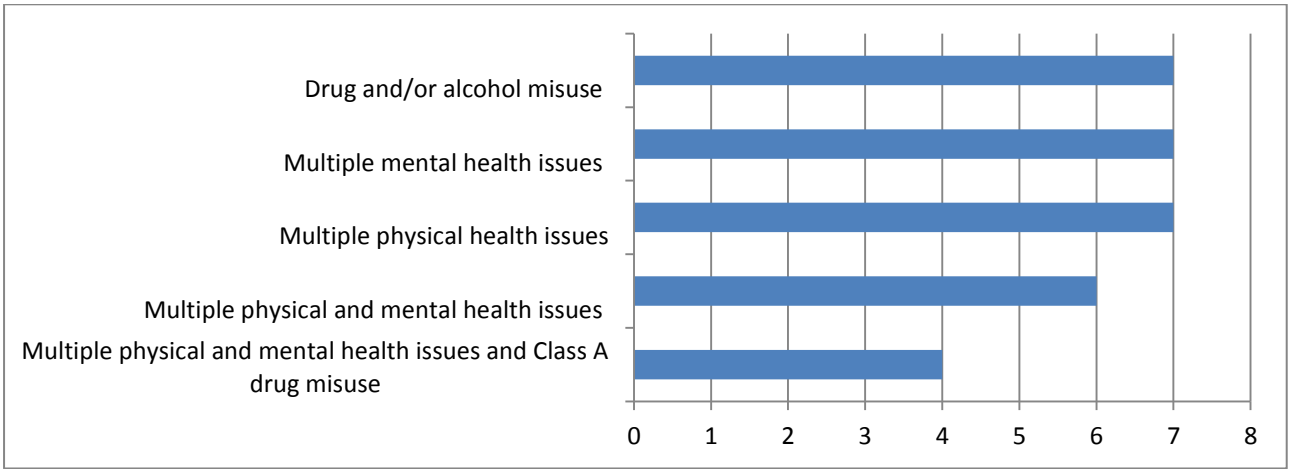
Three of those that accessed A&E due to mental health problems in the last 12 months, were also admitted to hospital. One individual was readmitted within 30 days of being discharged from hospital for a mental health problem.

Of eight individuals who advised that they had prolifically used A&E and ambulance services over the last 12 months e.g. they had used A&E and ambulance services three or more times:

- Seven out of eight respondents were living in supported accommodation commissioned by RBC; the majority of which were living in accommodation that provides a high level of support
- Seven out of eight respondents stated that they considered they had a longstanding illness, disability or infirmity
- One out of the eight respondents was sleeping rough

[18] Hill, K. B. and Rimington, D. (2011) Investigation of the oral health needs for homeless people in specialist units in London, Cardiff, Glasgow and Birmingham in *Primary Healthcare Research and Development*, 12(02): pp. 135-144.

These same eight respondents outlined the following multiple health issues, with multiple defined as two or more:



Where mental health or Class A drug misuse or chronic alcohol misuse were identified by respondents as a health need, respondents stated that this was the main reason for using emergency services and being admitted to hospital rather than an identified physical symptom from the list of ailments.

Where respondents stated that they were prolifically using A&E and ambulance services, the majority were admitted to hospital (seven out of eight) and the majority had accessed GP services 3+ times in the last 12 months. One of the eight individuals, within supported accommodation, stated that they had been refused access to GP services due to not having ID.

Half of all eight respondents advised that they had one of the following physical health problems:

- Joint aches, problems with bones and muscles
- Fainting or blackouts
- Epilepsy or seizures
- Liver problems
- Stomach problems

All but one identified as having depression *and* anxiety as well as at least one other mental health diagnosis. These other diagnoses were primarily Personality Disorder (five out of seven) and dual diagnosis (five out of seven). Six out of eight identified with using drugs and/or alcohol to alleviate symptoms of mental health.

Support and treatment

Physical health problems

55% of respondents advised that they were engaging with support or treatment for their physical health problems with 32% stating that they would like more support with managing their conditions.

39 respondents advised that they had required, but had not received, a medical examination or treatment in the last 12 months with the primary reason being they felt it was difficult getting an appointment with their GP.

Mental health problems

69% of respondents advised that they were engaging with support or treatment for their mental health problems with 44% stating that they would like more support with managing their conditions.

47 respondents advised that they required, but had not received, an assessment or treatment for their mental health in the last 12 months. The primary reasons given were that they felt waiting times for assessment were long; they felt that they had not being able to get an appointment and were feeling unmotivated to contact services due to their mental health condition.

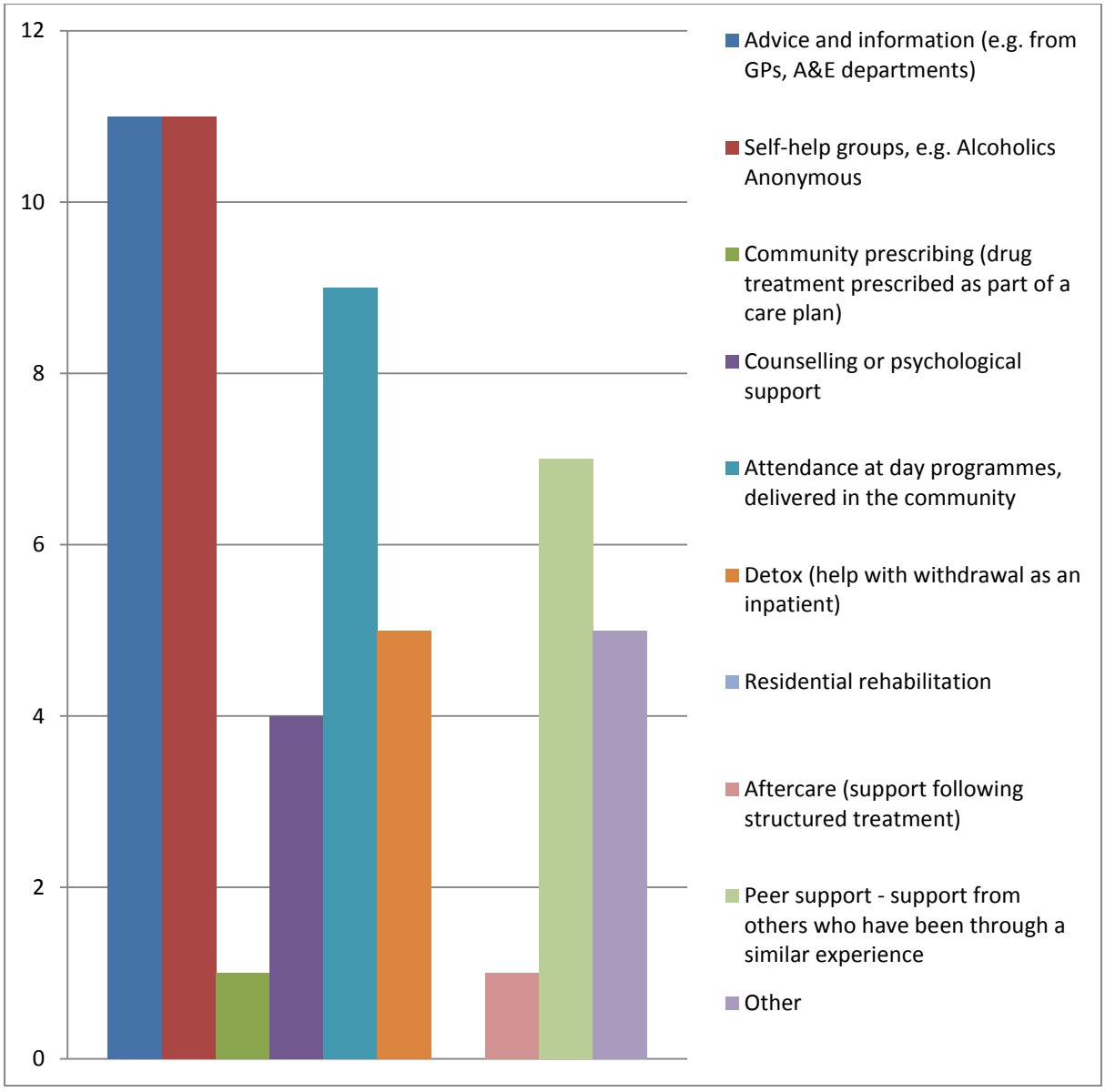
Predominantly respondents stated that they were being supported with their mental health through prescribed medication, with fewer people reporting that they were being supported by specialist mental health workers, counselling, activities or peer support.

35 respondents advised that they were receiving counselling support. Five respondents living in Launchpad accommodation were receiving in-house counselling services rather than NHS funded services.

Alcohol and drug use

49% of respondents were engaging with support or treatment for their alcohol use with 34% stating that they would like more support with managing their alcohol misuse.

The graph below shows the types of support respondents are receiving for their alcohol misuse with advice and information, self-help groups and community day programmes being accessed the most.


12
10
8
6
4
2
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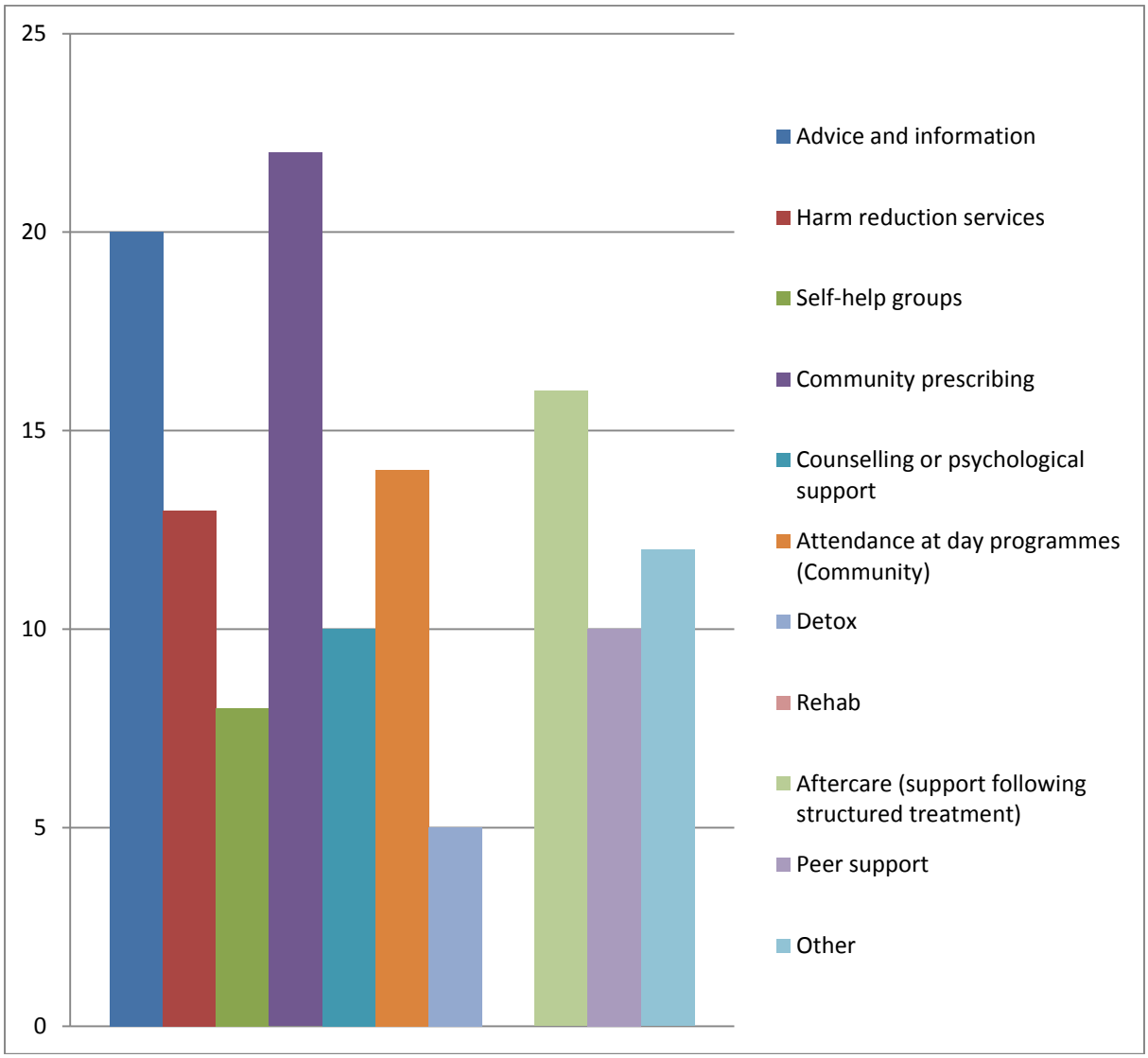
Advice and information (e.g. from GPs, A&E departments)
Self-help groups, e.g. Alcoholics Anonymous
Community prescribing (drug treatment prescribed as part of a care plan)
Counselling or psychological support
Attendance at day programmes, delivered in the community
Detox (help with withdrawal as an inpatient)
Residential rehabilitation
Aftercare (support following structured treatment)
Peer support - support from others who have been through a similar experience
Other

73% of respondents were engaging with support or treatment for their drug misuse, with 46% stating that they would benefit from more support in addressing their drug misuse issues.

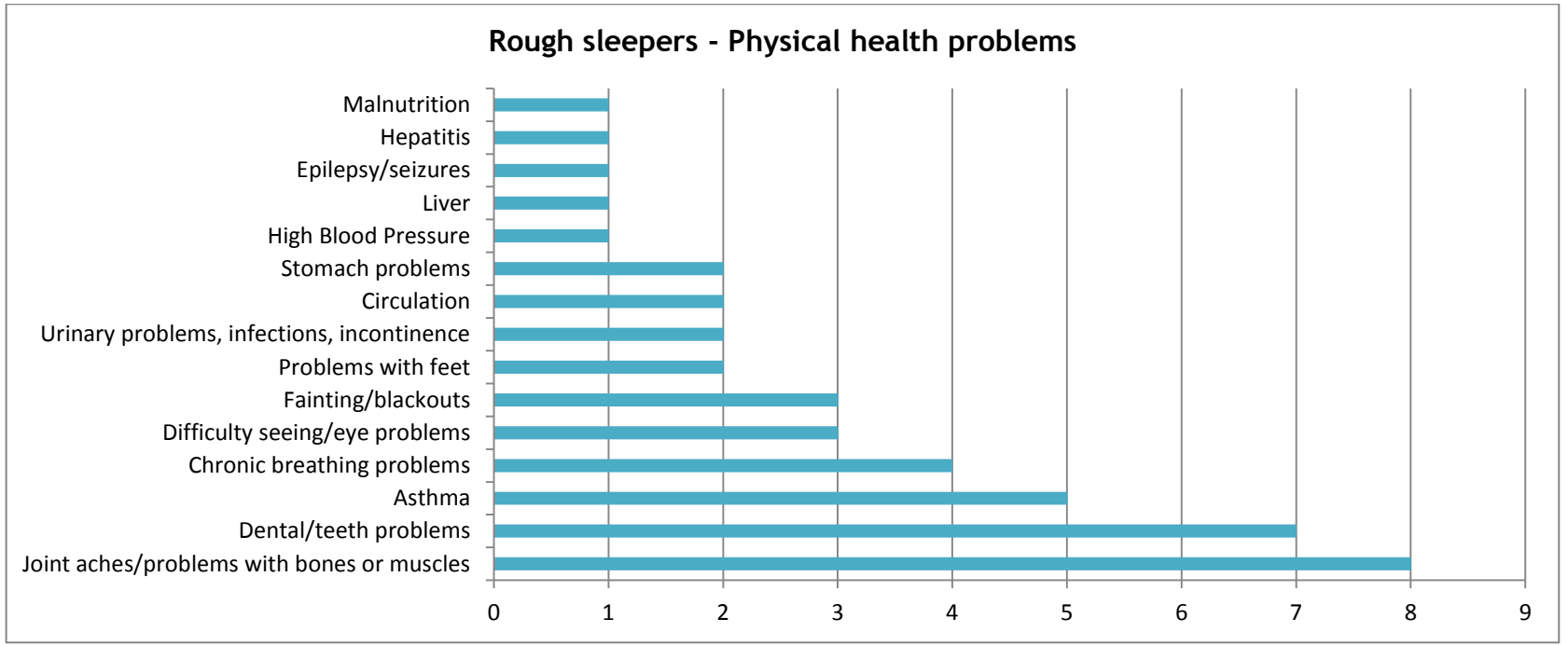
The graph below shows the types of support respondents are receiving for their alcohol misuse with community prescribing, advice and information and self-groups being accessed the most.



Focus on rough sleepers' health needs: Accessing primary and secondary healthcare services

17 respondents (11%) identified that they were currently sleeping rough and of this group, although there were a breadth of reasons for individuals becoming homeless, the main reasons identified by individuals were the end of a tenancy in the private or social rented sector (3); debt related issues (3); unemployment (2); non-violent relationship breakdown (2) and mental or physical health problems (2).

13 of 17 respondents who identified that they were rough sleeping also identified as having a physical health problem that would likely need regular monitoring by a GP or health professional to prevent deterioration, or that could result in the need for an emergency response at a later date if symptoms were exacerbated by continued rough sleeping. Six out of 17 respondents identified that they had a long-standing illness, disability or infirmity with the most commonly identified physical health problems being asthma or chronic breathing problems; joint aches/problems with bones and muscles and dental/teeth problems.

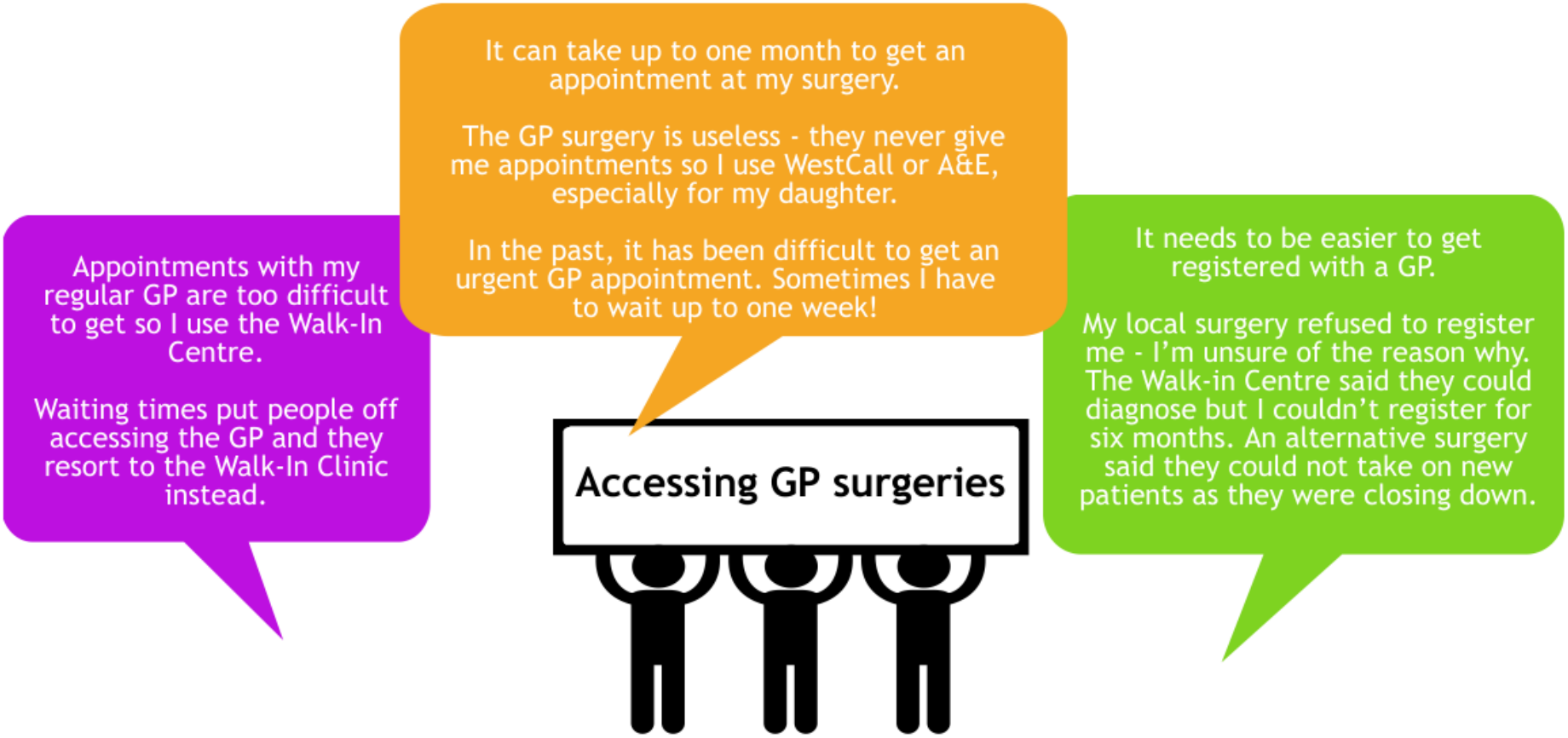


Five out of 17 respondents sleeping rough stated that they had a mental health diagnosis and four stated that they were using Class A drugs.

Respondent patterns of accessing GP services; accessing A&E; using an ambulance and/or being admitted to hospital show that those who had been sleeping rough for six months or less were more likely to access GP services. The Audit data shows a correlation between the length of time rough sleeping and a decrease in accessing GP services - e.g. the longer someone sleeps rough the less likely they are to access GP services.

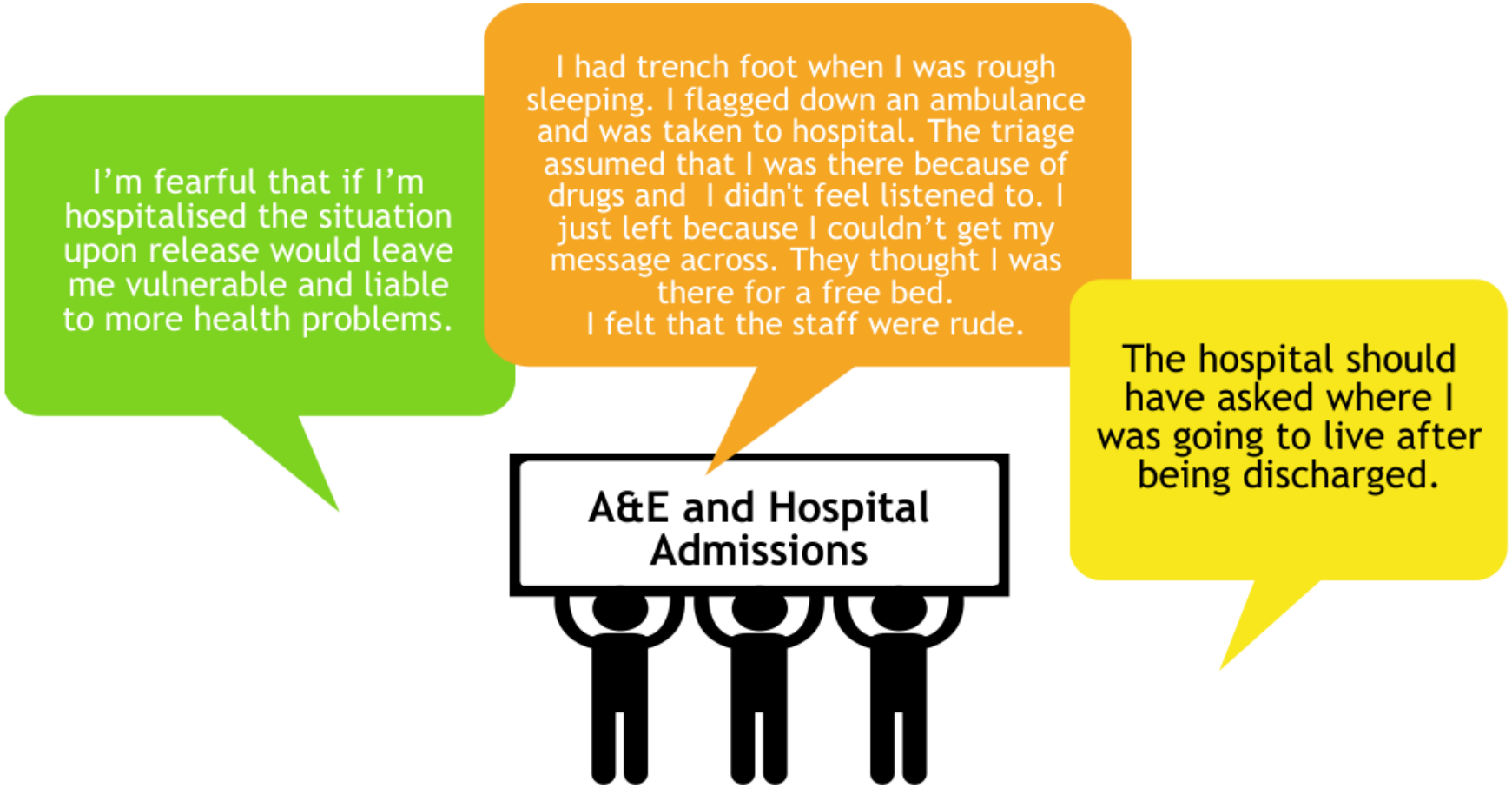
Five respondents had been sleeping rough for four or more months and had accessed A&E, used an ambulance and/or been admitted to hospital. Most went to A&E, used an ambulance and were admitted to hospital due to physical health symptoms, rather than attributing it to mental health or drugs/alcohol use. Respondents who had been sleeping rough for four or more months showed an increased propensity to access emergency services and to be admitted to hospital.

Hospital discharges to rough sleeping: Re-admissions
Of 41 respondents who stated that they had been admitted to hospital and then discharged onto the streets within the last 12 months, two were re-admitted within 30 days of being discharged.



Key messages from respondents: Getting appointments and registration

- Where respondents answered the question *"What works well with health care services in Reading?"* it was clear from respondents that having appointments with a regular and familiar GP was greatly valued.
- When asked what could be improved within health care services, not seeing the same GP and frustrations with getting an appointment in a timely way featured heavily amongst respondent comments.



Key messages from respondents: A&E and hospital admissions

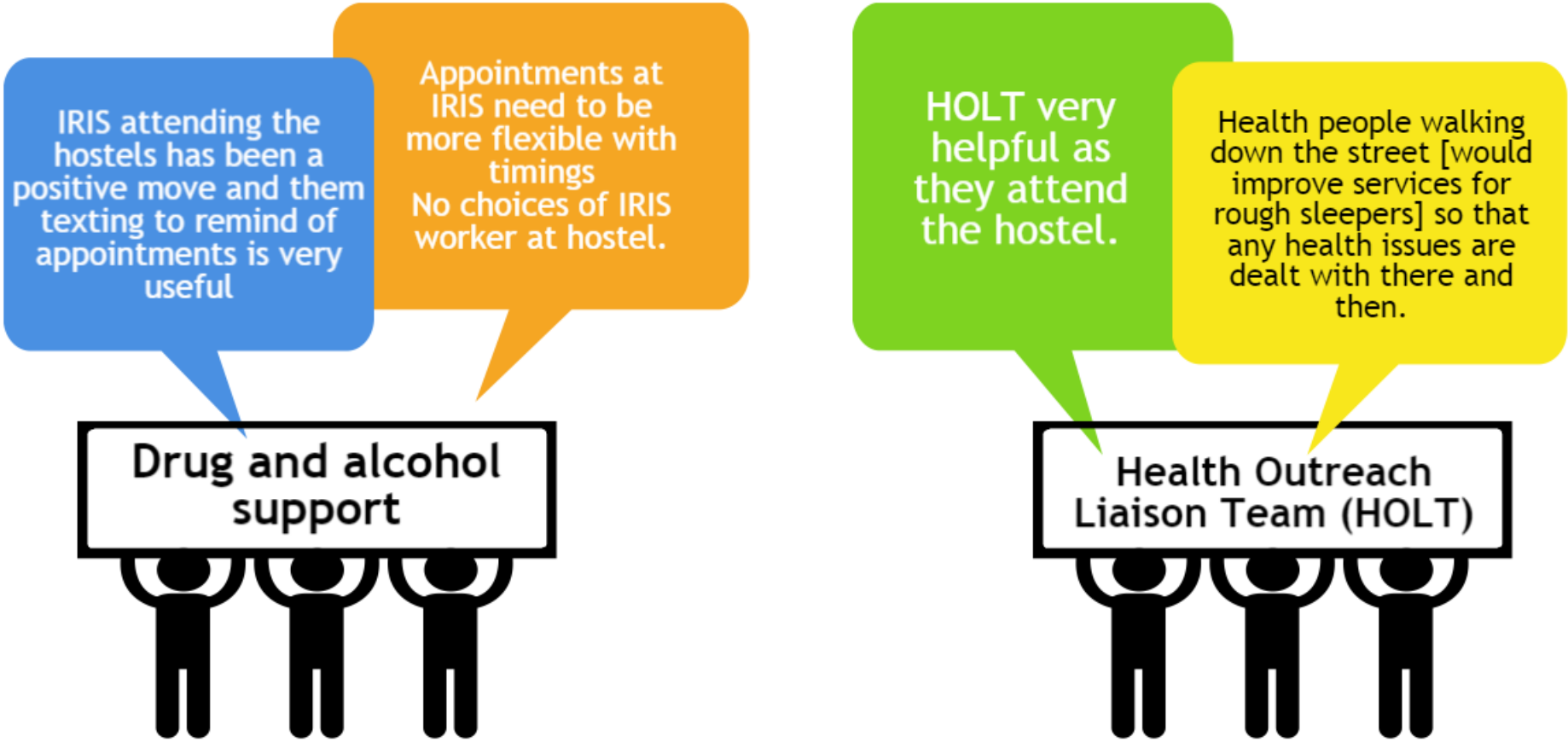
- Respondents that commented upon their use of emergency services and A&E provided examples of feeling disbelieved when presenting with physical symptoms and perceived that they were being judged when attending hospital whilst under the influence of drugs or alcohol. It is difficult in these circumstances to differentiate between individual perceptions and actual attitudes of professionals towards those who are homeless and accessing emergency services.
- Some respondents felt more could be done by discharge staff regarding establishing a patient’s housing situation.

Key messages from respondents: Experience of the Walk-in Clinic in Reading

- It was of significance that the Walk-in Centre in Reading was identified specifically as a positive and flexible option by a number of those who responded to the question *"What works well with health care services in Reading?"*
- Some respondents outlined specific frustrations (quoted above) regarding the Walk-in Centre facility, but as illustrated under *Accessing GP Surgeries* responses, respondents are accessing the Walk-in Centre where they are not accessing their GP and the Centre has limitations in the face of high demand from registered and unregistered patients across Berkshire.

Key messages from respondents: Relationships with professionals and attitudes of staff

- Respondents advised that they perceived, or felt experiences of, being treated differently and being judged by GP and hospital staff due to appearing to be misusing substances.
- Seeing the same doctor and having a consistent relationship with health professionals was important to respondents. It affected their perception of the quality of healthcare being received and the likelihood that they would engage with primary healthcare services.
- Respondents stated they had felt rushed during their GP appointments; they felt that staff could be more engaging and that feeling welcomed could have an effect on the likelihood of them engaging with primary healthcare services.



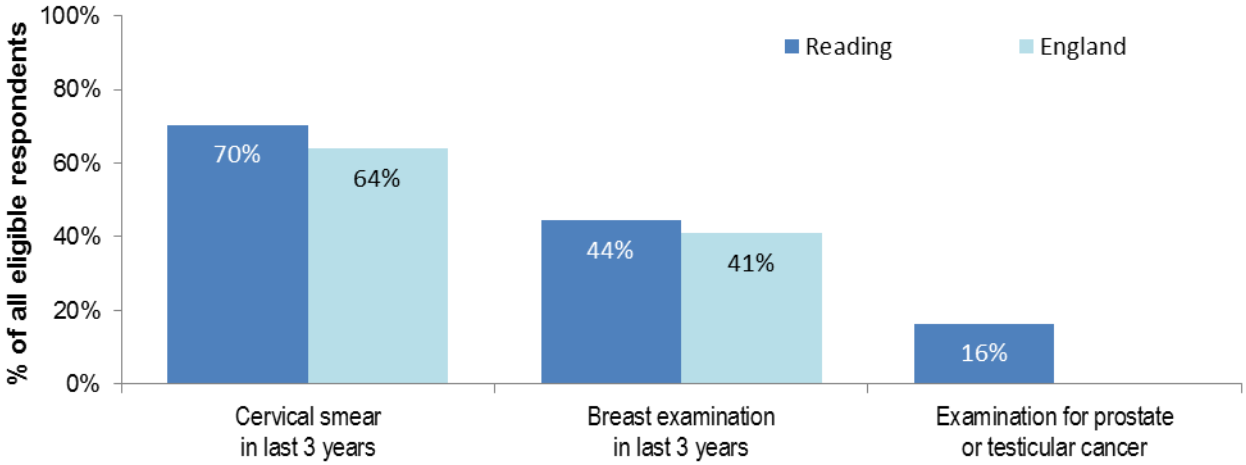
Key messages from respondents: Drug and alcohol support and HOLT

- Around a sixth of those who responded to the question *"What works well within health care services in Reading?"* felt that health care outreach services from HOLT and health care in-reach services to supported accommodation from IRIS, sexual health services and counselling (commissioned by Launchpad for their service users) were positive and effective in providing them with flexibility and continuity.
- Peer support groups for substance misuse were highlighted by many as a valued avenue of support.

Prevention Opportunities - Immunisations, sexual health screening and those leaving custody: Summary

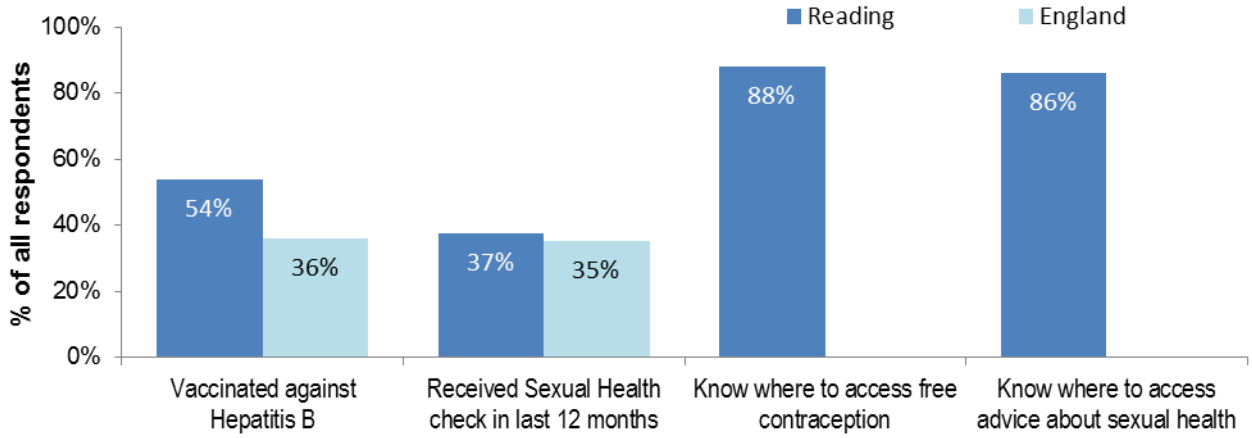
70% of eligible respondents in Reading had received a cervical smear test in the last three years and 44% had received a breast examination. These were both similar to findings from the other Health Needs Audits in England.

16% of men in Reading had received an examination for prostate or testicular cancer.



54% of respondents in Reading had been vaccinated against Hepatitis B, compared to 36% in other Health Needs Audits across England.

37% of respondents in Reading had received a sexual health check in the last 12 months, with 86-88% stating that they knew where to access free contraception and advice about sexual health.



Prevention Opportunities - Immunisations, sexual health screening and those leaving custody: Analysis of findings

Health promotion: Access to screening and disease prevention

There is limited data on the uptake of screening and vaccination programmes by those who are homeless. From what we understand of the homeless population - usually screenings and vaccinations are administered amongst the homeless population in an opportunistic way, rather than in a planned way, for example as part of an initial registration process or health check.

Female specific health

Uptake of cervical smear tests and breast examinations in Reading were above the average across other Homeless Health Needs Audits in England at 70% and 44% respectively.

Male specific health

16% of male respondents had received an examination for testicular and prostate cancer in the last 12 months. Whilst there is no Health Needs Audit data comparison for England, this seems to be a low screening rate for those eligible for this examination.

Sexual health

Whilst 37% of respondents had undergone a sexual health check in the last 12 months, which is slightly higher than the average across other Audits, a high percentage of respondents were confident that they knew how to access contraception and advice about their sexual health.

HIV

No respondents reported a diagnosis of HIV.

Tuberculosis (TB)

One respondent stated that they had a diagnosis of TB in the last 12 months and that they were not engaging in treatment for this. Two respondents advised that they had been diagnosed with TB 12 or more months ago and had engaged with treatment.

Hepatitis B

This is a blood-borne viral infection that often arises as a complication of injecting illicit drugs. Hepatitis B is thought to be prevalent among the homeless population. The three dose series of the vaccination is a highly effective way of producing long lasting protective levels of antibodies against the virus; therefore the disease is viewed as largely preventable. Those who have been in custody for a period of time are most likely to have engaged with the three dose vaccination.

Hepatitis B & C are sensitive conditions that are likely to be underreported generally. At 54% of respondents, Reading has significantly higher levels of engagement with the vaccination than other Audits in England.

Hepatitis C

This is also a blood borne viral infection where it is thought that over half of intravenous drug users will have this disease. There is no vaccination for Hepatitis C but 90% of cases will respond to treatment.

The estimated total infected with Hepatitis C in Reading is 665[19]. 14 respondents to Reading's Audit advised that they had a diagnosis of Hepatitis C. Half were engaging with or had engaged with treatment; whilst four had been offered treatment and refused and two stated that they had not been offered treatment. Those that had refused treatment were either currently rough sleeping or had recently accessed hostel accommodation. Almost all respondents that stated they had previously or currently had Hepatitis C were Class A drug users.

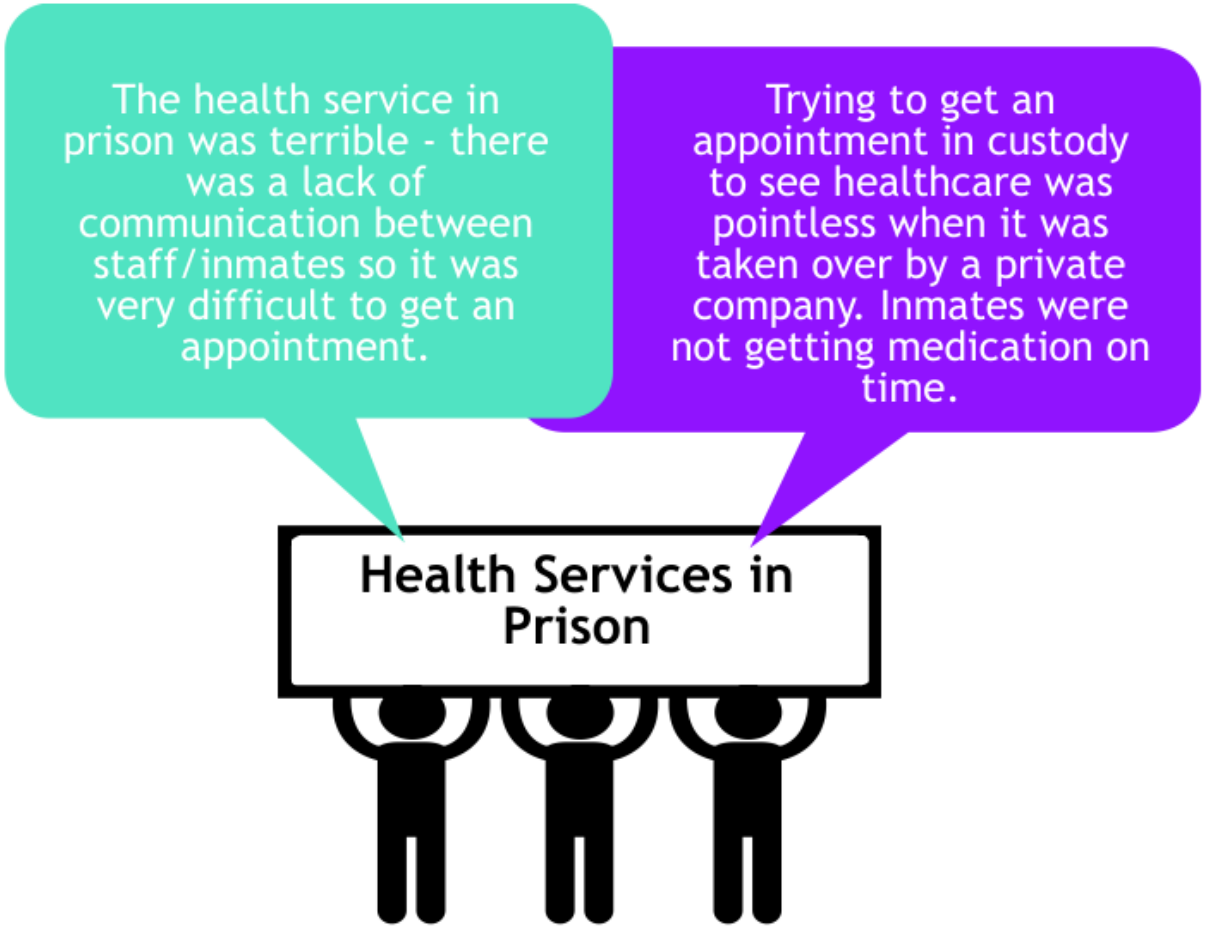
Health needs of those who were homeless upon leaving custody

20 out of 150 respondents stated that their most recent and primary reason for their current homelessness situation was leaving custody.

11 out of 20 individuals who were homeless due to leaving custody were living in supported accommodation; six were accommodated within Approved Premises; two were accessing Bed for the Night winter night shelter and one was sleeping rough.

Just over half of those who stated that the reason for their homelessness was leaving custody had served custodial sentences for three months or less. Two respondents had been in custody for over a year. Most individuals had undertaken custodial sentences of 12 months or less.

[19] Reading Borough Council (2017) *JSNA – Liver Disease* at http://www.reading.gov.uk/jsna/liver-disease, accessed on 6 September 2017.



Key messages from respondents: Health services in prison

- Responses regarding feelings about health services whilst in prison were smaller in number, but significant when considering that being homeless upon leaving custody was cited as one of the top three reasons for homelessness within the Audit. Respondents gave a clear message that they felt their health and well-being needs had not been addressed whilst in custody in preparedness for their release.

Case study comparison: Health needs of long-term/entrenched rough sleepers and those who are new to the streets

At the request of the project sub-group a case study comparison of two respondents who had been sleeping rough for 25+ months (long-term/entrenched) and two respondents who had been sleeping rough for three months or less (new to the streets).

All case study examples were male, heterosexual, UK Nationals that were smokers, had been abusing substances (drugs or alcohol) in the last 12 months and none had been examined for prostate or testicular cancer in the last three years. All were surveyed whilst accessing services set-up by faith and voluntary sectors to meet the basic needs of single homeless people.

Key themes from this case study sample show that longer-term rough sleepers are more likely to:

- Access the Walk-In Centre and emergency services, having disengaged from primary health care, drug/alcohol support and mental health services. When accessing emergency services, those rough sleeping are not being asked about their accommodation situation upon discharge.
- Have long-standing illnesses and more chronic issues associated with sleeping rough - e.g. moderate-extreme joint pain, breathing difficulties, dental problems. The list of ailments is longer for those who have slept rough for longer.
- Have alcohol misuse issues, whilst those newer to rough sleeping have Class A drug addictions and no alcohol misuse.
- Have a longer-term mental health diagnosis of depression and/or anxiety.

Comparison of two respondents sleeping rough for 25+ months (longer-term/entrenched)		
Commonalities:	**Differences:**	
	Respondent A Client ID: 36	**Respondent B Client ID: 54**
Slept rough for two or more years. Surveyed at CIRDIC day centre. Male, Heterosexual, White British, UK National. Indication of experiencing homelessness and entering homelessness services/provision at a young age.	43 years old First 'sofa surfed' and slept rough at 21. First entered supported housing at 28.	61 years old Slept rough for the first time at 57. First entered supported housing and experienced homelessness at 15.
Regularly using Reading's Walk-In Centre and reported positive experiences of this. Accessed GP once or more in the last 12 months.	Used an ambulance and accessed A&E once in the last 12 months due to self-harm/suicide attempt.	Used an ambulance and accessed A&E twice in the last 12 months due to alcohol misuse. Was admitted to hospital on both occasions.
Stated that was discharged from hospital onto the streets without being asked if they had suitable accommodation to go to	Not admitted to hospital from A&E.	Was readmitted to hospital within 30 days.

Feel they have long-standing illnesses which are: • Joint aches/problems with bones and muscles • Some issues with mobilising • Feeling moderate - extreme pain and discomfort day-to-day Both are long-term smokers. Neither have had a prostate or testicular cancer exam in the last three years.	Longer term illnesses stated as: • Asthma • Problem with feet Is receiving support with physical health, but feels that could benefit from more. Did not identify any point in the last 12 months where needed a physical or mental health exam or treatment and this was not received.	Longer term illnesses stated as: • Difficulty seeing/eye problems • Fainting/blackouts • Urinary problems • Liver problems • Dental/teeth problems • Epilepsy/seizures • Malnutrition Is not receiving support with physical or mental health, but feels could benefit from more support. Did not access examination/treatment for physical health in the last 12 months due to feeling depressed. Not currently receiving treatment for dental problems but would like it - has not accessed due to historical fear of dentists.
Diagnosis of depression. Feelings of being unsupported with mental health conditions.	Diagnosis of depression in the last year. Does not feel anxious or depressed.	Longer term diagnosis of depression plus diagnosis of anxiety disorder/phobia; dual diagnosis and potentially psychosis/schizophrenia. Feels extremely anxious or depressed. States that was refused an assessment/ treatment for mental health in the last 12 months.

Did not identify any drug use in the last 12 months.	Considers self to be in recovery from a former alcohol issue. However has been admitted to hospital twice in the last 12 months due to alcohol.	States that drinking alcohol almost every day - up to 40 units per day. Considers alcohol to be a problem. Is not currently receiving support for this, but feels would benefit from some.

Comparison of two respondents sleeping rough for less than three months (new to rough sleeping)		
Commonalities:	**Differences:**	
	Respondent C **Client ID: 50**	**Respondent D** **Client ID: 88**
Slept rough for less than three months. Male, Heterosexual, UK National	Surveyed at CIRDIC day centre 49 years old Other ethnic origin (not stated) First slept rough and applied to the Council at 36; first accessed supported accommodation at 37.	Surveyed at Bed for the Night (winter night shelter) 31 years old Black British: Caribbean History of rough sleeping and accessing supported accommodation not recorded.

Registered with both GP and dentist - no incidents of refusal of registration, treatment or examination for physical or mental health conditions in the last 12 months. No mention of using Reading's Walk-In Centre by either respondent. No use of A&E, ambulance or admissions to hospital.	Used GP services three or more times in the last 12 months. Has not accessed dental treatment as did not have income benefits in place to prove exemption.	Used GP services twice in the last 12 months.
Neither associate with having a long-standing illness. Both are smokers. Neither have had a prostate or testicular cancer exam in the last three years. No issues with mobilising or self-care	Health needs identified for 12+ months and prior to rough sleeping as: • High blood pressure • Stomach problems, including ulcers • Dental/teeth problems • Depression • Dual diagnosis More recent health needs (in the past 12 months) as: • Joints aches/problems with bones and muscles • Difficulty seeing/eye problems Has moderate pain/discomfort and moderate anxiety/depression. Receiving support for mental health issues, but feels could benefit from more support if offered - main source of support is IRIS.	No long term or recently diagnosed physical or mental health problems stated.

Class A drug use in the last 12 months. No identified issues with alcohol misuse in the last 12 months.	Multiple Class A and B drug use in the last 12 months. On a Methadone script and considers self to be in recovery. Engaging with IRIS drug and alcohol support, but feels could benefit from more support.	Heroin (IV) use only Considers that has a current drug problem. Not engaging with IRIS drug and alcohol support, but feels this would help.

Conclusions

This Audit report has outlined the cross-sector partnership approach taken to conducting an audit of the health needs of those who are single, or part of a couple without dependent children, who are homeless - for example, those who are rough sleeping, sofa surfing, living in supported accommodation, refuges or bail hostels.

Commissioned by partners of Reading's Homelessness Forum, the Audit aimed to listen to and take account of single homeless people's views on their health; provide an evidence base and fill in any information/evidence gaps; contribute to Reading's Joint Strategic Needs Assessment (JSNA); consider what is currently working well within services, with a view that this could inform improvements and develop a case for change for homeless people in Reading.

A snapshot of the health needs of 150 single homeless individuals was taken over a five week period and this report has analysed the data and findings.

The report is intended as a research piece to inform improvement and service development across sectors. Key issues from respondents have been highlighted and management within sector services are invited to set out their responses to these findings and develop subsequent action plans.

Decisions should be made by health and homelessness services regarding whether it would be valuable to conduct the Audit on a regular basis as part of mapping trends and progress. If considered valuable, it will be important to determine how often and whether a full Audit would be necessary, or if an alternative and/or complementary research would be beneficial. Learnings from this first Audit should be carried forward to inform any future Audit projects.

The main areas for focus within this report were:

- Statements of health
- Physical and mental health
- Smoking, drug and alcohol use
- Access to health services
- Focus on rough sleepers' health needs
- Prevention opportunities

Under each of these headings the reports key finding have been set out below:

Key findings regarding statements of health

- Compared to concerns about mobility, self-care, being able to go about daily activities and pain and discomfort, respondents showed particular concerns about managing their mental health needs where a majority stated that they felt moderately or extremely anxious on a day-to-day basis.

Key findings regarding physical health

- The top three recent and longer-term physical health diagnoses identified by homeless people in Reading corresponded with the national picture and were: (1) joint aches or problems with bones/muscle; heart problems or chronic breathing problems and dental/teeth problems.
- Male respondents reported higher levels of physical health problems than women and this is likely attributed to local responses to the vulnerability of women sleeping rough.

- A third of respondents reported problems with their teeth or mouth with few receiving treatment for their issues.

Key findings regarding mental health

- 80% of single homeless respondents to the Audit reported having a mental health problem.
- Women identified as having much higher levels of mental health problems than men, with women aged 18 - 25 having the highest levels.
- A diagnosis of anxiety and depression were respondent's main mental health issue with 44 out of 150 stating that they had a dual diagnosis.
- There seemed to be no significance in the levels of mental health problems experienced within different housing situations.
- Of significance, respondents stated that:
    - They had experienced difficulties in accessing mental health services
    - They would rather have face-to-face assessments and ongoing support
    - Not having accommodation and substance misuse are a barrier in accessing mental health services
    - Waiting times are long and there can be feelings of uncertainty between arranged appointments
    - Specialist trauma services are needed
    - Poor mental health is exacerbated by being homeless.

Key findings regarding smoking, alcohol and drug use

- Compared to national and other health need audit data, a significantly higher number of respondents stated that they currently smoked.
- Respondents that considered they had a drug or alcohol problem were at 43% and 30% respectively and this was in line with other health need audit responses.
- Reading's Audit data shows that:
    - Alcohol misuse is more prevalent amongst homeless men than women; amongst those aged 26 and over and those who are rough sleeping.
    - Drug misuse within Reading's homeless cohort is predominantly affecting those aged 26 - 45 which differs from national findings for the whole population of England and Wales. However, where Class A intravenous drug use is more prevalent amongst those who are homeless and where heroin and crack cocaine are more addictive, leading to longer term use, the age range for Class A drug misuse is representative.
    - Cannabis use was most prevalent amongst those aged 18 - 25
    - Men were more likely to be misusing drugs than women
    - Use of NPSs was minimal which is synonymous with national data
    - Over half of respondents stated that they were using drugs and/or alcohol as a means to cope with mental health or trauma.

Key findings regarding access to health services

- Compared to other health needs audits, Reading's respondents had a slightly lower GP registration rate and significantly lower registration refusals. Considering overall feedback, this can be attributed to Reading having a well-used Walk-In Centre facility.
- Women were more likely to be registered and accessing GP and dental services than men.
- Those within supported accommodation were more likely to be accessing primary health care and less likely to be refused access to services.
- Women aged 18 - 25 or aged 66 and over and living in supported accommodation or sofa surfing/squatting were more likely to use an ambulance and attend A&E.

- Respondents who were sleeping rough were more likely to be admitted to hospital once emergency services had been accessed.
- 20% of respondents stated that they had not received treatment for dental health problems in the last 12 months primarily due to fear of examination; not being able to get an appointment and not feeling motivated to get treatment.
- Over a third of respondents stated that they had accessed A&E at least once in the last year; with just under a third admitted to hospital from A&E.
- Those most prolifically using A&E and ambulance services over the last year were primarily living in supported accommodation; had multiple and longstanding health issues and only one was sleeping rough. All but one respondent identified as having depression and anxiety as well as at least one other mental health diagnosis - primarily Personality Disorder and a dual diagnosis (alcohol/drug misuse and a mental health diagnosis).
- Over a third of those who stated that they had a physical or mental health or substance misuse problem stated that they would like more support with managing this problem.
- Respondents stated that they valued having appointments with a regular and familiar GP; were frustrated with not being able to get an appointment with a GP in a timely way; sometimes felt disbelieved and judged when presenting with symptoms at A&E and felt that discharge staff could do more in establishing a patient's housing situation.

Key findings regarding prevention opportunities

- Uptake of cervical smear tests and breast examinations in Reading were above the average across other Homeless Health Needs Audits in England at 70% and 44% respectively.
- Sexual health checks and confidence about accessing sexual health advice were higher than in other health needs audit areas.
- Reports of HIV, TB and Hepatitis B and C were very low. Uptake of the Hepatitis B vaccination was significantly higher than other local authority areas.
- Feedback from those who had recently been in custody stated that they considered their health and wellbeing needs had not been addressed whilst in custody in preparedness for their release.

Key findings regarding rough sleeper case study comparison

Key themes from case study samples showed that longer-term rough sleepers are more likely to:

- Access the Walk-In Centre and emergency services, having disengaged from primary health care, drug/alcohol support and mental health services. When accessing emergency services, those rough sleeping are not being asked about their accommodation situation upon discharge.
- Have long-standing illnesses and more chronic issues associated with sleeping rough - e.g. moderate-extreme joint pain, breathing difficulties, dental problems. The number of ailments increases for those who have slept rough for longer.
- Have alcohol misuse issues having slept rough for longer, whilst those newer to rough sleeping tended to have Class A drug addictions and no alcohol misuse.
- Have a longer-term mental health diagnosis of depression and/or anxiety.

Positive feedback from respondents

There were several examples of responses from those who partook to highlight the following positive experiences of health care and support in Reading:

- Availability and accessibility of Reading's Walk-In Centre.

- Accessibility due to in-reach services provided by the Health Outreach Liaison Team (HOLT).
- Peer support services in support of those with substance misuse issues.
- High levels of respondents knowing how to access contraception and advice about sexual health.

Respondents showed that they would like to see improvements in the following areas:

- Obtaining GP appointments and wanting consistency of support from the same GP.
- Access to accommodation and a feeling of home to improve overall mental health and well-being.
- How mental health support is obtained, delivered and it's availability
- Access to more support, including peer support and specialist trauma support, for mental health and/or substance misuse.
- Attitudes of health care staff towards those who have physical and/or mental health issues alongside substance misuse issues; wanting to feel believed, not judged, and given time by professionals.
- Feeling able and comfortable in accessing dental health services.

Actions taken to improve support and services for homeless individuals

Recommissioning of homelessness support services

Currently the Council commissions the following homelessness support services in Reading at a cost of £1.49m per annum:

- A rough sleeper street outreach service that supports rough sleepers to access supported accommodation or reconnect to their area of origin.
- 217 supported accommodation bed spaces for individuals/couples, who are homeless, currently collectively referred to as the Homelessness Pathway. The Pathway comprises 73 units offering intensive support within a 24-hour staffed environment and 132 units of move-on accommodation where individuals develop their basic living skills to move-on into independent accommodation. There are also seven assessment units and five units used for longer term clients.
- A cross-tenure floating support service which supports individuals, couples and families with tenancy sustainment and homelessness prevention.

From September 2018, the Council will be re-modelling current homelessness support services to provide more flexible and innovative ways of delivering services that better meet the needs of single homeless people and those at risk of homelessness. The aim is for the revised service model to encompass new ideas and national best practice that will optimise outcomes for individuals and value for money.

Due to the Council's current overall financial position and its need to deliver significant budget savings, in remodelling Homelessness Support Services the Council is reducing the budget for these services by £245,000 per annum from £1.49m to £1.25m. With this reduction in budget there will be a reduction in bed spaces within supported accommodation services. However, the new model intends to improve the efficiency of Council funded services to minimise the impact upon individuals that use these services.

Due to a reduction in the budget for homelessness support services in Reading there will be a reduction in bed spaces within supported accommodation. However, the new model proposes to improve the cost and effectiveness of commissioned services with the aim of minimising the impact upon individuals that use these services.

National guidance, new ways of tackling homelessness and best practice from other local authority areas have been considered and explored to inform the reshaping and redevelopment of homelessness support services. The following principles will underpin new services:

(1) Immediate and emergency responses to those who are homeless or rough sleeping.

Key features of this would be a:

- A hub that centralises accommodation and support services available to those who are homeless or rough sleeping, including emergency assessment beds and hostel accommodation for those that need 24/7 on-site staffing support.
- Rough sleeper outreach team focussed on supporting rough sleepers into accommodation and reconnecting those without a local connection to their area of origin.
- No Second Night Out (NSNO) model to ensure that anyone who is sleeping rough for the first time receives a rapid response offer to prevent them sleeping out for a second night.
- Severe Weather Emergency Protocol (SWEP) to provide emergency bed spaces for rough sleepers, regardless of their immigration or local connection status, during short periods of high risk weather.

(2) Housing and support offers to address the differing needs of single homeless people

Key features of this would be:

- Shared supported accommodation that provides a high level of support where staff are not on site but available when required 24/7, as well as shared accommodation for people who do not require a high level of support, but are presently unable to manage independent living.
- Some accommodation under Housing First principles where an unconditional offer of stable, independent housing is made alongside intensive support for people with multiple and complex needs where more conventional supported accommodation offers have been unsuccessful.
- A Making Every Adult Matter (MEAM) approach across services for complex individuals that have ineffective contact with statutory and support services where cross-sector partners find shared, flexible solutions and develop a coordinated approach.
- Psychologically and trauma informed practice and principles within all services to take into account the psychological make-up, experiences and needs of its users. This is effective for those who have experienced complex trauma in child or adulthood.
- The delivery of gender informed homelessness support services that understand that women experience homelessness and interact with support in ways that are unique to their gender.
- Wrap-around support to ensure that if an individual's needs increase, a move into alternative accommodation is a last resort.

(3) Services that pre-empt and prevent homelessness

Key features of this principle would be a:

- Cross-tenure floating support service that offers support to those who are at risk of homelessness, require support sustaining their accommodation or with accessing alternative accommodation.

- No First Night Out (NFNO) approach to explore why individuals are sleeping rough for the first time and create locally tailored pre-emptive measures to identify 'pre-rough sleepers' at a phase of their housing crisis which precedes rough sleeping.

Housing First: Two year pilot with St. Mungo's

In June 2017, a two year Housing First pilot began in Reading, funded by St. Mungo's who currently provide the borough's rough sleeper outreach team, where the pilot is co-ordinated collaboratively with the Council.

The Housing First model acknowledges that conventional 'staircase' or 'pathway' models of accommodation with support, that have a treatment first approach to securing accommodation, do not work for some individuals. It argues that, for some, communal hostels can cause conflict resulting in eviction or abandonment and that there is often a mixture of clients at different stages of recovery for substance and alcohol addictions. The Housing First model aims to provide sustainable housing solutions for complex and long term rough sleepers and more difficult to engage rough sleepers and individuals that have experienced multiple evictions/abandonments from traditional accommodation with support models.

The aims of Reading's Housing First pilot are to:

- Enable clients to manage and maintain accommodation and improve their quality of life
- Assist clients to actively engage with their local community enabling a sustained living situation
- Empower clients to make positive and informed choices around their engagement
- Collate outcomes information to support if and how Housing First might be funded and commissioned in Reading in the future

St. Mungo's have a full-time Housing First Worker to work specifically with Housing First clients. Independent tenancies will be provided to Housing Frist clients via social housing and the private rented sector. St. Mungo's are providing intensive personalised support to between 8 – 10 clients over the pilot period. All properties will be sought and let sensitively to ensure that any identified anti-social or dependency issues clients have will have minimum impact upon their chances of successfully sustaining a tenancy; upon other residents and upon the wider community.

Reading Housing First clients will have access to a personal budget, funded by St. Mungo's, to purchase services and items that support their resettlement. They will receive robust, intensive and tailored support with a view that they will graduate from the service at which point support from the Housing First Worker will become 'dormant'.

Appendix 1

Homeless Health Needs Audit Project Group
Terms of Reference - Agreed on 27 October 2016

Purpose

The aims of the Homeless Health Needs Audit itself are as follows:

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

The role of the Homeless Health Needs Audit Project Group is as follows:

- To implement and monitor the progress of the Audit for Reading.
- To ensure that the Audit is delivered to prescribed timescales.
- To develop an Action Plan for the dissemination of data collated from the Audit and how this information can be utilised to meet the overall aims of the Audit (as above).
- To work in partnership to provide the resources to conduct, review and follow-up actions from the Audit.

Membership

Lead members, as recommended by Homeless Link, as:

- RBC Housing and Adult Social Care Commissioning Teams
- Health Outreach Liaison Team (HOLT)
- Street Outreach Team (SOT)
- Public Health and Clinical Commissioning Group (CCG)
- Substance misuse services - IRIS
- Mental health services
- Probation and NPS
- Voluntary/community sector representation
- Peer mentor
- Any other relevant local health, social care and housing services

Members are to provide alternative representation if they are unable to attend a meeting. Membership may be extended as and when required.

Meeting Arrangements

Meetings will be scheduled for every two months. Additional/more frequent meetings to be agreed as required.

Review

These Terms of Reference will be regularly reviewed and revised should the role and agenda of the group change significantly.

Appendix 2
Homeless Health Needs Audit Questionnaire for Reading

Homeless Health Needs Audit

Printable version of the survey

Welcome to the Health Needs Audit. This is the paper version of the audit questions. If you are using the paper version, please input the responses afterwards onto the online tool.

This survey asks clients questions about their health needs and access to health services in your local area. Please refer to the Guidance to help you carry out the survey. Make sure that the client has read Appendix Two of the Guidance, **Information for participants** and that they understand how this information will be used.

Questions marked with an asterisk (*) are mandatory. If the client does not wish to answer the question, please tick the 'No answer' option.

INTRODUCTION

Before you get started, please ask the client to confirm that they understand how their data will be used and that they have not already completed a survey for the current audit. Please also confirm which local authority they reside in:

☐ I (the client) understand how this information will be used and am happy to go ahead

☐ I have not previously undertaken this survey

WHICH LOCAL AUTHORITY ARE YOU IN?.....

A FEW QUESTIONS ABOUT YOU

1* **HOW OLD ARE YOU?**

……..

o No answer

3* **HAVE YOU EVER (IN YOUR LIFETIME) DONE ANY OF THE FOLLOWING? IF YES, PLEASE INDICATE THE AGE AT WHICH THIS FIRST OCCURRED.** Tick **all** that apply:

	Yes	Age
Stayed at a hostel, foyer, refuge, night shelter or B&B hotel, or any other type of homelessness service	☐	……..
Stayed with friends or relatives because had no home of own ('sofa surfed')	☐	……..
Slept rough	☐	……..
Applied to the council as homeless	☐	……..
None of the above	☐	
No answer	☐	

4* **WHERE ARE YOU CURRENTLY SLEEPING?** (if this frequently changes, please say where you slept last night). Please tick **only one**:

- o Sleeping rough on streets/parks
- o In a hostel or supported accommodation
- o Squatting
- o Sleeping on somebody's sofa/floor
- o In emergency accommodation, e.g. nightshelter, refuge

- O In B&B or other temporary accommodation
- O Housed - in own tenancy
- O Other (please state)……..
- O No answer

RD1 AND HOW LONG HAVE YOU BEEN STAYING THERE?

Please tick **only one**:

- O Less than 1 month
- O 1-3 months
- O 4-6 months
- O 7-12 months
- O 13-18 months
- O 19-24 months
- O 25+ months

5 THINKING ABOUT THE MOST RECENT TIME YOU BECAME HOMELESS, WHAT WAS THE MAIN REASON FOR THIS? Please give **one primary** reason and **one secondary** reason if applicable.

	Primary reason	Secondary reason
Parents / care-givers no longer able or willing to accommodate	O	O
Other relatives or friends no longer able or willing to accommodate	O	O
Non-violent relationship breakdown with partner	O	O
Abuse or domestic violence	O	O
Overcrowded housing	O	O
Eviction or threat of eviction	O	O
Rent or mortgage arrears	O	O
Other debt-related issues	O	O
End of tenancy (social housing)	O	O
End of tenancy (private rented sector)	O	O
Financial problems caused by benefits reduction	O	O
Unemployment	O	O
ASB (anti-social behaviour) or crime	O	O
Drug or alcohol problems	O	O
Mental or physical health problems	O	O
Leaving institutional care (e.g. hospital, prison, care etc.)	O	O
Other (please state)……..	O	O

7* WHAT IS YOUR GENDER? Please tick **only one**:

- O Male
- O Female
- O Other (please state)……
- O No answer

8 WHICH OF THE FOLLOWING BEST DESCRIBES YOUR SEXUAL ORIENTATION?

Please tick **only one**:

- O Heterosexual or straight
- O Gay or lesbian
- O Bi-sexual
- O Other (please state)……..

9* **WHAT IS YOUR ETHNIC GROUP?** Please tick **only one:**

White				Mixed/Multiple ethnic groups				Asian/Asian British					Black/Black British			Other ethnic group	
English / Welsh / Scottish / Northern Irish / British	Irish	Gypsy or Irish Traveller	Other white	White & Black Caribbean	White & Black African	White & Asian	Other mixed	Indian	Pakistani	Bangladeshi	Chinese	Other Asian	African	Caribbean	Other black	Arab	Any other ethnic group
O	O	O	O	O	O	O	O	O	O	O	O	O	O	O	O	O	O

Please state: ……

O No answer

10 **WHAT IS YOUR IMMIGRATION STATUS?** Please tick **only one:**

O UK National
O European Economic Area (EEA) national
O National from outside of the EEA
O Asylum Seeker
O Refugee
O Permanent residence/Indefinite leave to remain
O Unknown
O Other (please state)……

12* **DO YOU HAVE ANY LONG-STANDING ILLNESS, DISABILITY OR INFIRMITY?** By long-standing I mean anything that has troubled you over a period of time or that is likely to affect you over a period of time. Please tick **only one**:

O Yes O No O No answer

SOME QUESTIONS ABOUT YOUR PHYSICAL HEALTH

13* **HAS A DOCTOR OR HEALTH PROFESSIONAL EVER TOLD YOU THAT YOU HAVE ANY OF THE FOLLOWING PHYSICAL HEALTH PROBLEMS?** Please choose the appropriate response for each item:

	Yes, in past 12 months	Yes, 12 months + ago	No	No answer
Heart problems (heart attack, angina, murmur or abnormal heart rhythm)	☐	☐	☐	☐
Chronic breathing problems (bronchitis, emphysema, obstructive airways disease)	☐	☐	☐	☐
Asthma	☐	☐	☐	☐
Cancer	☐	☐	☐	☐
High blood pressure	☐	☐	☐	☐
Joint aches/problems with bones and muscles	☐	☐	☐	☐
Difficulty seeing/eye problems	☐	☐	☐	☐
Skin/wound infection or problems	☐	☐	☐	☐

Problems with feet	☐	☐	☐	☐
Fainting/blackouts	☐	☐	☐	☐
Urinary problems/ infections/ incontinence	☐	☐	☐	☐
Circulation problems/blood clots	☐	☐	☐	☐
Liver problems	☐	☐	☐	☐
Stomach problems, including ulcers	☐	☐	☐	☐
Dental/teeth problems	☐	☐	☐	☐
Diabetes	☐	☐	☐	☐
Epilepsy/seizures	☐	☐	☐	☐
HIV	☐	☐	☐	☐
Tuberculosis (TB) (*go to Q13a)*	☐	☐	☐	☐
Hepatitis C (*go to Q13b)*	☐	☐	☐	☐
Other (please state)……	☐	☐	☐	☐

13a ***IF YES TO TB*, HAVE YOU RECEIVED ANY TREATMENT?** Please tick **only one**:

O Yes O No

13b ***IF YES TO HEPATITIS C*, HAVE YOU RECEIVED ANY TREATMENT?** Please tick **only one**:

O Yes O No, offered but didn't take it up O No, not offered any

13c ***IF YES TO ANY PHYSICAL HEALTH NEED*, ARE YOU RECEIVING SUPPORT/ TREATMENT TO HELP YOU WITH YOUR PHYSICAL HEALTH PROBLEM?** Please tick **only one**:

O Yes, and it meets my needs O Yes, but I'd still like more help

O No, but it would help me O No, I do not need any

14 **WAS THERE ANY TIME DURING THE PAST TWELVE MONTHS WHEN, IN YOUR OPINION, YOU NEEDED A MEDICAL EXAMINATION OR TREATMENT FOR A PHYSICAL HEALTH PROBLEM BUT YOU DID NOT RECEIVE IT?** Please tick **only one**:

O Yes, there was at least one occasion O No, there was no occasion (*go to Q15*)

14a ***IF YES TO Q14*, WHAT WAS <u>THE MAIN REASON</u> FOR NOT RECEIVING THE EXAMINATION OR TREATMENT (THE MOST RECENT TIME)?** Please tick **only one**:

O Couldn't get an appointment
O Waiting list
O Have been banned from the service
O Too far to travel/no means of transportation
O Fear of doctor/hospitals/examination/ treatment
O Wanted to wait and see if problem got better on its own
O Was refused treatment/examination
O Other (please state)……..

15* **DO YOU SMOKE CIGARETTES, CIGARS OR A PIPE?** Please tick **only one**:

O Yes O No O No answer

RD 2 **FEMALE CLIENTS ONLY: ARE YOU PREGNANT?**

O Yes O No O No answer

SOME QUESTIONS ABOUT MENTAL HEALTH AND DEVELOPMENT

16* **HAS A DOCTOR OR HEALTH PROFESSIONAL EVER TOLD YOU THAT YOU HAVE ANY OF THE FOLLOWING MENTAL HEALTH OR BEHAVIOURAL CONDITIONS?** Please choose the appropriate response for each item:

	Yes, in past 12 months	Yes, 12 months + ago	No	No answer
Depression	☐	☐	☐	☐
Anxiety disorder or phobia	☐	☐	☐	☐
Psychosis (incl. schizophrenia or bipolar disorder)	☐	☐	☐	☐
Personality disorder	☐	☐	☐	☐
Post traumatic stress disorder (PTSD)	☐	☐	☐	☐
Eating disorder	☐	☐	☐	☐
Dual diagnosis - a mental health problem alongside drug or alcohol use	☐	☐	☐	☐
ADHD (attention deficit hyperactivity disorder)	☐	☐	☐	☐
Learning disability or difficulty	☐	☐	☐	☐
Autism/Asperger's	☐	☐	☐	☐
Other (please state)…….....	☐	☐	☐	☐

16a ***IF YES TO ANY MENTAL HEALTH NEED*, ARE YOU RECEIVING SUPPORT/ TREATMENT TO HELP YOU WITH YOUR MENTAL HEALTH PROBLEM?** Please tick **only one**:

- O Yes, and it meets my needs
- O Yes, but I'd still like more help
- O No, but it would help me (*go to Q17*)
- O No, I do not need any (*go to Q17*)

16b ***IF YES TO Q16a*, WHAT TYPE OF SUPPORT ARE YOU RECEIVING?** Tick **all** that apply:

- ☐ Talking to a professional like a counsellor or therapist (e.g. counselling, CBT, psychological therapies)
- ☐ Support from a specialist mental health worker – e.g. Community Mental Health team, Community Psychiatric Nurse
- ☐ A service that deals with my mental health and drug/alcohol use at the same time
- ☐ Activities like arts, volunteering or sport
- ☐ Practical support that helps me with my day to day life
- ☐ Training and activities to learn new skills/gain employment
- ☐ Medication that has been prescribed for me
- ☐ Peer support - support from others who have been through a similar experience
- ☐ Other (please state)……

17 **WAS THERE ANY TIME DURING THE PAST TWELVE MONTHS WHEN, IN YOUR OPINION, YOU PERSONALLY NEEDED AN ASSESSMENT OR TREATMENT FOR A MENTAL HEALTH PROBLEM BUT YOU DID NOT RECEIVE IT?** Please tick **only one**:

- O Yes, there was at least one occasion
- O No, there was no occasion (*go to Q18*)

17a ***IF YES TO Q17*, WHAT WAS <u>THE MAIN REASON</u> FOR NOT RECEIVING THE ASSESSMENT (THE MOST RECENT TIME)?** Please tick **only one**:

- O Couldn't get an appointment
- O Waiting list
- O Have been banned from the service
- O Due to my drug or alcohol use
- O Too far to travel/no means of transportation
- O Fear of doctor/hospitals/examination/ treatment
- O Wanted to wait and see if problem got better on its own

O Was refused treatment/examination
O Other (please state)……

18 DO YOU USE DRUGS OR ALCOHOL TO HELP YOU COPE WITH YOUR MENTAL HEALTH – this can be called 'self-medicating'? Please tick **only one**:

O Yes O No

SOME QUESTIONS ABOUT DRUG AND ALCOHOL USE

19* IN THE PAST 12 MONTHS HAVE YOU TAKEN ANY OF THE FOLLOWING? Tick **all** that apply:

☐ Heroin
☐ Crack
☐ Cocaine
☐ Cannabis/weed
☐ Amphetamines/speed
☐ Tranquilisers, such as benzodiazepines/benzos, not prescribed for you
☐ Any other prescription drugs, not prescribed for you
☐ New Psychoactive Substances (also known as legal highs)
☐ IV drugs (drugs you inject)
☐ No drug use in the past 12 months
☐ Other (please state)……
☐ No answer

20 DO YOU TAKE METHADONE, SUBUTEX OR ANY OTHER SUBSTITUTE DRUGS? Please tick **only one**:

O Yes, it is prescribed for me O Yes, but it is not prescribed for me O No

21* DO YOU HAVE OR ARE YOU RECOVERING FROM A DRUG PROBLEM? Please tick **only one**:

O Yes, I have a drug problem O Yes, I am in recovery O No (*go to Q22)*

21a *IF YES TO A DRUG PROBLEM,* ARE YOU RECEIVING SUPPORT/TREATMENT TO HELP YOU WITH YOUR DRUG PROBLEM? Please tick **only one**:

O Yes, and it meets my needs O Yes, but I'd still like more help
O No, but it would help me (*go to Q22)* O No, I do not need any (*go to Q22)*

21b *IF YES TO Q21a*, WHAT SUPPORT ARE YOU RECEIVING TO HELP YOU ADDRESS YOUR DRUG USE? Tick **all** that apply:

☐ Advice and information (e.g. from GPs, A&E departments)
☐ Harm reduction services, such as needle exchange
☐ Self-help groups (often called Mutual Aid), e.g. Narcotics Anonymous
☐ Community prescribing (drug treatment prescribed as part of a care plan)
☐ Counselling or psychological support
☐ Attendance at day programmes, delivered in the community
☐ Detox (help with withdrawal as an inpatient)
☐ Residential rehabilitation
☐ Aftercare (support following structured treatment)
☐ Peer support - support from others who have been through a similar experience
☐ Other (please state)……

22* **HOW OFTEN HAVE YOU HAD AN ALCOHOLIC DRINK DURING THE PAST 12 MONTHS?**
Please tick **only one**:

- O Almost every day
- O Five or six days a week
- O Three or four days a week
- O Once or twice a week
- O Once or twice a month
- O Once every couple of months
- O Once or twice a year
- O Not at all in the past 12 months (*go to Q24*)
- O No answer

23* **HOW MANY UNITS DO YOU DRINK ON A TYPICAL DAY WHEN YOU ARE DRINKING?** Please refer to flashcard to work this out.

……..

- O No answer

24* **DO YOU HAVE OR ARE YOU RECOVERING FROM AN ALCOHOL PROBLEM?** Please tick **only one**:

- O Yes, I currently have an alcohol problem
- O No (*go to Q25)*
- O Yes, I am in recovery
- O No answer

24a ***IF YES TO AN ALCOHOL PROBLEM,* ARE YOU RECEIVING SUPPORT/TREATMENT TO HELP YOU WITH YOUR ALCOHOL PROBLEM?** Please tick **only one**:

- O Yes, and it meets my needs
- O No, but it would help me (*go to Q25)*
- O Yes, but I'd still like more help
- O No, I do not need any (*go to Q25)*

24b ***IF YES TO Q24a*, WHAT SUPPORT ARE YOU RECEIVING TO HELP YOU ADDRESS YOUR ALCOHOL USE?** Tick **all** that apply:

- ☐ Advice and information (e.g. from GPs, A&E departments)
- ☐ Self-help groups, e.g. Alcoholics Anonymous
- ☐ Community prescribing (drug treatment prescribed as part of a care plan)
- ☐ Counselling or psychological support
- ☐ Attendance at day programmes, delivered in the community
- ☐ Detox (help with withdrawal as an inpatient)
- ☐ Residential rehabilitation
- ☐ Aftercare (support following structured treatment)
- ☐ Peer support - support from others who have been through a similar experience
- ☐ Other (please state)……

SOME QUESTIONS ABOUT YOUR DENTAL HEALTH

RD 3 **DO YOU CURRENTLY HAVE A PROBLEM WITH YOUR TEETH/ MOUTH?**

O Yes O No O No answer

RD3 a ***IF YES TO RD3:* ARE YOU RECEIVING SUPPORT OR TREATMENT TO HELP YOU WITH YOU TEETH/MOUTH PROBLEM**
Please tick **only one**:

- O Yes, and it meets my needs
- O Yes, but I'd still like more help
- O No, but it would like to
- O No, I do not need any

RD3b ***IF YES TO RD3a:*** **WHERE ARE YOU RECEIVING SUPPORT/ TREATMENT FROM?** Please tick **all that apply**

- O GP
- O Dental Surgery
- O A&E Department
- O Other (please state) ……

RD4 **WAS THERE ANY TIME DURING THE PAST 12 MONTHS WHEN, IN YOUR OPINION, YOU NEEDED TREATMENT FOR A PROBLEM WITH YOUR TEETH OR MOUTH BUT YOU DID NOT RECIEVE IT?**

- O Yes, there was at least one occasion
- O No

RD4a ***IF YES TO RD4:*** **WHAT WAS THE MAIN REASON THAT YOU DID NOT RECEIVE THE EXAMINATION OR TREATMENT? (PLEASE CONSIDER THE MOST RECENT TIME)**

- O Couldn't get an appointment
- O Waiting on a waiting list
- O Have been banned from the service
- O Too far to travel/ no means of transportation
- O Fear of doctor/ hospitals/ examination/ treatment
- O Wanted to wait and see if problem got better on its own
- O Was refused treatment/ examination
- O Difficulty with receiving written correspondence due to having no fixed address
- O Attitude of staff within health services
- O Other (please state) ……

SOME QUESTIONS ABOUT YOUR ACCESS TO SERVICES

25* **ARE YOU REGISTERED WITH THESE SERVICES IN YOUR LOCAL AREA?** Please choose the appropriate response for each item:

	Yes	No	No answer
GP or homeless healthcare service	☐	☐	☐
Dentist	☐	☐	☐

26 **HAVE YOU BEEN REFUSED REGISTRATION TO A GP/ HOMELESS HEALTHCARE SERVICE OR DENTIST IN THE PAST 12 MONTHS?** Please choose the appropriate response for each item:

	Yes	No (*go to Q27)*
GP or homeless healthcare service	☐	☐
Dentist	☐	☐

26a ***IF YES TO Q26-<u>GP</u>*****, WHY WERE YOU REFUSED REGISTRATION TO A GP?**

.....

26b ***IF YES TO Q26-<u>DENTIST</u>*****, WHY WERE YOU REFUSED REGISTRATION TO A DENTIST?**

.....

27* **IN THE PAST 12 MONTHS HAVE YOU-:** Please choose the appropriate response for each item:

	No	Once	Twice	3 Times	Over 3 times	No answer
Been to a GP or homeless healthcare service?	☐	☐	☐	☐	☐	☐
Been to A&E?	☐	☐	☐	☐	☐	☐
Used an ambulance?	☐	☐	☐	☐	☐	☐
Been admitted to hospital?	☐	☐	☐	☐	☐	☐

27a **IF YOU HAVE USED <u>ANY</u> OF A&E, HOSPITAL OR AMBULANCE IN THE PAST 12 MONTHS PLEASE ANSWER THESE QUESTIONS: What was the reason why you last used:** *Please select the reason which best fits the primary cause of using the service, or use the other box if the reason is not listed.*

	A&E	Ambulance	Admitted into hospital
Domestic violence	☐	☐	☐
Other violent incident or assault	☐	☐	☐
Accident	☐	☐	☐
Relating to a physical health problem or condition	☐	☐	☐
Relating to a mental health problem or condition	☐	☐	☐
Self-harm/attempted suicide	☐	☐	☐
Relating to drug use	☐	☐	☐
Relating to alcohol use	☐	☐	☐
Relating to childbirth or pregnancy	☐	☐	☐
Other for A&E (please state)……..	☐		
Other for ambulance (please state)……		☐	
Other for hospital admission (please state)……..			☐

IF YOU WERE ADMITTED INTO HOSPITAL, PLEASE ANSWER QUESTIONS 27b-27d ABOUT YOUR MOST RECENT ADMISSION:

27b **DID STAFF ASK YOU IF YOU HAD SOMEWHERE SUITABLE TO GO WHEN YOU WERE DISCHARGED?** Please tick **only one**:

O Yes O No O I can't remember

27c* **WHEN YOU WERE DISCHARGED FROM HOSPITAL WHERE DID YOU GO?** Please tick **only one**:

O I was discharged onto the street
O I was discharged into accommodation, but it was *not* suitable for my needs
O I was discharged into accommodation, and it *was* suitable for my needs
O I can't remember
O No answer

27d* **AFTER BEING DISCHARGED, WERE YOU READMITTED WITHIN 30 DAYS?** Please tick **only one**:

O Yes O No O I can't remember O No answer

SOME QUESTIONS ABOUT STAYING HEALTHY

28* **BY PLACING A TICK IN ONE BOX IN EACH GROUP BELOW, PLEASE INDICATE WHICH STATEMENTS BEST DESCRIBE YOUR OWN HEALTH STATE TODAY:**

MOBILITY Please tick **only one**:

- O I have no problems in walking about
- O I have some problems in walking about
- O I am confined to bed
- O No answer

SELF-CARE Please tick **only one**:

- O I have no problems with self-care
- O I have some problems washing or dressing myself
- O I am unable to wash or dress myself
- O No answer

USUAL ACTIVITIES Please tick **only one**:

- O I have no problems with performing my usual activities
- O I have some problems with performing my usual activities
- O I am unable to perform my usual activities
- O No answer

PAIN/DISCOMFORT Please tick **only one**:

- O I have no pain or discomfort
- O I have moderate pain or discomfort
- O I have extreme pain or discomfort
- O No answer

ANXIETY/DEPRESSION Please tick **only one**:

- O I am not anxious or depressed
- O I am moderately anxious or depressed
- O I am extremely anxious or depressed
- O No answer

28a* **To help people say how good or bad a health state is, we have a scale on which the best state you can imagine is 100 and the worst state you can imagine is marked 0. We would like you to indicate on this scale how good or bad your own health is today, in your opinion. PLEASE DO THIS BY SAYING WHERE ON THIS SCALE YOUR HEALTH STATE IS TODAY.**

……

- O No answer

31 **HAVE YOU BEEN VACCINATED AGAINST HEPATITIS B?** Please tick **only one**:

O Yes (once) O Yes (twice) O Yes (three times)
O Never O Don't know

34 **HAVE YOU HAD A SEXUAL HEALTH CHECK IN THE PAST 12 MONTHS?** Please tick **only one**:

O Yes O No O Don't know

35 **DO YOU KNOW WHERE TO ACCESS FREE CONTRACEPTION?** Please tick **only one**:

O Yes O No

36 **DO YOU KNOW WHERE TO ACCESS ADVICE ABOUT SEXUAL HEALTH?** Please tick **only one**:

O Yes O No (*go to Q37)*

37 ***FEMALE CLIENTS OVER 25 ONLY*: HAVE YOU HAD A CERVICAL SMEAR IN THE PAST 3 YEARS?** Please tick **only one**:

O Yes O No O Don't know

38 ***FEMALE CLIENTS OVER 50 ONLY*: HAVE YOU HAD A BREAST EXAMINATION/ MAMMOGRAM IN THE PAST 3 YEARS?** Please tick **only one**:

O Yes O No O Don't know

RD5 ***MALE CLIENTS ONLY:* HAVE YOU HAD AN EXAMINATION FOR PROSTATE OR TESTICULAR CANCER IN THE PAST 3 YEARS?**

O YES - Prostate and Testicular
O YES - Prostate only
O YES - Testicular only
O No
O Don't Know

42 IS THERE ANYTHING ELSE YOU WOULD LIKE TO TELL US ABOUT YOUR HEALTH & THE SUPPORT YOU RECEIVE?

What works well?

.....
.....

What could be improved?

.....
.....

Any other comments:

.....
.....

Thank you for completing this survey.

READING HEALTH AND WELLBEING BOARD

DATE OF MEETING:	**13th July 2018**	**AGENDA ITEM:**	**17**
REPORT TITLE:	**READING'S ARMED FORCES COVENANT AND ACTION PLAN – MONITORING REPORT**		
REPORT AUTHOR:	**Jill Marston**	**TEL:**	**72699**
JOB TITLE:	**Senior Policy Officer**	**E-MAIL:**	**Jill.marston@reading.gov.uk**
ORGANISATION:	**Reading Borough Council**		

1. PURPOSE OF REPORT AND EXECUTIVE SUMMARY

1.1 The Armed Forces Covenant is a voluntary statement of mutual support between a civilian community and its local armed forces community.

1.2 This report presents an annual update on progress against the actions outlined in the action plan, in particular the heath related actions, and on the general development of the Reading Armed Forces Covenant.

2. RECOMMENDED ACTION

2.1 To note the progress against the actions set out in the Reading Armed Forces Covenant action plan (appendix A), in particular the section on Health and Wellbeing.

3. POLICY CONTEXT

3.1 In 2011, the Government published the Armed Forces Covenant, as a tri-Service document which expresses the enduring, general principles that should govern the relationship between the Nation, the Government and the Armed Forces community.

3.2 The 'Covenant for Communities' complements the Armed Forces Covenant but enables service providers to go beyond the national commitments. It allows for measures to be put in place at a local level to support the Armed Forces and encourages local communities to develop a relationship with the Service community in their area.

4. THE PROPOSAL

Background

4.1 A local Armed Forces Covenant is a voluntary statement of mutual support between a civilian community and its local armed forces community. It is intended to complement the national Armed Forces Covenant, which outlines the moral obligation between the nation, the government and the armed forces, at the local level.

4.2 The aims of the Armed Forces 'Covenant in the Community' are to:

- encourage local communities to support the Armed Forces community in their areas

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

4.3 The Reading Armed Forces Community Covenant was launched at the Afghanistan Homecoming Parade at Brock Barracks on 7th July 2012.

4.4 In addition to the Council, the covenant has been signed by 7 Rifles on behalf of the Armed Forces, and a range of other key partners.

4.5 Reading doesn't have a large military 'footprint', with no regular forces stationed in the town. However, Brock Barracks is the headquarters for the Territorial Army unit 7th Battalion The Rifles, and Reading is home to a large ex-Gurkha community. Reading's Armed Forces Covenant therefore focuses on Veterans and Reservists and aims to be proportionate in its scope to the size of the Armed Forces community in Reading.

Further development of the Armed Forces Covenant and action plan

4.6 The Reading Armed Forces Covenant working group with key stakeholders meets on a six monthly basis, the most recent held in March 2018. Partners continue to report that the meeting is valuable.

4.7 Progress to date against the actions in the action plan is shown in Appendix A. A number of the actions have now been completed. Successes to date include:

- Reading was awarded £21,730 from the Covenant grant scheme for an integration project for Veterans, aimed at raising awareness of health and social care services amongst the ex-Gurkha community in particular.

- The Museum service was awarded £10,000 from the Covenant grant scheme to support their exhibition, 'Reading at War', to mark the centenary of the beginning of the First World War in 2014.

- Reading Ex-British Gurkha Association was awarded £14,500 under the new Covenant Fund for two Nepalese community development workers.

- Soldiers, Sailors and Airmen Families Association (SSAFA) was awarded £1,000 to further update their leaflet on accessing health services, which has been translated into Nepalese and is being used by SSAFA to run classes; leaflet now updated and printed.

- Armed Forces personnel can now be given extra priority when applying for social housing on the Housing Register, as part of the Council's Housing Allocations Scheme.

- A domestic violence protocol is in place between the Service and the Police, to recognise military needs and ensure equitable service.

- Reading Borough Council now has a protocol in place for employment of Reserve Forces personnel.

- 'Operation Reflect' activities to mark the centenary of the beginning of the First World War included 7 Rifles visits to 5 primary schools.

- Job Centre Plus staff now receive regular briefings from 7 Rifles.

Health related actions

4.8 The action plan includes a section on health and wellbeing with the following actions:

- Feedback and input to the Health and Wellbeing Board
- Devise protocol for GPs to register Veteran status
- Raise awareness of and signpost to Veteran's Mental Health Service for the South Central region
- Development of a leaflet on accessing health services to be translated into Nepalese
- Develop and promote a discount scheme for serving personnel for arts and leisure facilities in Reading
- Consolidation of appropriate contact/ support lists in order to provide better signposting

4.9 Progress on each of these is summarised in the attached action plan. In particular, regarding GPs recording Veteran status, a number of measures have been put in place by CCGs:

- 'READ' codes provided to practices from Spring 2016.
- CCGs have developed guidance for practices on registering patients from the armed forces community
- Information on CCG web sites and social media (from June 2016).
- A number of practices in Reading piloted the recording of veteran status for patients attending flu clinics in the Autumn of 2017.
- This resulted in the numbers registered as Veterans up to 114 (which represents an increase of 11%). This represents 30% of Reading Borough residents in receipt of armed forces pension (a proxy measure for veteran numbers).
- Practices within the two Reading CCG localities are considering various ways to build upon the pilots, including possible local targets to increase the number of known veterans.

Covenant Grant Fund Trust

4.10 The national Covenant grant fund was launched in 2015 by the Ministry for Defence, with £10 million available every year. Since April 2018, the fund has become the independent Armed Forces Covenant Fund Trust and makes grants to support members of the Armed Forces community.

4.11 Under the 'local grants and digital developments programme', the trust will fund projects of up to £20,000 that support community integration or local delivery of services. Applications are open to charities, local authorities, schools, other statutory organisations, Community Interest Companies or Armed Forces units.

4.12 There are four application rounds for this programme in 2018/19, with remaining deadline dates of 29th July, 30th Sept, and 17th Dec. There have been some initial discussions about a potential bid to improve visibility of the Royal Berks Cenotaph from Oxford Rd via the keep entrance.

5. CONTRIBUTION TO READING'S HEALTH AND WELLBEING STRATEGIC AIMS

5.1 The work on the Armed Forces covenant is in line with the overall direction of the Reading Health and Wellbeing Strategy and contributes to a number of the Strategy's eight priorities, including the following as they relate to the Veteran community, through strengthening the support provided to Veterans and service leavers:

1. Supporting people to make healthy lifestyle choices
2. Reducing loneliness and social isolation
3. Reducing deaths by suicide
4. Reducing the amount of alcohol people drink to safe levels

5.2 The proposal recognises that plans in support of Reading's 2017-20 Health and Wellbeing Strategy should be built on three foundations - safeguarding vulnerable adults and children, recognising and supporting all carers, and high quality co-ordinated information to support wellbeing. The proposal addresses these by providing support to the Armed Forces community and their families, including Veterans.

6. COMMUNITY & STAKEHOLDER ENGAGEMENT

6.1 Two of the key aims of the Armed Forces Community Covenant are to:

- encourage local communities to support the armed forces community in their areas
- encourage the armed forces community to help and support the wider community, whether through participation in events and joint projects, or other forms of engagement

7. EQUALITY IMPACT ASSESSMENT

7.1 The covenant is intended as a vehicle for partners across Reading to help enable Veterans or Reservists to access health services, particularly mental health services, training and employment opportunities.

8. LEGAL IMPLICATIONS

8.1 The general power of competence, introduced as part of the Localism Act 2011, replaces the well-being power from February 2012. The Act gives local authorities the power to do anything which an individual generally may do, which they consider is likely to be of benefit (directly or indirectly) to the whole or any part of their area. It therefore gives local authorities the power to do anything they want, so long as it is not prohibited by other legislation.

9. FINANCIAL IMPLICATIONS

9.1 £30m of central government funding was allocated over four years to 2014/15 to financially support Community Covenant projects at the local level which strengthen the ties or the mutual understanding between members of the armed forces community and the wider community in which they live. Reading submitted bids in three bidding rounds. £10m per annum was made available in perpetuity from 2015/16 onwards through the new Armed Forces Covenant fund.

10. BACKGROUND PAPERS

10.1 Armed Forces Covenant Fund https://www.gov.uk/government/collections/covenant-fund

READING ARMED FORCES COMMUNITY COVENANT
ACTION PLAN JUNE 2018

The Armed Forces Community Covenant's key objectives:
Recognise, Remember, Integrate and Support

Armed Forces community comprises serving personnel (regular and reserves) and their dependants; and veterans and their dependants.

HQ 11 Infantry Brigade Workstrands:

- Health and Wellbeing
- Economy and Skills
- Education, Children and Young People
- Environment and Infrastructure
- Safer & Stronger Communities

Ref	Outcome	Responsibility	Timescale	Progress June 2018
HEALTH AND WELLBEING - *To ensure that the wellbeing of the Armed Forces community is not undermined by the nature of service life*				
Recognise: *Map and identify veterans status and represent special requirements of Armed Forces community in order to allow NHS to meet needs*				
1	Feedback and input to Health and Wellbeing Board	ROSO 7 Rifles	ongoing	• Annual report on health related actions to Board in July 2018 • Regimental Medical Officer to be invited to future meetings once in post
3	Devise protocol for GPs to register Veteran status	Clinical Commissioning Groups	ongoing	GPs currently being encouraged to record status and a number of measures have been designed by the CCGs: • 'READ' codes provided to practices from Spring 2016. • CCGs have developed guidance for practices on registering patients from the armed forces community • Information on CCG web sites and social media (from June 2016). • A number of practices in Reading piloted the recording of veteran status for patients attending flu clinics in the Autumn of 2017.

Ref	Outcome	Responsibility	Timescale	Progress June 2018
				• This resulted in the numbers registered as Veterans up to 114 (which represents an increase of 11%). This represents 30% of Reading Borough residents in receipt of armed forces pension (a proxy measure for veteran numbers). • Practices within the two Reading CCG localities are considering various ways to build upon the pilots, including possible local targets to increase the number of known veterans.
4	Raise awareness of and signpost to Veteran's Mental Health Service for the South Central region	Covenant partnership/ Armed Forces charities/other partners	ongoing	• JCP, SSAFA, RBL promote the service • SSAFA and RBL working with South Central Veterans mental Health Service within current casework • CCGs have been raising awareness at council of practice meetings, on CCG websites, and on social media • Veterans Mental Health Service to attend a future 7 Rifles 'health fair' when RMO in place • New hotline number added to RBC web page listing Armed Forces support organisations
5	Development of a leaflet on accessing health services to be translated into Nepalese	Clinical Commissioning Groups/SSAFA/RBC	Spring 2014	**ACHIEVED** • SSAFA runs classes with ex-Gurkha community using leaflet • Funding gained from covenant fund to develop the booklet further and to print and translate into Nepalese; revision version now complete and printed • Royal Berks Hospital now running 6 weekly meetings with ex-Gurkha community on diabetes, blood pressure etc, using the booklet
6	Develop and promote a discount scheme for serving personnel (both full time and reservists) for arts and leisure facilities in Reading	RBC/ ROSO 7 Rifles	Promotion summer 2013	**ACHIEVED** • Scheme developed and in place for leisure centres • Delivery of scheme via the Defence Discount Scheme being considered for leisure centres • Use of 'tickets for troops' by Hexagon
7	Consolidation of appropriate contact/ support lists in order to provide better signposting	ROSO 7 Rifles/ RBC	2014	**ACHIEVED** Reading Borough Council website includes key support contacts at: http://www.reading.gov.uk/article/7300/Reading-Armed-Forces-Community-Covenant

Ref	Outcome	Responsibility	Timescale	Progress June 2018
ECONOMY AND SKILLS - *Enhance the economic prosperity of Service personnel (including reservists), their families, and Veterans whilst benefitting the local economy wherever possible*				
Integrate: *Ensure Armed Forces benefit from ongoing economic development in county*				
Support: *Facilitate a sustainable pathway for Service leavers into civilian employment*				
8	Keep local authorities and business updated on re-structuring of Defence	ROSO 7 Rifles	ongoing half yearly	• Briefing provided at March 2018 working group meeting; 7 Rifles actively recruiting
9	Work with local businesses to encourage employment of Service leavers and Reservists	Reading UK CIC/ Jobcentre Plus/	ongoing	• JCP promoting Veterans Interview Programme to employers; promoting relevant employer events; circulating requests from employers for Service leavers; ongoing briefing sessions between 7 Rifles and JCP (including Back to Work Programme and Armed Forces Employment Pathways Scheme) • MOD employer engagement strategy to promote to employers the value of employing Reservists • 7 Rifles work with Gravity Personnel to promote the benefits of recruiting Reservists • UK CIC and Business Improvement District newsletters promotion of benefits of employing Reservists • 7 Rifles presence at Hexagon job fair Oct 2017; Reading College job fair March 2018
10	Encourage Jobcentre Plus to register Veterans	Jobcentre Plus	ongoing	• Jobcentre Plus systems allow recording of Veteran status, though for JSA claimants only, but advisors are finding that interview times are becoming shorter with less opportunity to ask additional questions, therefore monitoring is incomplete • Ongoing briefing sessions between 7 Rifles and JCP
11	Promote the Armed Forces (Regular and Reserve) as a career for the residents of Reading,	Reading UK CIC/ 7 Rifles/ Jobcentre Plus	ongoing	• Regular recruiting activities in Oxon, Bucks and Berks in support of Operation Fortify recruiting initiative • JCP advisors kept up to date with Armed Forces vacancies, and promote Army Reserve generally

Ref	Outcome	Responsibility	Timescale	Progress June 2018
	particularly young people Not in Education, Training or Employment			• MOD employer engagement strategy • Ongoing briefing sessions between 7 Rifles and JCP • 7 Rifles presence at Hexagon job fair Oct 2017; Reading College job fair March 2018
12	Support Service leavers, former Armed Forces personnel and reservists to access careers guidance, CV support and interview preparation courses	Jobcentre Plus / New Directions/ other partners	ongoing	• SERFCA have set up jobs4reservists website, promoted via Reading UK CIC e-news • New Directions offer an employability course in partnership with JCP, covering employability and essential IT skills - for Universal Jobmatch, CV creation, job applications and interview preparation • Advice and support contacts promoted via RBC Armed Forces Covenant web page: (www.reading.gov.uk/reading-armed-forces-community-covenant) and new Armed Forces Covenant website: (www.armedforcescovenant.gov.uk)
13	Defence discount service/ card	Reading UK CIC	2014/15	• Awareness raised with Business Improvement District businesses • A number of large companies with Reading branches already signed up to scheme
14	Promotion of relevant events to businesses/ employers	Reading UK CIC/ROSO 7 Rifles/Jobcentre Plus	ongoing	• JCP and Reading UK CIC general promotion of relevant events • Sandhurst Leadership Challenge (employers) March 2017, March 2018 and Sept 2018 • Hexagon job fair Oct 2017; Reading College job fair March 2018
15a	Development of Reading Borough Council protocol for employment of Reserve Forces personnel	RBC	March 2014	**ACHIEVED** Agreed at Personnel Committee March 2014
15b	Promotion of Armed Forces Covenant to employers	RBC/ Reading UK CIC/ Covenant partnership	ongoing	• Article in Reading UK CIC e-News • Ongoing work with MOD Defence Relationship Management to engage employers • RBC awarded Employer Recognition Scheme bronze award July 2017
16	Survey schools to determine numbers of Service family pupils and ensure schools maximise	RBC/ Schools in Reading Borough area/ 7 Rifles	annual survey (next due Jan 15)	• Latest figures (Jan 18, School Census) - no service children in Reading schools • Best practice examples of how service pupil premium spent in other areas to be circulated to schools

Ref	Outcome	Responsibility	Timescale	Progress June 2018
	the value of the Service Pupil Premium by encouraging registration and promoting best practice in utilisation of funding			
17	Being sensitive and supportive to the possible emotional and psychological needs of some Service children	RBC/ Schools in Reading Borough area/ 7 Rifles	ongoing	Reminder to encourage parents to inform school of Armed Forces status sent to schools in Autumn 16
ENVIRONMENT AND INFRASTRUCTURE - *Ensure that the wider Armed Forces' infrastructure requirements (inc Housing) are met in synchronisation with the Defence Infrastructure Organisation (DIO) and cognisant of the requirements of the local community. Where possible, create efficiencies with the local community*				
Support: *Develop a common understanding of infrastructure needs of the Armed Forces community, in order to inform Local Authority planners to optimise provision. This incorporates a common, equitable housing protocol for Veterans within the local area.*				
18	Develop and implement a plan for the identification of Veterans locating to the Reading area in order to ensure that they are informed and included in relevant initiatives	ROSO 7 Rifles / RBC/ charities	ongoing	• Some Veterans claiming JSA can now be identified and support offered • Support, initiatives and opportunities disseminated via charities' existing mechanisms (e.g. SSAFA, RBL, Reading Ex-British Gurkha Association, Forgotten British Gurkhas) • Total number of veterans in Reading difficult to ascertain; around 380 residents are in receipt of armed forces pension (a proxy measure for veteran numbers).
19	Ensure Veterans receive equitable treatment in allocation of social housing	RBC	ongoing	**ACHIEVED** • Incorporated into Reading Borough Council's Housing Allocations Scheme • 66 households have been given additional priority for housing via the Housing Register since 2011; 25 currently on the register (March 2018)
20	Explore options for facility sharing in line with local needs and Defence	PSAO HQ Coy 7 Rifles/ RBC	ongoing	• Greater use of Brock Barracks for community purposes agreed and promoted via alternativevenues.org • Promoted to community groups via Reading Voluntary Action newsletter

Ref	Outcome	Responsibility	Timescale	Progress June 2018
	Infrastructure Organisation plans			and Reading Borough Council website
SAFER AND STRONGER COMMUNITIES - *Develop a stable and robust Armed Forces community which integrates into the wider society, whilst retaining a sense of itself*				
Integrate: *Promote common understanding and closer integration between military and civil communities*				
21	Ensure that appropriate links are in place between the Local Authority and Armed Forces in order to allow the effective activation of Military Aid to the Civil Community (MACC) in the event of a civil emergency (e.g. severe weather event) and/ or community projects where manpower is required	RBC/ X0 7 Rifles	ongoing	• Civil emergency liaison in place • Armed Forces assistance during flooding events in 2014
Support: *Support civil agencies in their dealings with members of the Armed Forces community, in order to optimise outcomes and use resource more efficiently*				
22	Establish and implement domestic violence protocol between Service and Civil Police, agencies and charities to recognise military needs and ensure equitable service	ROSO 7 Rifles	ROSO to advise	**ACHIEVED** Protocol in place
23	Identify key areas for application of Community	RBC/Covenant partnership/	Ongoing	• Grant fund promoted on RBC website and via Reading Voluntary Action • Successful bid for £21,730 for 'health weeks' project aimed at raising

Ref	Outcome	Responsibility	Timescale	Progress June 2018
	Covenant grant funding which will benefit both the civil and Armed Forces communities	ROSO 7 Rifles		awareness of health and social care services amongst the ex-Gurkha community, December 2012 • Successful bid for £10,000 for museum centenary project, December 2013 • New Covenant grant fund launched Aug 2015 • Successful bid from REBGA for two Nepalese community development workers (£14,500) • Successful bid from SSAFA for funding to update, develop and print copies of a health booklet translated into Nepalese (£1,000)
24	Encourage organisations and communities to sign up to the Armed Forces Community Covenant	RBC/ Covenant partnership/ ROSO 7 Rifles	Ongoing	• Signatories include Thames Valley Chamber of Commerce, Reading College and University of Reading • Ongoing work with MOD Defence Relationship Management to engage employers
RECOGNISE AND REMEMBER - *Encourage recognition and remembrance of the unique sacrifices made by Armed Forces personnel in defence of society*				
***Recognise**: Support civil events that allow the community to recognise the Armed Forces*				
25	Support the annual Armed Forces Day	PSOA HQ Coy 7 Rifles/RBC	Annual (June)	• Armed Forces Day planned for 30th June 2018 in Broad St and Forbury Gardens; flag raising at the Civic Offices • Reserves Day 27th June 2018
26	Armed forces participation in public events as appropriate	RBC/ PSAO HQ Coy 7 Rifles (PSOA HQ Coy)	ongoing	• Carol concert at St Georges church in December 2017, planned again for 2018 • Numerous recruiting and other community events throughout the year
***Remember:** Commemorate those members of the Armed Forces who have made the ultimate sacrifice*				
27	Plan and conduct remembrance event at Brock Barracks as focal point for annual armistice event in Reading	PSAO HQ Coy 7 Rifles	ongoing	Event planned for Nov 2018 in Forbury Gardens

Ref	Outcome	Responsibility	Timescale	Progress June 2018
28	Plan and conduct appropriate event(s) in support of the centenary anniversary of the outbreak of the First World War	RBC/ Adjt 7 Rifles/ communities	Aug 2014 - 2018	• Successful bid submitted to Community Covenant Grant Fund by Museum service for funding to support their forthcoming exhibition,' Reading at War', to mark the centenary of the beginning of the First World War • Royal British Legion commemoration services on 6th July and 4th Aug 2014 at Reading Minster • Operation Reflect activities including 7 Rifles visits to 5 primary schools • Commemorative paving slabs for home towns of Victoria Cross winners, placed with Trooper Potts VC Memorial • Trooper Potts VC Memorial unveiled in October 2015 outside the Crown Courts in Reading

List of abbreviations

SSAFA – Soldiers, Sailors and Airmen Families Association
SERFCA – South East Reserve Forces and Cadets Association
ROSO – Regimental Operations Support Officer
RBC – Reading Borough Council
NHS – National Health Service
GPs – General practitioners
JCP – Jobcentre Plus
CCGs – Clinical Commissioning Groups
MOD – Ministry of Defence
JSA – Job Seekers Allowance
TBC – to be confirmed
AF – Armed Forces
BID – Business Improvement District
PSAO HQ Coy – Permanent Staff Admin Office HQ Company
TM or TM(V) – Training Major
CCRF- Civil Contingency Reaction Force
CIMIC – Civil Military Corporation
Adjt – Adjutant
RMO – Regimental Medical Officer

READING HEALTH AND WELLBEING BOARD

DATE OF MEETING:	**13 JULY 2018**	**AGENDA ITEM:**	**18**
REPORT TITLE:	**INTEGRATION PROGRAMME UPDATE**		
REPORT AUTHOR:	**MICHAEL BEAKHOUSE**	**TEL:**	**01189 373170**
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ORGANISATION:	**READING BOROUGH COUNCIL / NORTH, WEST AND SOUTH READING CCGs**		

1. PURPOSE OF REPORT AND EXECUTIVE SUMMARY

1.1 The purpose of this report is to provide an update on the Integration Programme – notably, progress made within the Programme itself, as well as the overall performance against target against the national BCF targets for the financial year 2017/2018.

1.2 Of the 4 national BCF targets:

- Performance against two (limiting the number of new residential placements & increasing the effectiveness of reablement services) is strong, with key targets met.
- We have not reduced the number of delayed transfers of care (DTOCs) in line with our targets, but DTOC rates since October have shown a strong downwards trajectory which represents very positive progress.
- We have not met our target for reducing the number of non-elective admissions (NELs), but work against this goal remains a focus for the Berkshire West wide BCF schemes.

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 (DTOCs) as well a number of national conditions that partners must adhere to (including reducing the number of

non-elective admissions to hospital; reducing admissions to residential accommodation; and increasing the volume of individuals remaining at home 91 days after receiving reablement services).

4. BCF PERFORMANCE UPDATE

4.1 Please note the following in relation to performance against our national BCF targets:

DTOC

4.2 Under our 3.5% trajectory, we have aspired to no more than 240 bed days lost per month from September 2017 through to the end of March 2018.

4.3 We have not been able to meet our DTOC targets per month.

4.4 However, it is worth notice that since October there has been a decline in DTOCs per month, with 710 days lost in October, 661 in November, 493 in December, 435 in January, 413 in February and 374 in March (with a slight increase to 421 in April).

4.5 The figures of 493, 435 and 413 (a trajectory of 6.3%, 5.7% and 5.5% respectively) also represent the lowest number of DTOCs recorded in the financial year to date, and are the lowest reported number of DTOCs since April 2016 (in which 393 were reported). March's performance of 374 is lower even than that.

4.6 In terms of our local schemes' impact on the DTOC rates:

- *Community Reablement Team (CRT)* - the service appears to have engaged with 86 clients referred by acute hospital settings across the financial year. Consequently it would appear that the service may have prevented and/or reduced the impact of 86 delayed transfers of care. Given that the average length of stay in the service is 3.06 weeks (or 21.42 days), it would appear that this equates to 1842.12 delayed days avoided. Assuming a cost of £400 per NHS bed/day, this would equate to cost avoidance of £ 736,848.

- *Discharge to Assess (D2A)* - the service has engaged with 78 clients referred by acute hospital settings. Consequently it would appear that the service may have prevented and/or reduced the impact of 78 delayed transfers of care. Given that the average length of stay in the service is 4.5 weeks (or 31.5 days), it would appear that this equates to 2457 delayed days avoided. Assuming a cost of £400 per NHS bed/day, this would equate to cost avoidance of £ 982,800.

4.7 We believe that a number of factors have impacted on the DTOC performance, such as - severe winter pressures; reductions in the volume of available home care; and sometimes-limited capacity in reablement services (which is linked to the difficulties in sourcing home care for people who are ready to leave reablement services, thereby creating capacity issues for new referrals from hospitals).

4.8 We continue to proactively address DTOC performance through our the High Impact Model (HIM). We recently partook in a Local Government Association-led Peer Review of our HIM and based on the feedback, have begun collaborating with neighbouring authorities to ensure we are maximising opportunities for integration and sharing best practice in the course of implementing the High Impact Model.

Residential Admissions

4.9 Our target is to have no more than 116 new residential admissions for older people.

4.10 Based on our performance in the year to date we have had 112 new residential admissions in the financial year.

4.11 In terms of our local schemes' impact on the rate of residential admissions:

- *D2A* - 21 clients were living at home prior to entering the service, and of these 13 did not go on to a residential or nursing placement after leaving the service. The service therefore appears to have prevented 13 entrances into residential care.

4.12 This target has therefore been met (based on year-end data available at the current time).

Reablement

4.13 Our target is to maintain an average of 88% of people remaining at home 91 days after discharge from hospital into reablement / rehabilitation services; and to see 1195 people engaging with reablement (representing a 30% increase in the number of people accessing the service, compared to figures from 2016/17, during which 919 used the service).

4.14 Based on our performance to date, we have achieved an average of 93% of service users remaining at home 91 days after discharge from hospitals into our Community Reablement Service. We have also engaged with 1122 clients within our Community Reablement Service to date.

4.15 This target has therefore been met (based on year-end data available at the current time).

Non-Elective Admissions (NELs)

4.16 Our BCF target is to achieve a 0.97% reduction (expressed as 142 fewer admissions) against the number of NEL admissions seen in 2016/2017. This equates to a target of no more than 14,483 NELs in 2017-2018.

4.17 Based on our most recent performance data, we have seen 15,339 NELs across 2017-2018. This equates to an increase of 714, or 4.9%.

4.18 This target has therefore not been met.

4.19 However, in terms of the local versus national position on NELs the 4 Berkshire West CCGs are in the top 10 out of 211 CCGs for lowest numbers of NELs.

4.20 In terms of our local schemes' impact on the rate of NELs:

- *CRT* - by engaging with 126 "rapid referrals" (clients who are seen prior to hospital admission, hopefully negating the need for a non-elective admission), the service has potentially prevented up to 126 NELs[1].

- *D2A* - by engaging with 17 "rapid referrals" (14 of which did not progress onwards to hospital following discharge from the service), the service appears to have prevented 14 NELs.

[1] *Please note that further analysis is required to determine how many of these clients were subsequently admitted to hospital, in order to calculate the exact impact the service has had on NELs.*

4.21 Further actions to improve NEL performance are being progressed by the Berkshire West 10 Integration schemes that are designed to reduce NELs.

Additional local performance updates.

4.22 Please note the following successful areas of performance within CRT:

- The service aimed to support 48 "rapid referrals" across the financial year. Instead, the service has supported 126 "rapid referrals".
- The service aimed to ensure that 90% of service users found the service to be "satisfactory" or "very satisfactory". The service delivered a 99% satisfaction rate.
- The service aimed to ensure that no clients exceeded a 6 week stay with the service. On average, clients stayed with the service for 3.06 weeks.
- Please see 4.6 above for additional information re. the service's impact on DTOC rates; and 4.20 above for additional information re. the service's impact on NEL rates.

4.23 Please note the following successful areas of performance within D2A:

- The service aimed to support 88 clients across the year. Instead, the service supported 108 clients.
- The service aimed to ensure that 58% of clients remained at home 91 days after leaving the service. Based on year-end data, 75% of clients remain at home 91 days after departing the service.
- The service aimed to support 12 "rapid referrals" across the financial year; and instead supported 17.
- The service aimed to ensure that no clients exceeded a 6 week stay with the service. On average, clients stayed with the service for 4.5 weeks.
- The service aimed to have no more than 60 clients per annum readmitted to hospital following departure from the service; only 29 clients were readmitted.
- The service aimed to ensure that 90% of service users found the service to be "satisfactory" or "very satisfactory". The service delivered a 93% satisfaction rate.
- The service aimed for a 75% return rate when issuing service user feedback forms; and instead generated a 78% return rate.
- Please see 4.6 above for additional information re. the service's impact on DTOC rates; and 4.20 above for additional information re. the service's impact on NEL rates.

5. PROGRAMME UPDATE

5.2 Since March, the following items have been progressed:

- Following recruitment, 1x FTE **Performance & Data Analyst** is now in post.
- **Value for Money reports** continue to be submitted to Reading Integration Board in respect of key BCF-funded schemes. These outline the extent to which the funded

services have delivered against their remits. As part of this work, we have revised several targets for the BCF-funded CRT and D2A services, and have set more challenging goals to reflect and build upon their achievements outlined in 4.22 and 4.23 above.

- **Joint working between Adult Social Care (ASC) and North/West and South Reading GP Alliances** – an initial scoping document has been produced which outlines the standard operating procedures for a 6 month pilot, alongside a set of performance targets. Under the pilot, a multi-discipline team will be assembled comprised of representatives from Adult Social Care, Community Nursing, GPs, Primary Care, the Community Mental Health Team, Public Health and the Voluntary Sector. Monthly multi-disciplinary team (MDT) meetings will jointly review clients/patients who are referred to the MDT – with a focus on clients who are or have experienced:

    - A decline in functional Activities of Daily Living (ADL's)
    - Falls or who are at risk of falls
    - Social isolation or recent dependence on crisis social support/re-ablement or any long term social support in the last 6 months
    - Dementia or severe and enduring Mental Health illness where it is not their primary issue
    - Severe and enduring Long term conditions
    - Patients on multiple medications
    - Two or more unplanned admissions to acute hospital or intermediate care facility in previous 6 month
    - Patients who make frequent appointments with GP that could be resolved through other professionals
    - Frequent call outs to SCAS which do not need action or conveyance

    The pilot will commence in August 2018 and aims to bring key professionals together to assist in communication and prevent duplication of work, by providing a forum for multi-disciplinary discussion, risk assessment and comprehensive care planning. This will ensure that all members are valued as equal partners, while reducing the likelihood of peoples' care needs being missed. The pilot aims to produce the following outcomes:

    - Jointly support 84 clients/patients
    - Reduce the number of non-elective admissions for those clients/patients who are supported by the MDT process (based on a comparison of the number of NELs generated pre-engagement compared with post-engagement).
    - Reduce clients/patients' need to engage with primary care services (based on a comparison of the volume of primary care engagement generated pre-MDT compared with post-MDT).
    - Reduce the number of safeguarding referrals for clients/patients who are supported by the MDT process (based on a comparison of the number of safeguarding referrals generated pre-MDT compared with post-MDT).

- Conversations with stakeholders are ongoing regarding new methods of **delivering reablement** within Reading.

- Completing the year-end NHS England and iBCF/DCLG data returns for the BCF.

- Conversations with NHS England to understand national expectations regarding "**Integration by 2020**".

- Analysis of Jeremy Hunt's first speech as Health & Social Care Secretary, to understand the "**7 Key Principals**" that are likely to underpin the forthcoming Green Paper.

- Conversations with stakeholders to begin generating ideas for meeting the NHS England expectations & delivering against Jeremy Hunt's 7 Key Principals.

6. NEXT STEPS

6.1 The planned next steps for the Summer include:

- Overseeing the redesign of the BCF dashboard to provide additional clarity on the impact made by the BCF-funded schemes.
- Supporting further Berkshire West-wide discussions and working groups concerning the Berkshire West-wide implementation of the High Impact Model.
- Piloting the joint working arrangements between Adult Social Care and the North/West and South GP Alliances.
- Continuing to explore and pursue new ways of delivering reablement services.
- Developing a draft set of high-level proposals for what "wider integration" could look like (in line with Jeremy Hunt's and NHS England's expectations).

Future BCF targets for 2018/2019

6.2 NHS England have recently provided details of the proposed DTOC targets for 2018/2019. Based on a revised methodology for calculating DTOC trajectories, Reading's proposed target is to have no more than 419.75 bed days lost per month from September 2018 onwards; and to be actively working toward achieving this target between now and September 2018. Based on our recent performance, we have been frequently meeting this target.

6.3 Please note that at the current time this target is still at the "proposal" stage and has not yet been finalised. The 2018/2019 target will be confirmed in the publication of the BCF Operating Guidance for 2018/2019; which will also explain how Localities can propose changes to the additional (non-DTOC) BCF metrics (should they wish to do so).We understand that the Operating Guidance is due to be published in July 2018.

7. CONTRIBUTION TO STRATEGIC AIMS

7.1 While the BCF does not in itself and in its entirety directly relate to the HWB's strategic aims, Operating Guidance for the BCF published by NHS England states that: *The expectation is that HWBs will continue to oversee the strategic direction of the BCF and the delivery of better integrated care, as part of their statutory duty to encourage integrated working between commissioners* […] *HWBs also have their own statutory duty to help commissioners provide integrated care that must be complied with.*

8. COMMUNITY & STAKEHOLDER ENGAGEMENT

8.1 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".

8.2 In accordance with this duty, the Project Manager has met with Healthwatch to review and refine the existing service user engagement metrics set against the CRT, Discharge to Assess and High Impact Model schemes services, to ensure that they reflect best practice.

Meetings are ongoing to identify potential ways of improving service user feedback mechanisms.

8.3 Additionally, the Programme Manager will be meeting with Healthwatch in early May to discuss potential ways of satisfying NHSE's and Jeremey Hunt's additional expectations regarding service user engagement in the future.

9. EQUALITY IMPACT ASSESSMENT

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

10. LEGAL IMPLICATIONS

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

11. FINANCIAL IMPLICATIONS

11.1 There was a slight underspend on BCF overall of £57,292 which represents less than 0.5% of the funding. This was made up of an overspend on the CCG components of BCF of £64k and an underspend on the LA components of BCF of £121k. The overspend on CCG components will be covered by the CCG and the underspend on LA items will, subject to agreement with the CCG, be carried forward to 2018-19 in line with provisions of the s75 agreement, for use on Better Care Fund priorities.

12. BACKGROUND PAPERS

12.1 N/A