Reading Borough Council
Working better with you

HEALTH AND WELLBEING BOARD

15 MARCH 2024

ADDITIONAL INFORMATION

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READING BOROUGH COUNCIL

HEALTH & WELLBEING BOARD **15 MARCH 2024**

QUESTION No. 1 in accordance with Standing Order No 36

Jamie Gordon to ask the Chair of the Health & Wellbeing Board:

ADHD Assessment & Support

Hello, my name is Jamie & I am an ambassador for ADHD UK in Reading.

My question today relates to Attention Deficit Hyperactivity Disorder, the lack of post diagnostic support for individuals with ADHD & the wait time from when a person firsts speaks to their GP about ADHD until they receive confirmation of an ADHD assessment.

Adults with ADHD are five times more likely to take their own life than those without ADHD.

One quarter of women with ADHD have tried to take their own life.

One in 10 men with ADHD have tried to take their own life.

It is believed that 25% of adults in the criminal justice system have ADHD compared to 2.5 adults in the general population.

In Berkshire there is a 3-year waiting list from when an adult or child discusses ADHD with their Dr to when they are granted an assessment

If someone is coming to Berkshire from elsewhere in the country there is an additional 2 year waiting list for a medication review that determines wither your original diagnosis is recognised or not. It is a similar story for those who chose to go for a private assessment.

So, my questions for the panel today are:

- *To what extent are you aware of these problems?*
- *What is being done to raise awareness across all sectors about these issues?*
- *Is there anything being done to tackle the 3 year waiting lists for ADHD assessments amongst adults and children?*

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

Waiting times

Below is the picture Berkshire wide. Waits can vary as some assessments will be prioritised due to high levels of clinical need or risk.

Children/Young People ADHD - at the end of February

- 10% have been waiting for more than 2 years
- The average wait for those who were seen in February was 104 weeks

Adult ADHD - of those seen 2023-24 to date

The majority of those seen (59%) had a wait of 2-3 years, with 33% waiting less than 2 years. However 8% waited longer than 3 years.

Transfer from another NHS provider or from a private provider

When a child/young person or adult (taking ADHD medication) transfers from another NHS provider or wishes to move their care to the NHS from a private provider, the assessment report

is reviewed. Providing it contains all of the information we need; the wait for a medication appointment will be up to 18 months for children/young people and over a year for adults. If the report does not contain all of the information required to make decisions about medication, then the wait will be the same as for a new assessment. The GP will usually be able to continue prescribing ADHD medication while they wait for the appointment. Unfortunately, we are not able to prioritise appointments on the basis of a private provider having started ADHD medication. When a private provider initiates medication, the responsibility for monitoring and reviewing this remains with them until we can offer an appointment.

To what extent are you aware of these problems?

The system is very aware of the issues affecting ADHD services. Referrals have long outstripped the service capacity and this has resulted in large numbers waiting and long waits. This is a national picture with services across the country facing similar pressures and waits being measured across the country in years (with waits of up to 10 years being reported in some cases). This has combined with additional pressures from Covid-19 and a national shortage of qualified staff. The recent global shortage of ADHD medication has also placed additional pressures on the services. The service understands how difficult waits can be for children/young people and adults, and reducing the waiting time remains a top priority, with a great deal ongoing work. It is essential for Berkshire Healthcare, Buckinghamshire, Oxfordshire and Berkshire Integrated Care Board (BOB ICB) and system partners to work together to respond to the challenges.

What is being done to raise awareness across all sectors about these issues?

We work in the system to emphasise the importance of early needs led support, which does not need to rely on or wait for an assessment. In terms of the support on offer, we are fortunate that in Berkshire much of the same support and advice that is available after a diagnosis is also available before an assessment.

Children and Young People: Our website has "Getting Help Now" information for families and this is also sent out. In the west of Berkshire, the NHS commissioned Children and Young People's autism and ADHD support service is delivered by Autism Berkshire and Parenting Special Children and provides a wide range of support including advice, workshops and courses which are all available to families at any point. Further information is available on their website: https://www.autismberkshire.org.uk/berkshire-west-autism-adhd-support-service/

NICE Guidelines recommend parent advice and training programmes following an ADHD diagnosis and families are in fact able to access this even prior to an assessment through this service and this includes a series of linked workshops:

- *Workshop 1*: Introduction to ADHD: What is ADHD/Challenges & concerns/Strengths and opportunities/Signposting to support
- *Workshop 2:* Anxiety and ADHD: What is anxiety/What is the relationship between ADHD and anxiety/Coping strategies for children/young people and parents/carers
- *Workshop 3:* Managing ADHD Behaviours: Attention Deficit Behaviours/Hyperactive Behaviours/Impulsive Behaviours/Behaviour Management Strategies

We also emphasise the need to provide support as early as possible as the young person's needs will be the same the day after an assessment as the day before. This includes free PPEPcare training to empower settings to understand and meet needs. Neurodiversity newsletters provide updates to families and other stakeholders.

The Adult ADHD service offers signposting to online support guides that offer behavioural and psychological strategies to support ADHD symptoms (including education, work, sleep, managing mood, relationships etc) and an on demand webinar. All of these resources are available at any point (including prior to assessment or without a referral).

System collaboration: Berkshire Healthcare has also been collaborating with other service providers across the region to share learning and innovation to respond to the challenges that are being faced by all services. Within Buckinghamshire, Oxfordshire and Berkshire Integrated Care Board (BOB ICB) we have projects underway for both children/young people and adult ADHD services to determine the most effective assessment models and pathways. This includes the role of Artificial Intelligence in supporting assessments and a pilot of Spencer3D in schools (digital tool to profile and support identified needs in school settings which can happen with or without assessment or referral).

Is there anything being done to tackle the 3 year waiting lists for ADHD assessments amongst adults and children?

An ongoing programme of quality improvement and service transformation is in place. In addition both children/young people's and adult services have worked in partnership with private providers to increase the number of appointments offered. However, referrals have also increased.

Below is some of the work currently underway:

Children and Young People's ADHD

- **Increasing capacity:** Despite the national shortage of qualified staff, the service has been able to recruit to a number of new posts. We have also offered a number of weekend clinics.
- **Quality Improvement:** Current projects include improvements to the referral process, reducing DNAs, concluding assessments in as few appointments as possible, ongoing review of processes to identify and implement ways to further increase productivity (while providing good clinical quality and family experience, automating tasks to release more clinical and administrative capacity; ongoing review of skill mix required for tasks to reduce the impact of the national shortage of qualified professionals.

Adult ADHD service

- **Referral and triage process:** The Adult ADHD and Autism triage process ensures that clients referred to the service are provided with avenues for support as well as links to support with mental health to all clients referred to the service.
- **Reducing wait for annual ADHD medication review:** additional short term funding has been provided to reduce the wait for an annual medication review.
- **Quality improvement:** current projects include improving the transition for CYP (to reduce waits to be seen after transfer to the adult service and improve support and experience)

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Community Wellness Outreach Programme

A collaborative programme across Berkshire West

Reading specific Model

Bev Nicholson

Integration Programme Manager

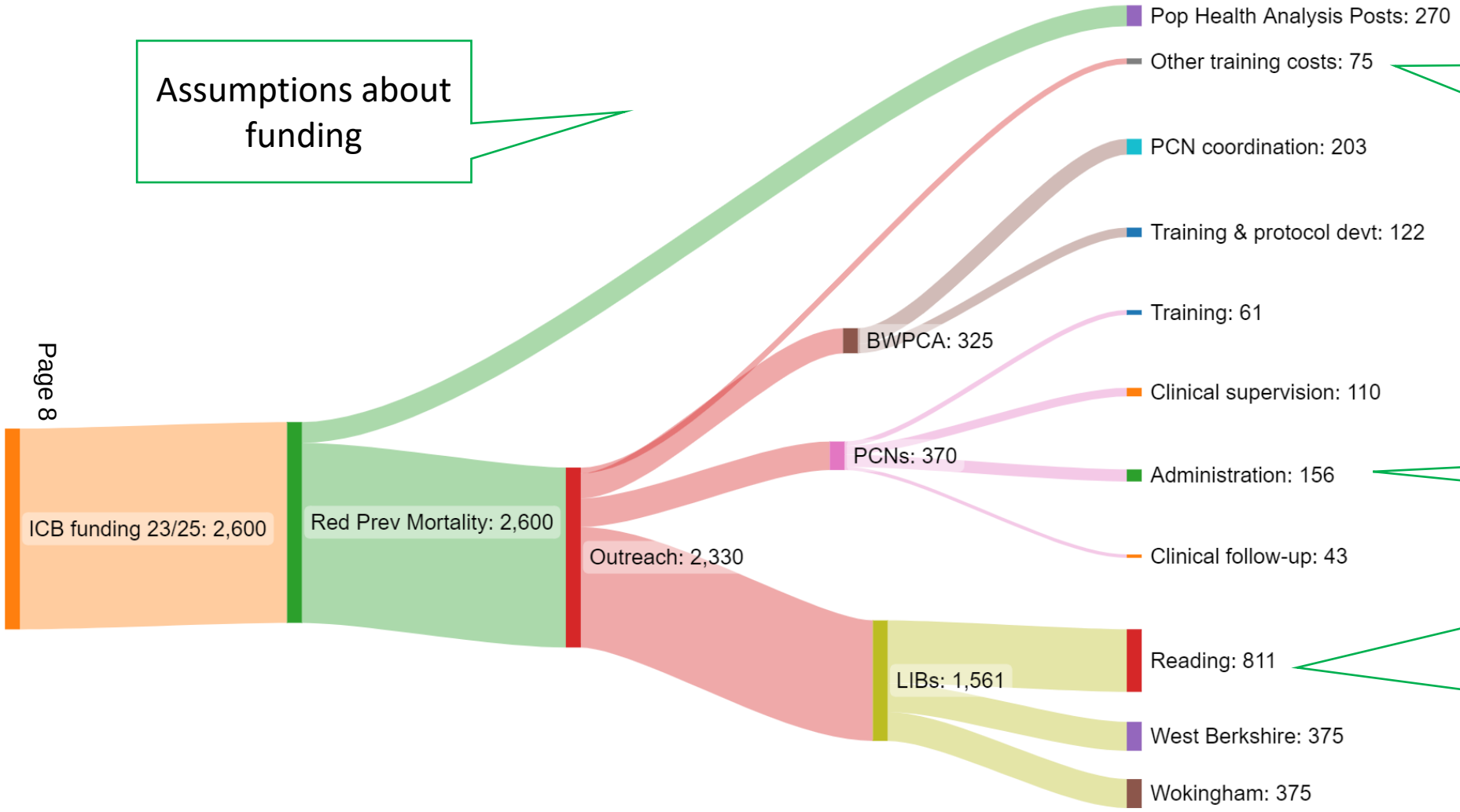
March 2024

Funding

Buckinghamshire, Oxfordshire and Berkshire West
Integrated Care Board

Analysis and dashboards

Assumptions about funding



Link with Reading University for core clinical Health Checker modules and a range of providers for Behaviour change training.

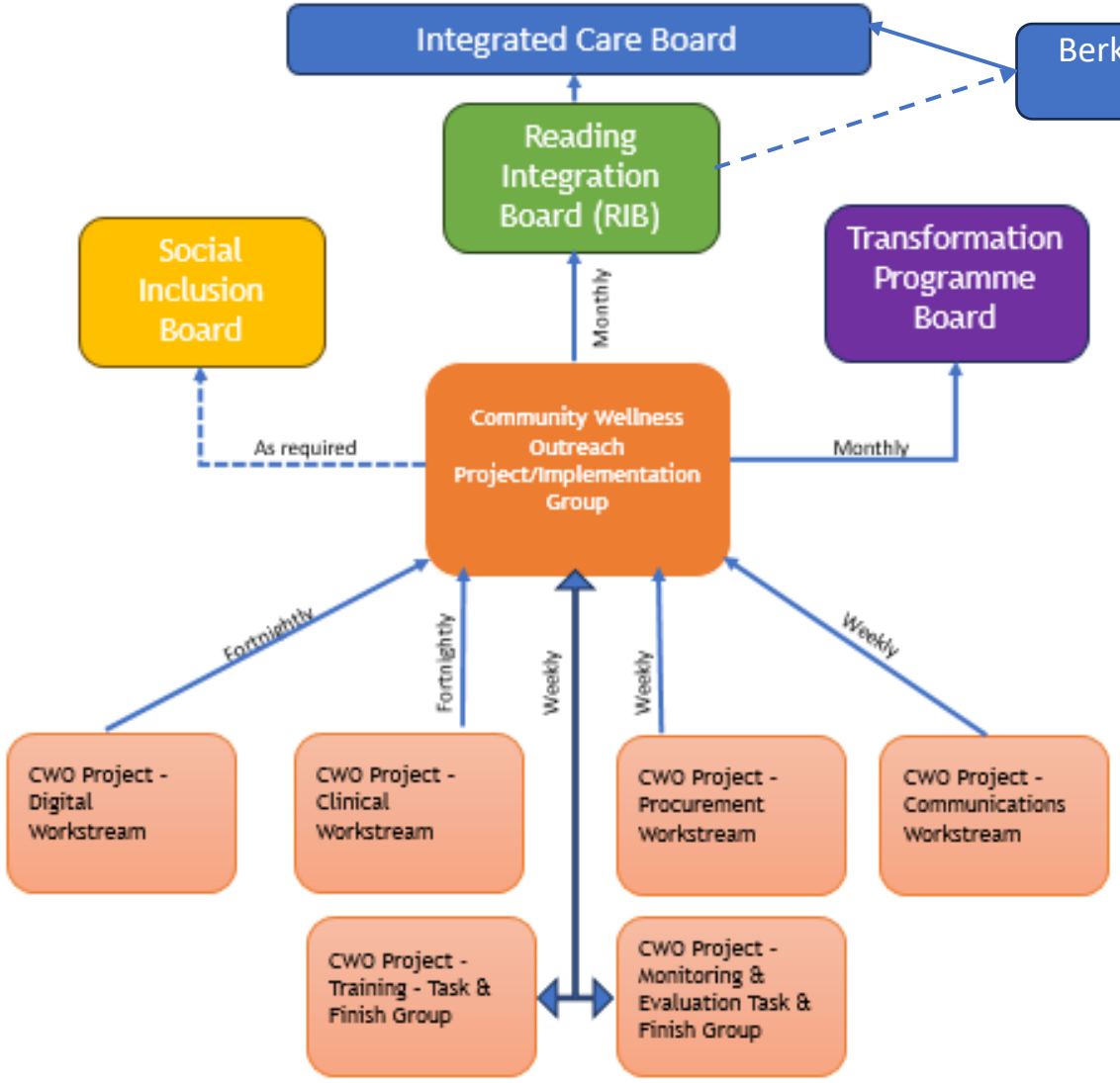
Case finding, Invitation and Follow up

Received over two years, first lump sum to be invoiced for Q3 2023/24 and second in Q4 2023/24. Year 2 (2024/25) funding to be invoiced quarterly to ICB. Funding pooled into BCF Schedules 1 and 3 of S75 Agreement

The Community Wellness Outreach project will run up to 30th June 2025

(extended from 31st March 2025)

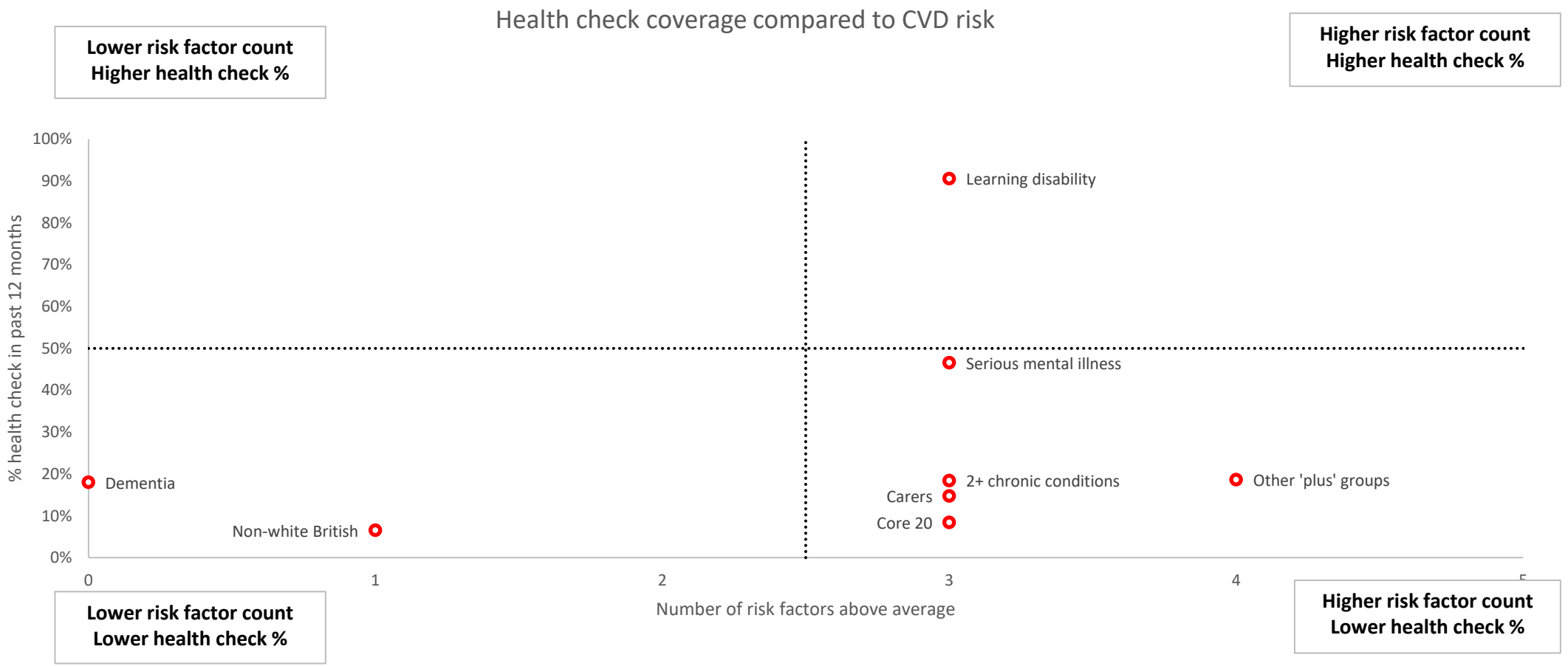
Governance



Community Wellness Outreach Project - Governance Structure

Note: Workstreams and Task & Finish Groups combining under the overall Project Update Meeting from March 2024

Health Check Data (Reading)



The Primary Care Alliance and GPs have limited capacity to deliver the NHS Health Checks required and our local data shows a low rate for NHS Health Checks in many of the GP Surgeries across Reading. We also know that there are people in our communities that do not attend a GP for a variety of reasons and may also be within the focused “Core 20 Plus 5” group i.e. “Those identified in System Insights as being on any of the following lists; Homeless, learning disability, left military service, refugee or asylum seeker, released from prison, requires support to communicate, social isolation”

Community Outreach Delivery Method

We were asked to implement an outreach service rapidly in order to start reaching into our communities to deliver NHS Health Checks primarily to address the risk of Cardiovascular Disease. We have worked alongside our neighbouring Local Authorities in West Berkshire and Wokingham, leading the project and sharing across Berkshire West aspects of the programme that will be beneficial to all and ensuring consistency. There will be some slight differences in the delivery of the health checks in each location which will enable comparison of the different models at the end of the programme.

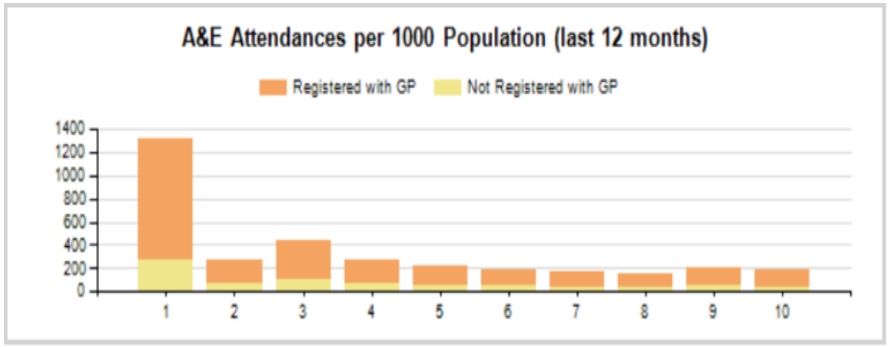
The Royal Berkshire Hospital, Patient Engagement and Experience Team (PEET) were already running a programme in our communities working in collaboration with Reading Voluntary Action (RVA) to provide mini–Health Checks. We worked with them to identify what additional resource and equipment would be needed to scale up this scheme to delivering the full NHS Health Check and to support the voluntary and community sector partners to provide the wrap around Wellbeing support, such as debt and benefits advice, mental health support, and lifestyle behavioural change such as smoking cessation, weight management and exercise through the JOY platform for Social Prescribing.

The Programme is available to all people over the age of 18 and will prioritise people from communities and groups that may be more disadvantaged and have not had any Health Checks or identified long term conditions.

Why is engagement important?

Royal Berkshire NHS Foundation Trust

1) Data shows that those in lower deciles on the Deprivation Index:
   - Are significantly more likely to attend A&E.
   - Are more likely to be admitted as inpatients.
   - Are more likely to have longer waits for outpatient appointments.
   - Are more likely to 'do not attend' (DNA) appointments.



2) We know particular community groups are disproportionately affected in their experience of health care.
   - More likely to have a poorer patient experience.
   - Find it harder to access our services
   - Need our services adapted to meet their needs.

Source: Presentation by Meet PEET to RBH Board (January 2024)

Web page for calendar of events

12 March 2024

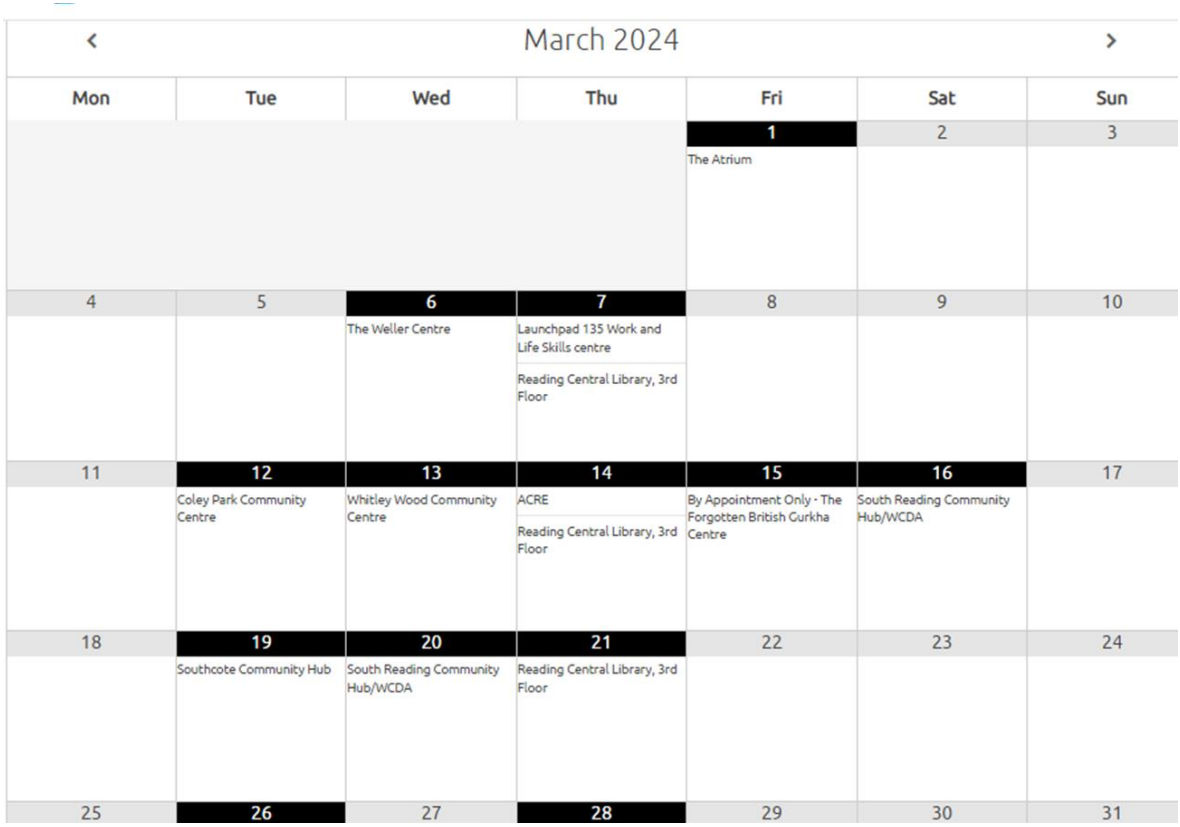
Coley Park Community Centre
140 Wensley Road RG1 6DW
10.00 am - 2.00 pm
This community centre is served by the No 11 bus. A few car parking spaces are available on site, or park in nearby streets. Enter through the double doors.

13 March 2024

Whitley Wood Community Centre
Swallowfield Drive, RG2 8UH
9.00 am - 1.00 pm
The centre is served by the No 6 bus, bus stop Engineers Court.Car park available on site, drive down Copenhagen Close, car park on the right.

14 March 2024

ACRE
344 Oxford Road RG30 1AF
9.00 am - 1.00 pm
How to find us: On Oxford Road, go through the blue gates underneath the old Battle Hospital sign. This hub is served by the No 15, No 16 and No 17 buses, bus stops Beresford Road and West Village Tesco. Small car park on site



March 2024

Mon	Tue	Wed	Thu	Fri	Sat	Sun
				1 The Atrium	2	3
4	5	6 The Weller Centre	7 Launchpad 135 Work and Life Skills centre Reading Central Library, 3rd Floor	8	9	10
11	12 Coley Park Community Centre	13 Whitley Wood Community Centre	14 ACRE Reading Central Library, 3rd Floor	15 By Appointment Only - The Forgotten British Gurkha Centre	16 South Reading Community Hub/WCDA	17
18	19 Southcote Community Hub	20 South Reading Community Hub/WCDA	21 Reading Central Library, 3rd Floor	22	23	24
25	26	27	28	29	30	31

As well as the drop in option, Letters / messages will be sent to eligible patients with a link to enable them to book an appointment at one of the regular sessions: https://booking.appointy.com/healthchecks

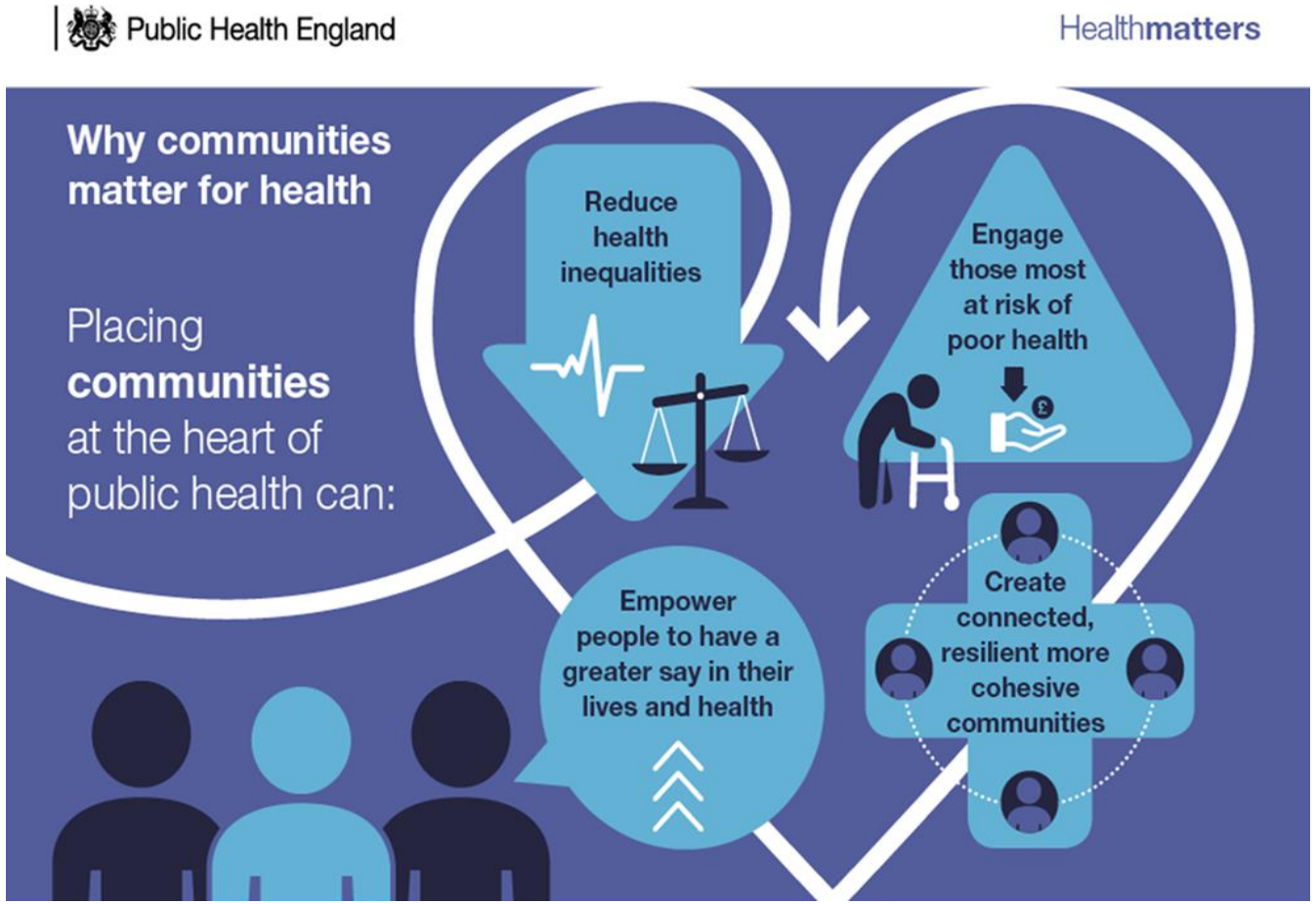
Info and clinic list: https://rva.org.uk/community-wellness-outreach/

Details of the health check: https://rva.org.uk/nhs-health-check/

Calendar of the clinics: https://rva.org.uk/health-checks-grid-calendar/

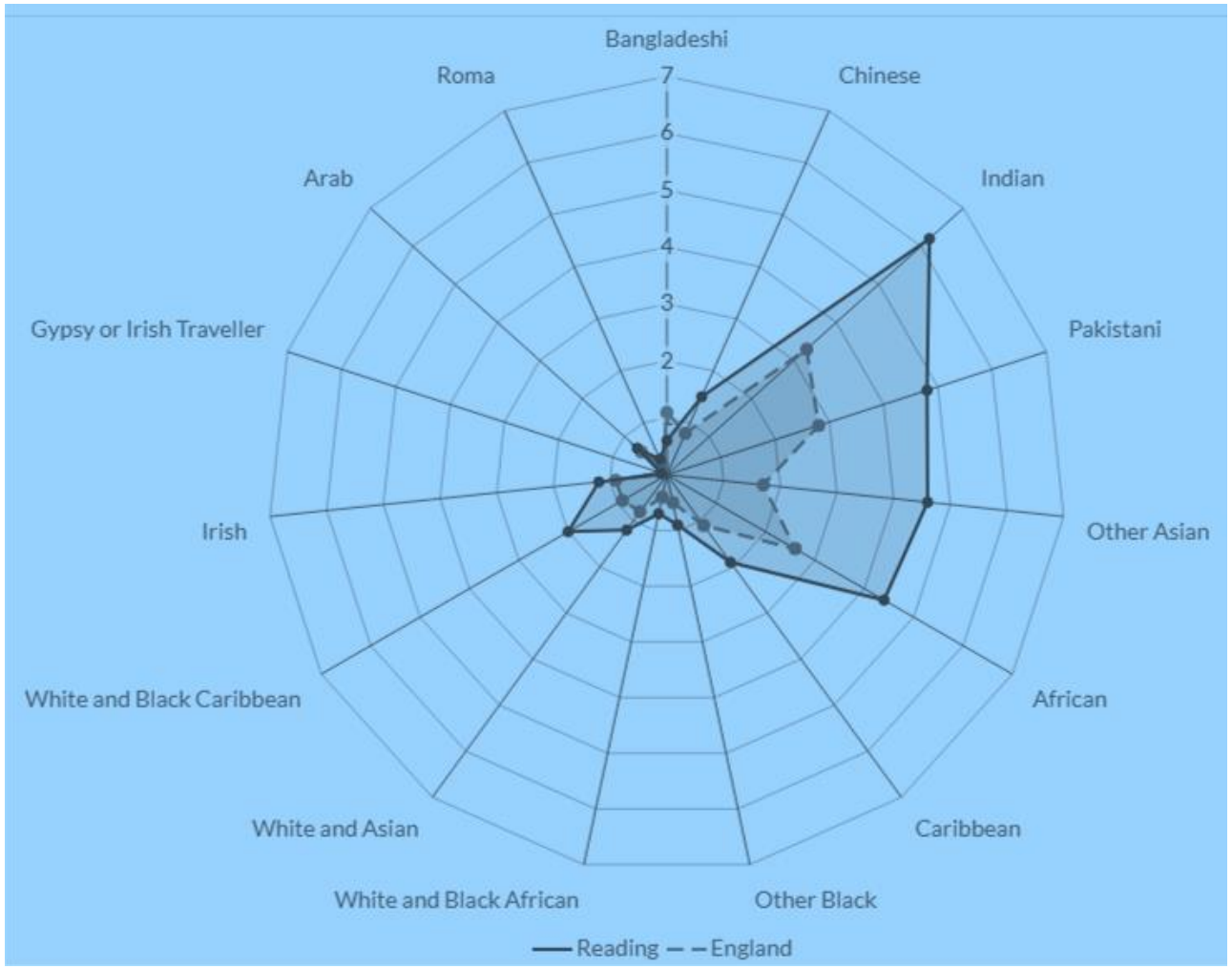
Adopting the Public Health approach

It is all about improving access, experience and the health outcomes.



- The NHS Health Check data will be automatically fed into the GP records system
- Where someone is not registered with a GP, the programme team will support them to register.
- They will also be able to take away the outcomes of their check and this can either be delivered via a digital transfer or on a “results” card, whichever suits their needs best.

Reflection on data …



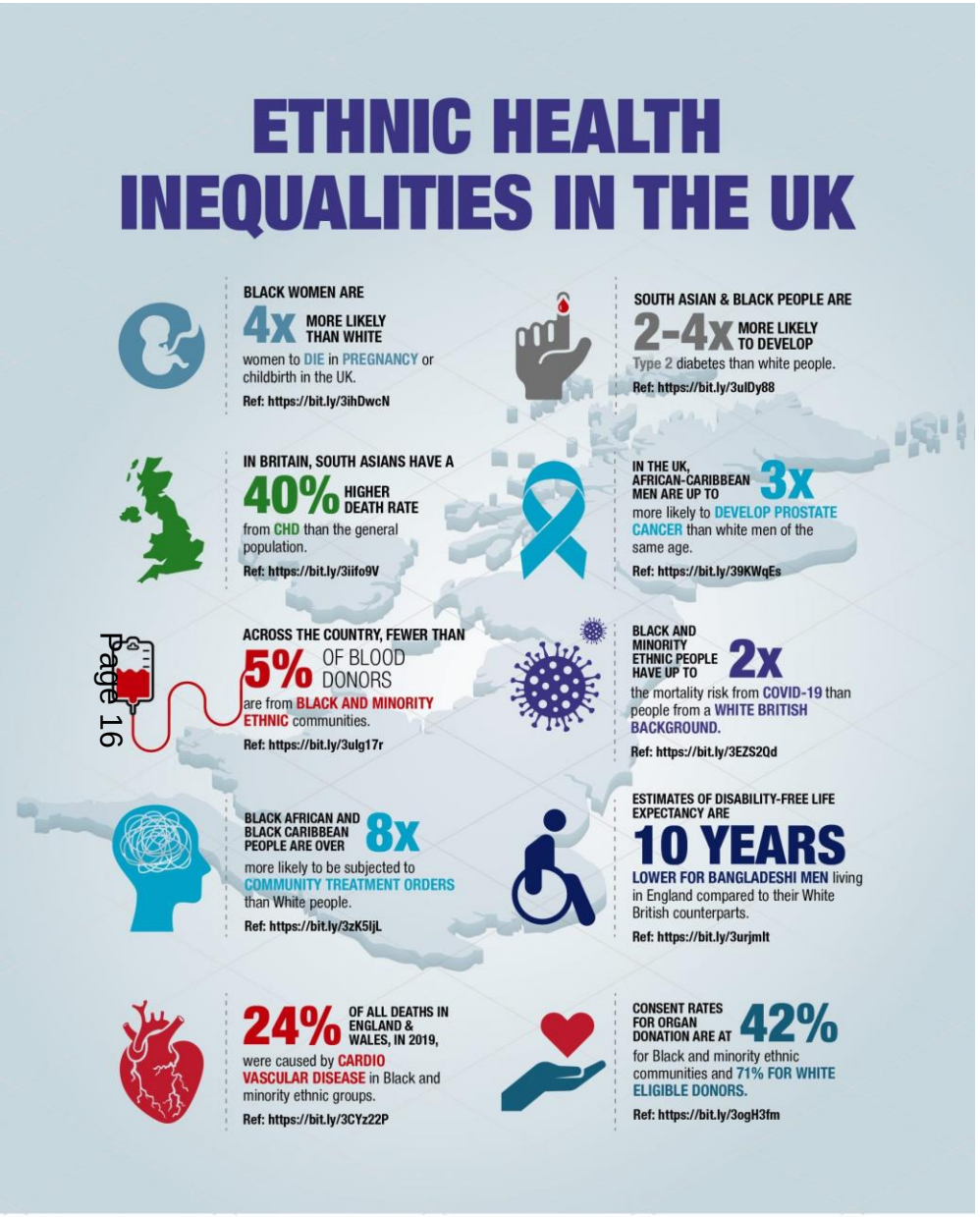
Percentage of population by ethnic group (2021)
Source: ONS, Census 2021

There is a larger proportion of people from an Indian, Pakistani, Asian or African ethnicity in Reading, compared to the ratios for England.
ONS Census (2021)

Black, Asian and other Minority Ethnic groups are at higher risk of type 2 diabetes and other health conditions at equivalent BMI levels. For Asian (South Asian and Chinese), Black African and African-Caribbean populations rising BMI and or waist circumference levels indicate increasing health risks such as Diabetes.
NICE (2013)

Diabetes is a key risk condition in developing CVD.
https://fingertips.phe.org.uk/profile-group/cardiovascular-disease

One of the aims of delivering the NHS Health Check in the community is to help people feel more comfortable in accessing the checks and increase opportunities to address health and wellbeing concerns.



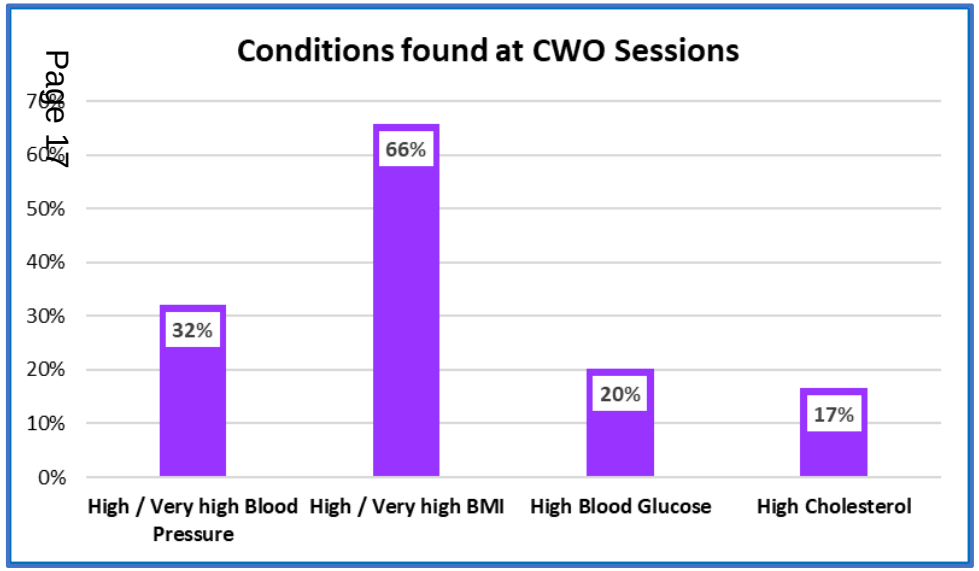
Data from the Race & Health Observatory (2021) indicated that:

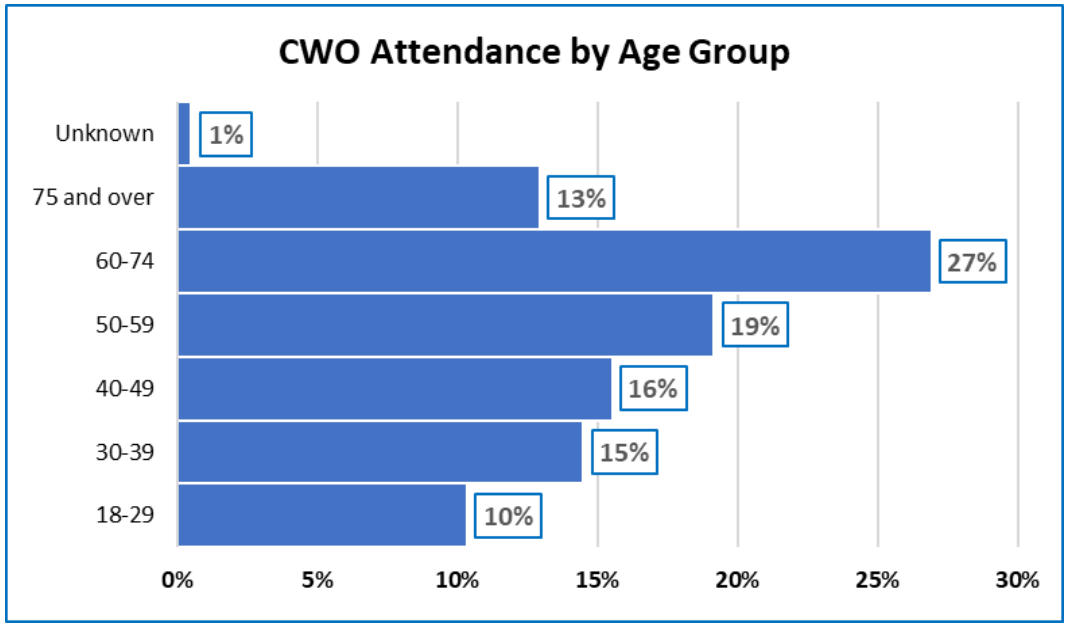
- South Asian and Black people are 2 to 4 times more likely to develop Type 2 Diabetes than White people
- 40% of South Asians have a higher death rate from Coronary Heart Disease than the general population
- 24% of all Deaths in England and Wales in 2019 were caused by Cardiovascular Disease in Black and minority ethnic groups.

Progress so far...

- 32% of people had High or Very high Blood Pressure
- 66% had High or Very high BMI.

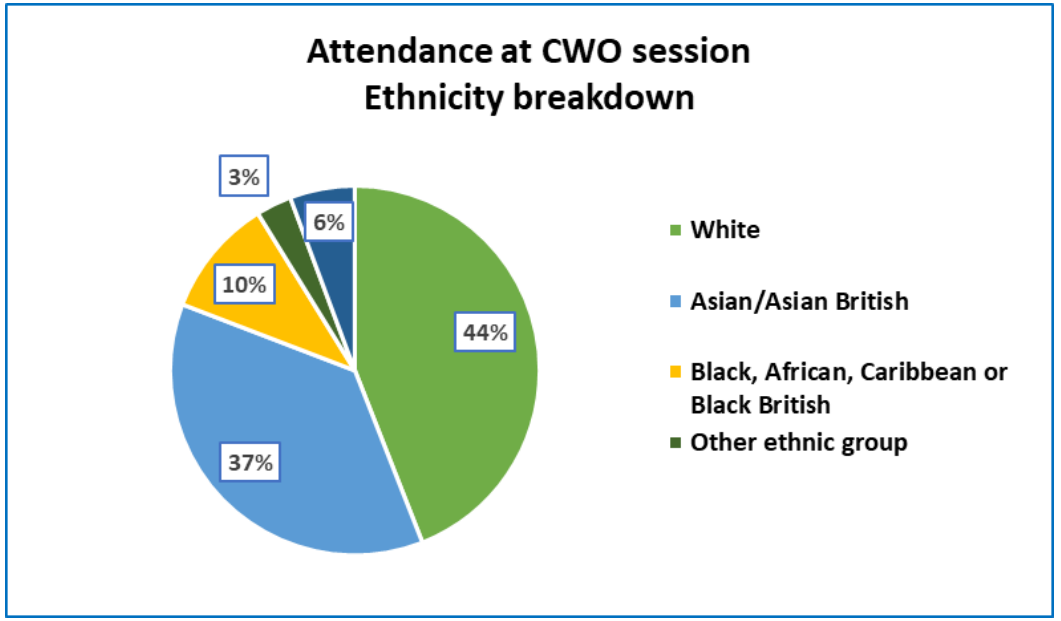
Note: Percentages do not total to 100% because some people had more than one health risk identified.





38% were outside the usual age range (40-74) for NHS Health Checks

- 13% aged 75+
- 25% below aged 40



- 37% of people attending sessions were from an Asian or Asian/British ethnic background.

- **193 people seen as at the end of February 2024**
- **Capacity building – 15 to 20 people per session, 5 sessions per week + Larger events planned**

Outcomes

- In Reading we need to achieve 5,200 NHS Health Checks through this outreach programme
- We had a ‘soft launch’ of the service in December 2023 whilst resources were being sourced and equipment was being tested, working collaboratively across Health, Social Care, Voluntary and Community services.
- Increase the awareness of the impact of cardiovascular disease and opportunities to prevent or effectively manage conditions and reduce cardiovascular disease health inequalities.
- Increase the number of NHS Health Checks, and particularly for more disadvantaged groups and aligned to the Core20Plus5 health inequalities programme.
- To refer people identified as being at risk to the appropriate services to support their needs and reduce their risk of cardiovascular disease.
- Reduce inequalities in relation to accessing Health Checks and Wellbeing advice and support.
- To provide other support in relation to issues impacting on Wellbeing.
- To hear from people in the community about their experience of the Health Check outreach programme.
- To identify academic research opportunities in relation to health inequalities.

Outcomes

From a Community Health Champion:

"I've just got back to the centre, and a lady has just thanked me for the health check as Angina, cholesterol and high blood pressure were picked up and she is now under a consultant."

The voice of our teams

Let's hear from our key delivery partners, one of our community providers and our Clinical lead, about their experience of setting up the Community Wellness Outreach Service and why it is important to them…

- Sharon Herring – Royal Berkshire Foundation Trust (RBFT) Meet PEET
- Rachel Spencer – Reading Voluntary Action
- Trisha Bennett – Whitley Community Development Association (CDA)
- Dr Lizzie Mottram – Project Clinical Lead (Primary Care Alliance)

Questions

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Community Health Champions – Correct Video Link

The correct link to the video referred to in paragraph 2.4 of the report is

https://youtu.be/7BBANB3A0FI?feature=shared

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