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CHIEF EXECUTIVE

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To: All Members of the Health and Wellbeing Board

(Agenda Sheet to all Councillors)

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4 October 2018

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NOTICE OF MEETING - HEALTH AND WELLBEING BOARD 12 OCTOBER 2018

A meeting of the Health and Wellbeing Board will be held on **Friday, 12 October 2018 at 2.00 pm** in the **Civic Offices, Bridge Street, Reading RG1 2LU**. The Agenda for the meeting is set out below.

AGENDA Page No

6. YOUR EXPERIENCES AS LESBIAN, GAY, BISEXUAL, TRANSGENDER PEOPLE ACCESSING HEALTH & SOCIAL CARE SERVICES IN READING 21 - 56

A report produced jointly by Healthwatch Reading and local LGBT+ charity, Support U, published in September 2018, on "Your experiences as Lesbian, Gay, Bisexual, Transgender people accessing Health & Social Care Services in Reading".

7. READING'S DRUG AND ALCOHOL CONSULTATION ON THE COMMISSIONING STRATEGY FOR YOUNG PEOPLE AND ADULTS FOR 2018 TO 2022 57 - 100

A report on the consultation outcome of the draft Reading Drug and Alcohol Commissioning Strategy for Young People and Adults from 2018 to 2022.

8. END OF LIFE (EOL) STARTING THE CONVERSATION - PRESENTATION 101 - 122

A presentation on starting the conversation with people about End of Life care.

9. A PROPOSED NEW MODEL FOR READING'S JOINT STRATEGIC NEEDS ASSESSMENT 123 - 132

A report and presentation providing a summary of a proposed new model for Reading's Joint Strategic Needs Assessment (JSNA).

10. INFLUENZA [FLU] PLAN UPDATE 2018 133 - 216

A report on the performance of the influenza (flu) vaccine campaign in winter 2017-18 to summarise lessons learned and to inform the Board of changes to the national flu programme for the coming 2018-19 flu season and how these will be implemented locally.

11. CONSULTATION - PHARMACEUTICAL SERVICES APPLICATION 217 - 236

A report on an application received to consolidate two pharmacies - Boots UK Ltd, 45 St Martins Precinct, Church Street Reading, Berkshire RG4 8BA and Day Lewis PLC, Rankin Pharmacy currently at 30 Church Street, Reading, Berkshire, RG4 8AU, for the Board to make representations on the application to the NHS Commissioning Board by 29 October 2018.

12. INTEGRATION PROGRAMME UPDATE 237 - 278

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.

13. HEALTH & WELLBEING DASHBOARD - OCTOBER 2018 279 - 316

A report presenting the Health and Wellbeing Dashboard to keep Board members informed of local trends in priority areas identified in the Health and Wellbeing Strategy.

14. DATE OF NEXT MEETING - FRIDAY 18 JANUARY 2019 AT 2PM

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Present:

Councillor Hoskin (Chair)	Lead Councillor for Health, Wellbeing & Sport, Reading Borough Council (RBC)
Seona Douglas	Director of Adult Care & Health Services, RBC
Councillor Jones	Lead Councillor for Adult Social Care, RBC
Councillor McEwan	RBC (substituting for Councillor Lovelock)
Sarah Morland	Partnership Manager, Reading Voluntary Action
Kajal Patel	South Reading Locality Clinical Lead, Berkshire West Clinical Commissioning Group (CCG) (substituting for Andy Ciecierski)
David Shepherd	Chair, Healthwatch Reading
Cathy Winfield	Chief Officer, Berkshire West CCG

Also in attendance:

Michael Beakhouse	Integration Programme Manager, RBC & Berkshire West CCG
Gwen Bonner	Clinical Director, Berkshire Healthcare NHS Foundation Trust (BHFT)
Alice Carter	Reading Families Forum
Pauline Hamilton	Reading Families Forum
Verena Hutcheson	Homeless & Housing Pathways Manager, RBC
Jo Jefferies	Consultant in Public Health, Bracknell Forest Council
Kim McCall	Health Intelligence, Wellbeing Team, RBC
Clare Muir	Policy & Voluntary Sector Manager, RBC
Janette Searle	Preventative Services Manager, RBC
Nicky Simpson	Committee Services, RBC
Mandeep Sira	Chief Executive, Healthwatch Reading
Paul Wagstaff	Head of Education, RBC

Apologies:

Andy Ciecierski	North & West Reading Locality Clinical Lead, Berkshire West CCG
Marion Gibbon	Consultant in Public Health, RBC
Stan Gilmour	LPA Commander for Reading, Thames Valley Police
Tessa Lindfield	Strategic Director of Public Health for Berkshire
Councillor Lovelock	Leader of the Council, RBC
Bev Searle	Director of Transformation, BHFT
Councillor Terry	Lead Councillor for Children, RBC

1. MINUTES

The Minutes of the meeting held on 16 March 2018 were confirmed as a correct record and signed by the Chair.

2. PROGRESS REPORT ON THE DELIVERY OF THE SPECIAL EDUCATIONAL NEEDS & DISABILITY (SEND) STRATEGY

Paul Wagstaff submitted a report providing a summary of progress made in delivering the SEND Strategy and the steps that had been taken to improve the transition between children's and adults' services.

The report stated that the Special Educational Needs & Disability (SEND) Strategy, which had been approved by ACE Committee in July 2017, had been discussed at the Health and Wellbeing Board on 19 January 2018 and the Board had agreed to support its delivery. The Board had requested an update on progress within six months, and that the update report include an update on progress on the issues around transition from children's to adults' services.

The report stated that the SEND Strategy provided a framework for SEND improvement, and the delivery of the provision and support required across key agencies to deliver the SEND Code of Practice (2015) in a coordinated way, ensuring that children and young people's needs were met at the right time, making best use of the resources available.

The SEND Strategy consisted of the following four strands, and the report gave details of progress to date in each strand of work:

- 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.

The report stated that it was anticipated that Strand 1 would be closed in September 2018, as a comprehensive data report had been produced, which would be updated annually, once national and statistical neighbour comparisons were published, and would be used by the SEND Strategy Board and the Board Leads to inform actions for the next academic year.

The report explained that joint working with partner agencies, the voluntary sector and families was integral to the delivery of the Strand 4 action plan, and the views of young people and their families were being sought on a range of their experiences, including the transition process, information, the annual review process, and where the gaps and barriers existed to achieving independence. The report proposed that the learning from this work in Strand 4 should be brought back to a future meeting of the Board and the Board agreed that this should be in six months' time.

The report also gave details of progress made on the issues around transition from children's to adults' social services, as requested at the 19 January 2018 Board meeting.

Pauline Hamilton and Alice Carter, from Reading Families Forum, addressed the Board, noting that it had taken some time for the SEND Strategy work to get going and that it would be important for the funding obtained to be used wisely, in order to make the best use of resources available. It was suggested, for example, that it could be used to increase awareness of the help that was already available but where young people were not aware of it. Alice Carter said that there was still a lot of work to do to implement the strategy and in some areas urgent action was needed to improve children's outcomes, as she thought that some legal requirements might not be being met. Councillor Jones agreed that further progress was required and noted that, prior to the development of the strategy, the funding available had not always all been spent, but he encouraged people to give officers details of any areas of specific concern so that they could be investigated further.

Resolved -

(1) That the progress made on delivery of the SEND Strategy 2017-2022 be noted;

(2) That the progress made on improving the transition between children's and adult's social care be noted;

(3) That a further report back on progress on delivery of the SEND Strategy be submitted to the Board in six months' time, and this report include the learning from the work in Strand 4 of the Strategy on transition to adulthood.

3. BERKSHIRE WEST INTEGRATED CARE SYSTEM (ICS) OPERATING PLAN 2018/19

Cathy Winfield submitted a copy of the Berkshire West Integrated Care System (ICS) Operating Plan for 2018/19. The ICS was a partnership between Berkshire West CCG (BWCCG), Berkshire Healthcare NHS Foundation Trust (BHFT) and Royal Berkshire NHS Foundation Trust (RBFT) and GP Alliances.

This was the first joint single operating plan for the new ICS, which was a collaboration between health organisations to improve services for the local Berkshire West population, delivering consistent high quality and safe care, ensuring the best possible outcome and experience for patients, whilst delivering financial stability across the health system. The ICS comprised RBFT, BHFT and BWCCG, as well as the Primary Care Provider Alliances covering four distinct localities – the Newbury, North & West Reading, South Reading and Wokingham GP Alliances. The ICS worked closely in partnership with local authorities in what had been the 'Berkshire West 10', and was now the 'Berkshire West 7' following merger of the CCGs, and the ICS was also a member of the Berkshire West, Oxfordshire and Buckinghamshire ('BOB') Sustainability and Transformation Partnership (STP).

The Operating Plan outlined the key goals, requirements and deliverables for the ICS in 2018/19 and detailed progress made in 2017/18. It gave details of the following five domains against which the ICS would deliver:

Domain 1 – Deliver the 5 Year Forward View (along with national priorities of cancer, mental health, urgent care, primary care, maternity and learning disabilities)
Domain 2 – Deliver local transformation priorities
Domain 3 – Deliver financial sustainability
Domain 4 – Embed a population health approach
Domain 5 – ICS Governance and Leadership

It stated that the following six key clinical areas of transformation had been developed for implementation in 2018-20:

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

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

Resolved - That the Berkshire West ICS Operating Plan 2018/19 be noted.

4. BERKSHIRE HEALTHCARE NHS FOUNDATION TRUST - MENTAL HEALTH STRATEGY 2016-21 – PROGRESS UPDATE

Further to Minute 5 of the meeting held on 6 October 2017, Gwen Bonner submitted a report giving an update on progress on the Berkshire Healthcare NHS Foundation Trust's (BHFT's) Mental Health Strategy 2016-21.

The report gave an overview of changes since November 2017, including:

- Developments in national policy and the local operating context:
    - Mental Health Strategy
    - System working, including both Berkshire-wide initiatives and work in Berkshire East and Berkshire West
- What had been done in terms of:
    - Ensuring effective governance
    - Taking forward key initiatives and strategic intentions
    - Progress against national targets

It also set out the next steps planned in terms of activities to deliver the strategy.

Resolved - That the report be noted.

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

Mandeep Sira submitted a report giving a voice to 'seldom heard' people on their top three priorities, which had appended reports by charities who supported those people: Reading Mencap, Talkback, Reading Community Learning Centre, Reading Refugee Support Group and Launchpad, as well as a guide to involving local people in planning and designing NHS services.

The Healthwatch Reading Team had spoken to people in Reading 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. The team had worked in partnership with charities who supported these people to arrange listening sessions where people could share their 'top three priorities'.

The report explained that Healthwatch had previously published five reports on the work with Reading Mencap, Talkback, Reading Community Learning Centre, Reading Refugee Support Group and Launchpad on their clients' priorities. The current summary report brought those priorities together to share with organisations

responsible for providing, funding or planning health or social care for those groups of people.

The report drew out the themes from the individual reports and concluded what mattered to people was:

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

The themes that the report concluded that the conversations with the charities had added to what had been heard from the clients were:

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

The report stated that, having reflected on the project, Healthwatch had produced a short guide to involving local people in planning and designing NHS services, which was attached to the report.

The Board discussed the reports, noting that, whilst there was a lot of useful information within them, which helped in understanding people's individual needs and circumstances, they were also snapshots reflecting the current situations of those individuals involved. It was noted that the project could be developed into bigger pieces of work as needed and Sarah Morland said that RVA was planning to work with Healthwatch Reading to gather wider data across different groups on a number of issues.

Resolved -

(1) That the report be noted;

(2) That health and social care officers review the information within the report and bring a response back to a future meeting of the Board.

6. 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

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

The report gave details of the event, noting that the contribution of an invited service user, about their lived experience of mental health needs, had been valued, and the Forum had also 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 had also attended the forum and taken an active role in discussions.

The report set out the findings of the forum and a summary table set out five main themes which the forum had identified as affecting the voluntary sector's ability to support clients with mental health needs, along with a series of proposed solutions.

It was noted that the number of service users with mental health needs was increasing, which had an impact on the individuals and on the network of support services.

The five themes were:

- Poor interaction between the statutory and 3rd sectors
- Inadequate 3rd sector funding
- Perception that some frontline statutory staff did not provide adequate or appropriate support at the client's first point of contact
- Clients did not know where to go for help, particularly at times of crisis
- Little resource for professional development within the 3rd sector

The report urged 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 would use the report to inform the way they planned, designed and funded local services to best meet the needs of people with mental health needs.

Resolved -

(1) That the report be noted;

(2) That RBC & CCG officers responsible for commissioning services from the voluntary sector bring a report to a future meeting of the Board responding to the proposals in the report and stating how they would use the report to inform the way they planned, designed & funded local services to meet the needs of people with mental health needs.

7. HEALTHWATCH READING ANNUAL REPORT 2017/18

Mandeep Sira submitted the 2017/18 Annual Report for Healthwatch Reading, which gave details of the work carried out by Healthwatch Reading in 2017/18.

The report set out highlights from the year, explained who Healthwatch Reading were, and detailed how Healthwatch had:

- listened to people's views on health and care
- helped people to find answers
- made a difference together with other organisations, the public, delivering advocacy and involving local people in its work, including work around the Council's consultation on the closure of Focus House, a care home for people with mental health needs

The report listed Healthwatch's plans for the next year, gave details of its finances, and set out its priorities for 2018/19 as follows:

- Visiting care homes to find out about the daily lives of residents
- Understanding the experience of drug and alcohol users
- Checking the quality of primary care at various GP services
- Delivering a top-class advocacy service
- Collecting experiences of university and college students

Resolved -

(1) That the report be noted;

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

8. READING HEALTH AND WELLBEING ACTION PLAN 2017-20 AND HEALTH AND WELLBEING DASHBOARD – JULY 2018 UPDATE

Kim McCall and Janette Searle submitted a report giving an update on delivery against the Health and Wellbeing Action Plan (attached at Appendix A) and the Health and Wellbeing Dashboard (attached at Appendix B), populated with the latest published data in relation to the Board's agreed strategic priorities. Taken together, these documents provided an overview of performance and progress towards achieving local goals as set out in the 2017-20 Health and Wellbeing Strategy for Reading.

The report summarised the position with regard to progress on each of the eight priorities in the Health and Wellbeing Strategy and paragraphs 2.2 to 2.4 set out details of updates to the data and performance indicators, which had now been included in the Health and Wellbeing dashboard, and listed where updated data was expected to be available for the next update to the Board in October 2018.

Resolved -

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

(2) That the updates and the expected updates to the Health and Wellbeing Dashboard at Appendix B and in paragraphs 2.2 to 2.4 be noted.

9. CHILDREN'S ORAL HEALTH IN READING

Marion Gibbon submitted 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.

The report explained that oral health was important for general health and wellbeing and that the level of dental decay in five-year-old children was a useful indicator of the success of programmes and services that aimed to improve the general health and wellbeing of young children. It also stated that there was a strong relationship between deprivation and both obesity and dental caries in children.

A ten-yearly dental health survey had been carried out in 2015 into the dental health of 5, 8, 12 and 15 year old children and had been published in March 2017. There had been a trend showing a reduction in dental caries in the South East and Reading had shown the greatest reduction in the proportion of five-year-old children with decayed, missing or filled teeth, but Reading remained third highest in the South East.

The report gave further details of data on children's oral health indicators and stated that the National Institute for Clinical Excellence (NICE) had 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. The report gave details of Reading's progress against these and noted that Reading already had a good foundation for the development of an oral health strategy, with its existing Health and Wellbeing and Healthy Weight Strategies.

It recommended that the logical next step would be for Reading Borough Council to take the lead on developing a partnership strategy for oral health to address:

- incorporating the importance of oral health into all relevant policies and service specifications
- developing training for frontline staff that emphasised the importance of oral health and enabled 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 needed them the most

Resolved - That the proposal for the Council to take the lead on developing an oral health strategy for Reading be supported, and Marion Gibbon report back on progress to a future meeting of the Board.

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

Janette Searle submitted 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 were available to identify and treat latent TB. It also presented a TB action plan. The report had appended:

Appendix 1- Healthwatch Reading TB Survey Report
Appendix 2- Berkshire TB Action Plan May 2018

The report explained that South Reading Clinical Commissioning Group (CCG) (now Berkshire West CCG) had worked with the Council, 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 had entered the UK in the previous five years from countries with a high incidence of TB. The success of this pathway was dependent on patients taking up the offer of latent TB screening. TB was considered to be stigmatising in some communities and a lack of knowledge about latent TB and the availability of free screening and treatment for latent and active TB, regardless of immigration status, could prevent people from accessing services.

In order to better understand knowledge, attitudes and behaviours of local people in regard to TB and TB services and to inform future engagement work, Healthwatch Reading had been commissioned to undertake a survey, delivered to over 300 people living in Reading and particularly reaching out to people and communities at increased risk of latent TB.

The Healthwatch TB survey result, which had been reported to the 16 March 2018 Health and Wellbeing Board, had provided a better understanding of how local people thought about TB during the first phase of a communication and engagement campaign focussing on latent TB. It had identified that, while referrals were starting to be made effectively, a substantial proportion of people invited chose not to attend their screening appointment, so there was still work to do to tailor the TB campaign so that people were better informed about the reason they were being asked to attend the appointment. The survey had also identified that stigma around TB was still an issue for some communities and those in the system recognised that further work with affected communities was needed.

The report stated that recent data from Public Health England showed that, in 2016, 27 cases of TB had been reported in Reading, with an incidence rate of 17 per 100,000 people. The TB rate in Reading had sharply decreased since 2014 but remained above South East and England rates. The age group with the highest number of cases was 40-49 years old, followed by 60-69, and the most common countries of birth for those notified in 2016 were India and Pakistan.

The results of the Healthwatch Reading survey had been discussed at a Berkshire-wide TB workshop on 5 December 2017, with the aim of reflecting on progress so far and setting priorities and activities for 2018/19. The outputs from the workshop had informed the production of an action plan which was being managed and implemented by Berkshire TB Operational Group, a Berkshire-wide group that ensured the delivery of Latent TB Infection (LTBI) objectives through collaborative working across providers, CCG, primary care & local authority public health partners.

Resolved -

(1) That the report be noted;

(2) That the plans for further community engagement activities aimed to identify, develop and support local community TB champions set out in the Berkshire TB Action Plan be supported.

11. A HEALTHY WEIGHT STATEMENT FOR READING – IMPLEMENTATION PLAN UPDATE

Further to Minute 8 of the meeting on 14 July 2017, Janette Searle submitted a report giving an annual update on the implementation plan for the Healthy Weight Strategy for Reading. A Healthy Weight Strategy Implementation Plan update was attached at Appendix A.

The report stated that Reading's Healthy Weight Strategy had 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 had been established which would help to facilitate a more consistent approach across the county.

The report explained that setting Reading Borough Council's budget for 2018-19 had been exceptionally challenging in light of other pressures. Unfortunately, this had included 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 would cease in September 2018. Work had progressed on the implementation of the Reading Healthy Weight Strategy since the last update to the Board in July 2017, but it had only been possible to take forward many of the planned actions on a skeleton basis. The report summarised work which had been progressed and listed the additional plans which had been put on hold.

Resolved -

(1) That the report be noted;

(2) That the impact of budget reductions on the delivery of the Reading Healthy Weight Strategy be recognised, and the essential re-evaluation of how the Council could support residents to achieve a healthy weight in light of reduced resources and service decommissioning be acknowledged.

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

Jo Jefferies submitted a report presenting the Berkshire Director of Public Health's (DPH) Annual Report 2018, on "Creating the Right Environments for Health", which was attached as an Appendix to the report.

The report explained that "Creating the Right Environments for Health" aimed 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 provided information and evidence that could support placed-based strategies to realise the potential of green and natural spaces for the health and wellbeing of local residents and communities and showcased examples of how local communities were already using the natural environment to stay healthy or improve their health and wellbeing.

The DPH report recommended that:

1. Local authorities and other agencies should continue to encourage community initiatives that made 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 were 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.

The report stated that, bearing in mind the DPH report's recommendations, the Council aimed to implement the following more specific recommendations:

- Reading Borough Council would use the massive opportunity it had with regard to its new leisure developments to drive engagement and promote community resilience and cohesiveness into its future plans;

- Reading Borough Council would continue to improve its green spaces and ensure that they were safe for everyone;

- Reading Borough Council would ensure all new developments incorporated consideration of how they would improve the health and wellbeing of residents and others, including provision of and links to green spaces where opportunities allowed.

It also gave examples of ongoing work that was being undertaken by the Council and partners which supported the recommendations made in the DPH Report and encouraged members of the Board to share the report widely within their respective organisations and local communities.

The Board discussed the DPH report and welcomed the opportunity to use it for more conversations about the use of the natural environment. For example, discussions could be held about how much should be spent on improvements to parks for 'beautification', in balance with increasing multi-functionality, managing the facilities and encouraging more people to be active in these spaces.

Resolved -

(1) That the report, its conclusions and the work being undertaken and planned, be noted;

(2) That members of the Board share the report widely within their respective organisations and local communities, and a copy of the DPH Report be sent to all Councillors.

13. READING HOMELESS HEALTH NEEDS AUDIT

Verena Hutcheson submitted 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. The results of the Homeless Health Needs Audit were appended to the report.

The report explained that, in January and February 2017, over a five week period, partners from Reading's Homelessness Forum had commissioned and undertaken a Homeless Health Needs Audit in Reading. The Audit had 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 had been 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 was 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 were intended to be a research piece that could inform improvement and service development across sectors where key issues from respondents had been highlighted, and management within sector services were invited to set out their responses to these findings and develop subsequent action plans.

Verena reported at the meeting that housing services had used the audit to inform the remodelling and recommissioning of its rough sleeper outreach, floating support and supported accommodation services, and that funding from a Rough Sleeper Initiative had recently been obtained for 2018/19.

Resolved -

(1) That the Reading Homeless Health Needs Audit report be noted and partners use the research to inform improvement and service development within their area and across housing, health and social care sectors;

(2) That management and commissioners within and across 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 were single, or part of a couple without dependent children experiencing homelessness.

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

Clare Muir submitted 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. The Action plan was appended to the report.

Resolved – That the progress against the actions set out in the Armed Forces Covenant action plan be noted.

15. INTEGRATION PROGRAMME UPDATE

Michael Beakhouse 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 strong, with key targets met.

It stated that partners were not currently reducing the number of delayed transfers of care (DTOCs) in line with targets, but DTOC rates since October 2017 had shown a strong downwards trajectory, which represented very positive progress.

Partners had not met the target for reducing the number of non-elective admissions (NELs) but work against this goal remained a focus for the Berkshire West-wide BCF schemes.

The report gave further details of BCF performance and additional local performance, as well as of items progressed since March 2018 and the next steps planned for the summer. It also explained the current situation regarding likely future BCF targets for 2018/19, noting that the Operating Guidance was due to be published in July 2018.

Resolved – That the report and progress be noted.

16. DATE OF NEXT MEETING

Resolved – That the next meeting be held at 2.00pm on Friday 12 October 2018.

(The meeting started at 2.00pm and closed at 4.32pm)

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READING HEALTH AND WELLBEING BOARD

DATE OF MEETING:	**12 October 2018**	**AGENDA ITEM:**	**5**
REPORT TITLE:	**Care Quality Commission (CQC) Reading Local System Review October 2018**		
REPORT AUTHOR:	**Seona Douglas**	**TEL:**	**0118 937 2094**
JOB TITLE:	**Director of Adult Health and Care Services**	**E-MAIL:**	**seona.douglas@reading.gov.uk**
ORGANISATION:	**Reading Borough Council**		

1. PURPOSE OF REPORT AND EXECUTIVE SUMMARY

1.1 To provide the board with a briefing on the details of a Local System Review that the Reading system has been selected for by The Care Quality Commission.

The Reading system comprises not just Reading Borough Council, but also Berkshire West CCG, The Royal Berkshire Hospital, Berkshire Healthcare Foundation Trust (BHFT) and the South Central Ambulance Service – in addition to the providers of health and social care services within the wider marketplace (including voluntary and community-sector organisations).

2. RECOMMENDED ACTION

2.1 To note the details provided and the key dates that reviewers will be on site in Reading.

3. POLICY CONTEXT

3.1 It is important to note that the Reading System has been selected for review based on the significant improvements that it has made to its performance in reducing delayed transfers of care (DTOC) across the last year.

The Reviewers have noted that this is not a formal inspection under their regulatory powers, but a review of how well integration is working. They are keen to gather examples of good practice within Reading that can be shared nationally. They are specifically interested in exploring the interfaces between social care, general primary care, acute health services and community health services and on older people aged over 65 or, how we ensure that the right care is delivered to the right people, at the right time.

The local system reviews look at how people, particular focus is on those over 65 years of age, move between health and social care.

4. THE PROPOSAL

4.1 The review in Reading began on Monday 24th September and will run for 12 weeks and ends when we receive the report of findings. CQC have provided us with a helpful summary of the key events that will take place each week, which is attached for reference. A report of the review will be prepared and is expected to be shared with us in mid-December 2018. Senior Leaders from across the system will also then have the opportunity to work with the Social Care Institute for Excellence (SCIE) to create an action plan, which will outline how we will address any areas that the CQC reviewing team feel we could do even better than we are currently doing in delivering health and social care services for Reading residents.

4.2 Reading Borough Council Adult Services Directorate is tasked with leading the review. We have assembled a project group to coordinate the work across the system. The project group can be contacted at CQCLocalsystemreview@reading.gov.uk.

Each organisation within the system has also nominated a lead. The assembled project leads will be meeting every Wednesday morning to ensure that we are providing CQC with all of the necessary information they require in order to complete the review in a timely and efficient manner.

The current focus is on organising a number of visits for the key dates that the reviewers have identified and with the people and groups they wish to meet with. Another requirement is the co-production of a System Overview Information Return, or SOIR. These are a set of questions allowing the involved organisation leaders to set out the current strategies and plans.

Lastly we are identifying 6 cases that demonstrate the care and services that have been provided for people over 65 and that CQC reviewers will track and audit during their visits. They will look at all case notes related to that individual case from all of the involved organisations.

4.3 The key dates to be aware of are:

- **This week on 9th - 10th October** → During this period, the CQC reviewing team have met with the following stakeholders to gather their views on how the health and social care system is working for Reading residents. They are particularly keen to have:
    - Spoken to senior staff members, to hear their views on the local system
    - Attended local events that are attended by local residents
    - Met with other local partners – such as voluntary services and community groups, and other health and social care providers
    - Run several focus groups with representatives from across the system

- **29th October - 2nd November** → During this period, the CQC reviewing team will wish to:
    - Hold additional focus groups with commissioning teams, providers, social workers, occupational therapists, and people who use health and social care services.
    - Explore the different services that residents make use of during their journey through the health and social care system
    - Review case files
    - Speak with senior leaders.

The outcome of the review will not include or affect existing CQC ratings that providers of health and social care already hold.

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

5.1 The Reading Health and Wellbeing Strategy has eight priorities:

1. Supporting people to make healthy lifestyle choices (with a focus on tooth decay, obesity, physical activity and smoking)
2. Reducing loneliness and social isolation
3. Promoting positive mental health and wellbeing in children and young people
4. Reducing deaths by suicide
5. Reducing the amount of alcohol people drink to safe levels
6. Making Reading a place where people can live well with dementia
7. Increasing breast and bowel screening and prevention services
8. Reducing the number of people with tuberculosis

5.2 Strategic Aim 6. Making Reading a place where people can live well with dementia

5.3 The system overview return that the 5 key organisations are submitting to CQC will make reference all of the strategy and policy context that is relevant to both the individual organisations involved along with joint working initiatives However it will specifically focus on those over 65 and with Dementia and so will provide a useful reflection for the system, highlighting what is working well and where there are opportunities for improving how the system works for people using services.

5.4 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 specifically addresses these in the following ways:

This review will address the health and well-being of the residents of Reading and will take particular note of the safeguarding policy and procedures as the reviewers are very familiar with those requirements and responsibilities through their statutory role. Carers are being seen by the reviewers in one of the early focus groups so their role and views will be referenced in the report.

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 CQC reviewers will use a variety of methods to ensure full engagement is undertaken across the area. Areas of the community will be involved in specially arranged focus groups. One of these is with the local voluntary sector partners and another is with group of carers. The reviewers will visit services such as lunch clubs and sheltered housing and day centres that are accessed by Readings older population and so will have direct contact with individuals who use these services. The case tracking will evidence an individual's interactions with all of the involved organisations involved in the review..

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 aspects of the Adult Services teams undertake Equality Impact Assessments. CQC and their review team are mindful of the equality framework and how it impacts on their visits and meetings. As well as qualified inspection staff they are always accompanied by experts by experience who will be involved in the visits and focus groups. They will be particularly looking at how they can interact with the residents of Reading in order to get a representative sample and view.

8. LEGAL IMPLICATIONS

8.1 CQC has been commissioned to carry out a targeted programme of local system reviews under section 48 of the Health and Social Care Act (2008).

8.2 This particular review process was commissioned by the Secretaries of State of Health and Social Care and for Housing, Communities and Local Government.

8.3 CQC has powers under section 63(2)(b) of the Health and Social Care Act 2008, that allow them to access peoples' medical and care records. They do not need a person's consent in order to do this. All personal and confidential information reviewed as part of their onsite activity will be handled in line with CQC's information governance code of practice.

9. FINANCIAL IMPLICATIONS

9.1 Any financial commitment and spend in relation to the review is likely to be minimal. CQC reviewers will cover their own costs in relation to hotel accommodation and travel. There will be some costs in relation to room booking and refreshments; however these costs will be shared by the 5 organisations involved.

10. BACKGROUND PAPERS

10.1 CQC timetable methodology is attached.

10.2 The findings from the 20 reviews that have been completed to date, nation-wide, can be found in the CQC publication "Beyond Barriers", which is available at: https://www.cqc.org.uk/publications/themed-work/beyond-barriers-how-older-people-move-between-health-care-england

Local system review timeline

Pre-preparation Week 1-3 → **Preparation Weeks 4-5** → **Review Week 6** → **Report Writing Week 7-9** → **Quality Week 10-14**

Weeks 1-2

- Letter
- Contact request.
- System Overview Information Return (SOIR) sent out.
- Discharge Information flow
- Case tracking
- Call for evidence from inspectors.
- Call for evidence from local stakeholders
- Agree review schedules

Week 2

- Relational audit.

Week 3

Review leads:

- Meet senior staff/ run through local context
- Attend local events with people living in the area
- Meeting with other local partners
- Cross-directorate inspectors focus group

Weeks 4-5

- SOIR returned
- Analysis of documents.
- Analysis of qualitative and quantitative data.
- Data profile
- Liaison with statutory bodies and others (e.g. NHS England, NHS Improvement, Health Education England, Sustainability and Transformation Partnerships, regional leads).
- Agree escalation process if required.

People's experience, quality and access

(Days should include out-of-hours)

Day 1: Focus groups

- Commissioning staff.
- Provider staff (across broad groups).
- Social workers and occupational therapists.
- People using services, carers and families.
- VCSE sector.

Day 2-3: Interface pathway interviews

- Focus on individuals' journey through the interface through services (with scenarios) and case tracking/dip sampling

Day 4: Well-led interviews

- Senior leaders
- Sense check with nominated people from key partners

Day 5: Final interviews, mop up and feedback.

Single shared view of quality

Team – 4-5 CQC/ 3-4 SpA

- Drafting
- Quality assurance
- Editorial
- Focused report / letter with advice for the area Health and Wellbeing Board (cc other partners
- Factual accuracy
- Local summit (with improvement partners)
- Publication

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Item 6, HWBB meeting 12 October 2018, Cover note

Your experiences as Lesbian, Gay, Bisexual, Transgender people accessing Health & Social Care Services in Reading is a report produced jointly by Healthwatch Reading and local LGBT+ charity, Support U and was published in September 2018.

National reports state that people identifying as LGBT+, experience significant health inequalities. Healthwatch Reading sought to shed light on the experience of Reading people identifying as LGBT+, and to work in partnership with a local charity that has the networks and lived experience of this group of people.

The report includes findings of an online survey answered by 35 people:

- Just over one-third were not 'out' to their GP about their sexual orientation
- **11 out of 35 (31%) had experienced anxiety and 13 (37%) had sought help for depression**, much higher rates than the general population
- Nobody felt they had been discriminated against by a health professional due to their sexuality, but **17% reported some prejudice**, and others felt health professionals showed a lack of knowledge or respect (see comments below). **This echoes a government 2017 survey finding: 16% of 108,000 LGBT+ people said they experienced prejudice from health professionals**

'[When I went for a] regular abdominal scan related to gender transition – operator did not read my medical record and assumed I was cisgender male there for prostate scan.'

'Being asked continually about pregnancy tests when I have a female partner, am female-bodied and have stated multiple times that I will not be conceiving and there is no chance of being pregnant gets very tiring very quickly!'

Respondents' main suggestion for change was better training for professionals:
'Some people are very good or at least act professionally, while others are completely ignorant and/or have no idea how to behave, but I have no way of knowing how they will react or what assumptions they will make until I am actually talking to them.'

Healthwatch Reading urges local organisations to use a Stonewall toolkit on building an LGBT-inclusive service, and to also engage with Support U about potential local staff training opportunities.

We hope our report is the start of a wider discussion with local organisations and their equality leads, about how they might adopt our recommendations and to also understand how, or if, they are implementing 'EDS2', the NHS Equality Delivery System programme that aims to help them meet their Public Sector Equality Duty.

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LGBT+ Your experiences as Lesbian, Gay, Bisexual, Transgender people accessing Health & Social Care Services in Reading

An online survey by Healthwatch Reading in partnership with SupportU

healthwatch Reading
advice • advocacy • action

Support U
diversity matters

Cover picture from SupportU.

Contact Healthwatch Reading at:
3rd floor, Reading Central Library
Abbey Square, Reading
RG1 3BQ
Telephone 0118 937 2295
Email info@healthwatchreading.co.uk

healthwatch Reading
advice • advocacy • action
'Campaigning for better care for our community'

Home of ReadingVoice
Your local advice & advocacy hub

Contents

About the survey

Why

to collect the views and experiences of Reading people who are Lesbian, Gay, Bisexual, Transgender, and other people identifying as members of this community (LGBT+) accessing health and social care services in Reading, and make those experiences and views known to commissioners and providers of local services. The survey asked people whether they are open about their gender and sexual orientation when they use health and care services, what their reasons are for disclosing or not disclosing, and what their experiences are when using services - with an opportunity to explain how staff behave if they are aware of the individual's personal characteristics.

Who

35 people replied. Almost all were white British. The majority described their sexual orientation as either Lesbian or Gay (male). Several Bisexual people also took part. A majority identified as male or female. Two Transgender men and one gender fluid person took part. The age range was 18 to 74 years.

How

Healthwatch Reading partnered with local charity SupportU and created an online survey, which was promoted on Twitter and on Facebook. The project ran from 27th February to 3rd April. Healthwatch Reading also contacted large local businesses and other local organisations to share the survey link. Paper copies of the survey were available to attendees at an event in Reading Central Library during LGBT+ Awareness Week in February 2018 and were also available at SupportU events during the survey period. SupportU circulated the survey link to a wide range of LGBT+ groups, including Reading Pride and MyUmbrella, and to other local groups including ACRE.

What does 'LGBT+' stand for?

LGBT stands for Lesbian, Gay, Bisexual or Transgender and the plus sign stands for a range of other descriptions people may choose to use.

The charity Stonewall's definition of these terms is below:

Lesbian

Refers to a woman who has an emotional, romantic and/or sexual orientation towards women.

Gay

Refers to a man who has an emotional, romantic and/or sexual orientation towards men. Also a generic term for lesbian and gay sexuality - some women define themselves as gay rather than lesbian.

Bi

Bi is an umbrella term used to describe an emotional, romantic and/or sexual orientation towards more than one gender. Bi people may describe themselves using one or more of a wide variety of terms, including, but not limited to, bisexual, pan, bi-curious, queer, and other non-monosexual identities.

Trans

Trans is an umbrella term to describe people whose gender is not the same as, or does not sit comfortably with, the sex they were assigned at birth. Trans people may describe themselves using one or more of a wide variety of terms, including (but not limited to) transgender, transsexual, gender-queer (GQ), gender-fluid, non-binary, gender-variant, crossdresser, genderless, agender, nongender, third gender, two-spirit, bi-gender, trans man, trans woman, trans masculine, trans feminine and neutrois.

+

Stands for other terms such as 'non-binary': An umbrella term for people whose gender identity doesn't sit comfortably with 'man' or 'woman'. Non-binary identities are varied and can include people who identify with some aspects of binary identities, while others reject them entirely.

Other terms:

Cisgender or Cis

Someone whose gender identity is the same as the sex they were assigned at birth. Non-trans is also used by some people.

Transitioning

The steps a trans person may take to live in the gender with which they identify. Each person's transition will involve different things. For some this involves medical intervention, such as hormone therapy and surgeries, but not all trans people want or are able to have this. Transitioning also might involve things such as telling friends and family, dressing differently and changing official documents.

https://www.stonewall.org.uk/help-advice/glossary-terms

Main survey findings & recommendations

Main survey findings

35 Reading people replied to the survey.

- 12 people (35%) told us that they are not 'out' to their GP about their sexual orientation
- Of those who are 'out', 14 people (60%) felt it had made no difference to how their GP treats them
- We noted that 6 people (17%) told us that they have a hidden disability, which could include mental health issues – it is well-established that LGBT+ people may experience significant inequalities that can lead to poorer health
- People's reasons for disclosing or not disclosing their sexual orientation or gender to healthcare professionals vary – some are concerned about the reaction to, and impact of, disclosure, while others feel that these aspects of them are not relevant to their healthcare
- Some people reported wrong assumptions being made about them – what their sexual orientation is, or what their gender or sexual orientation 'means' in terms of behaviour (stereotyping and prejudice, rather than seeing and respecting the individual)
- People were more willing to be open about themselves in some services (e.g. sexual health services, and mental health services), and less willing in other services (e.g. the A&E Department, or when speaking to a school nurse)

Recommendations

Healthwatch Reading and SupportU together recommend

1. NHS and social care services should ensure that the training of their staff is up to date regarding the health needs of LGBT+ people and working with diverse groups. It should take account of the advice given throughout this report, which includes:
    - Do not make judgemental comments
    - Do not ask questions about gender and sexual orientation beyond what they need to know to provide care or help
    - Do not make assumptions about the relationship between any person and the person(s) accompanying them
2. NHS and social care services should take steps to be more clearly welcoming to and respectful of diversity e.g. using posters, LGBT+ pins on their lanyards – and ensure greater ease of access to LGBT+ related information and points of contact for any LGBT+ concerns or issues patients/service users may wish to raise
3. Reading Borough Council should explore supporting social care provision that is sensitive to the needs of LGBT+ people
4. Local commissioners and providers should ensure that they use
    - this national resource[1], published in 2016 by The National LGBT Partnership and based on the views of more than 200 people identifying as LGBT+
    - this guide for the NHS[2] and this toolkit[3] from charity Stonewall
    - this Healthwatch Reading report and
    - the other resources mentioned in the discussion section of this report

to inform the commissioning of LGBT+ inclusive local health and social care services, and staff training in these services.

'Some people are very good or at least act professionally, while others are completely ignorant and/or have no idea how to behave, but I have no way of knowing how they will react or what assumptions they will make until I am actually talking to them.'

'I'm sure there are some health care professionals who would respect my orientation, but I have experienced negative treatment from older male doctors based purely on my gender and I doubt that my sexuality would improve that.'

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 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, which oversees progress on local priorities to improve the health and wellbeing of the Reading population.

About SupportU

SupportU is a charity providing a resource service for those needing help with Lesbian, Gay, Bisexual and Transgender issues, based in the Thames Valley.

The SupportU support team provides specialist resources for LGBT+ people and those affected by LGBT+ related issues. They help people with concerns ranging from employment to sexual health and coming out.

Background: the experiences of LGBT+ people in health and social care

"There is a substantial body of evidence demonstrating that lesbian, gay, bisexual and trans (LGB&T) people experience significant health inequalities, which impact both on their health outcomes and their experiences of the healthcare system. The relationship between sexual orientation and gender identity and health has often been overlooked by the healthcare system, and a lack of sexual orientation and gender identity monitoring in service provision and population level research means that the Public Health Outcomes Framework (PHOF) indicators alone will not generate data on LGB&T people."

(The LGB&T Partnership[6] commenting on the background to, and findings of, the LGBT Public Health Frameworks Companion[7] document in 2016)

It is known from national surveys that the experiences of LGBT+ people in health and social care may be affected adversely by care providers being unaware of - or else becoming aware of - their sexuality and/or gender identity. It is also known that many people who are LGBT+ will experience poorer health.

For example, there is evidence that

- Lesbian and Bisexual women, and women who have sex with women, experience inequalities across a range of areas, especially in relation to mental health, reproductive health, domestic violence, and behaviours such as smoking and alcohol misuse that can affect health and continued access to social care, and that
- there are higher rates of musculoskeletal health issues, asthma and respiratory conditions, and some types of cancer, among Lesbian and Bisexual women than among heterosexual women.[4]

This means that ensuring that the health needs of LGBT+ people are recognised, understood and provided for is important, as the LGB&T Partnership notes in the quotation on page 8.

Reading Borough Council has a detailed section on inequalities affecting LGBT+ people, and the health and care needs and experiences of LGBT+ people on its website.[5]

Aims of the survey

Healthwatch Reading has a statutory duty to collect the views of all Reading people regarding their needs for, and experience of, local care services, and then to make these views known to the commissioners and providers of services, so that services can be shaped to meet the needs of all local people.

The project aims were to:

- collect the views and experiences of Reading people who are Lesbian, Gay, Bisexual, Transgender, and other people identifying as members of this community (LGBT+) accessing health and social care services in Reading, and make those experiences and views known to commissioners and providers of local services
- to work in partnership with SupportU and to help them to raise awareness of the need for health and care professionals to be more aware of the needs of Reading people who identify as LGBT+
- promote awareness of Healthwatch Reading and its role in the LGBT+ community, including to people of working age
- to inform future work by Healthwatch Reading to enable LGBT+ people to share their experiences and views and to become involved in shaping local health and care services to meet local needs.

How the survey was carried out

Healthwatch Reading discussed possible approaches to conducting the survey with SupportU and we decided together on an online survey to be launched during LGBT+ Awareness month.

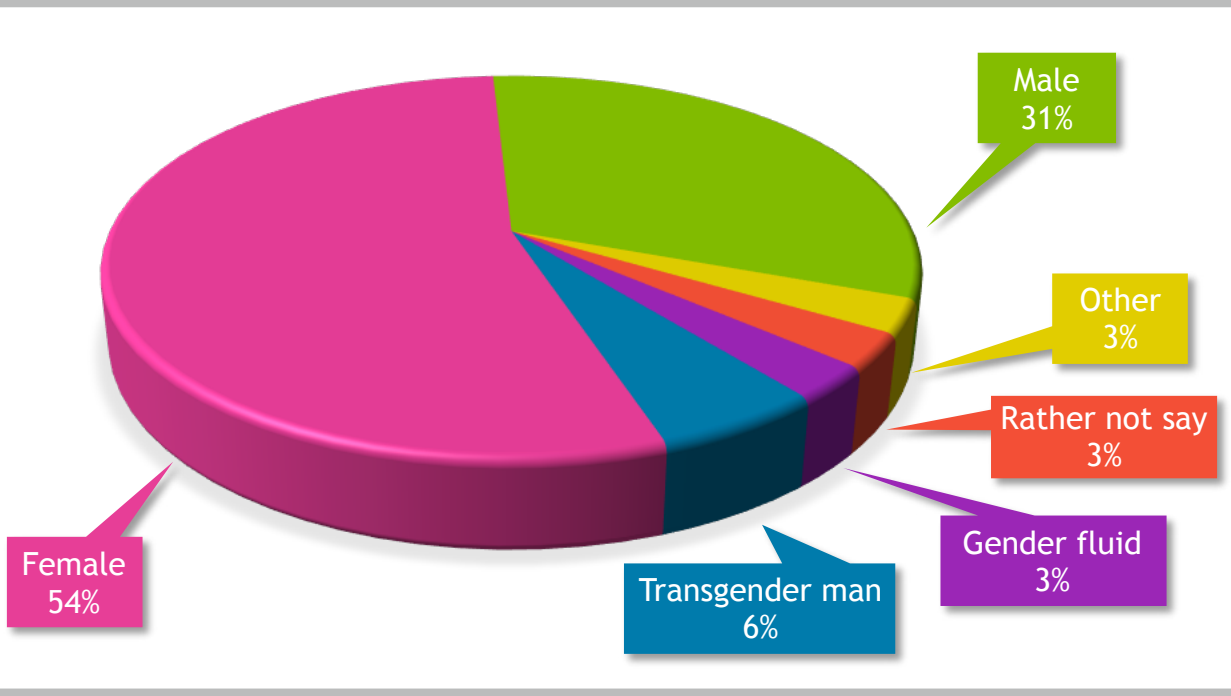
The survey design was adapted, with permission, from a survey conducted by Healthwatch Blackburn with Darwen in 2014.

The survey was promoted on the website of each organisation, on social media, and by direct contact with the organisations listed in Appendix 2. We also made paper copies of the survey available at some locations, as explained in the 'How' section in the quick-read summary at the beginning of this report.

The people who replied to our survey

What is your gender?

We heard from 35 Reading people – including people with transgender man (2), female (19), gender fluid (1), male (11) and other (1) identities. Of these, 31 people told us that their gender now is the same as the sex recorded on their birth certificate, and 4 told us that it is not. We were advised by SupportU that it is an important and personal decision what words people use to describe their identity.



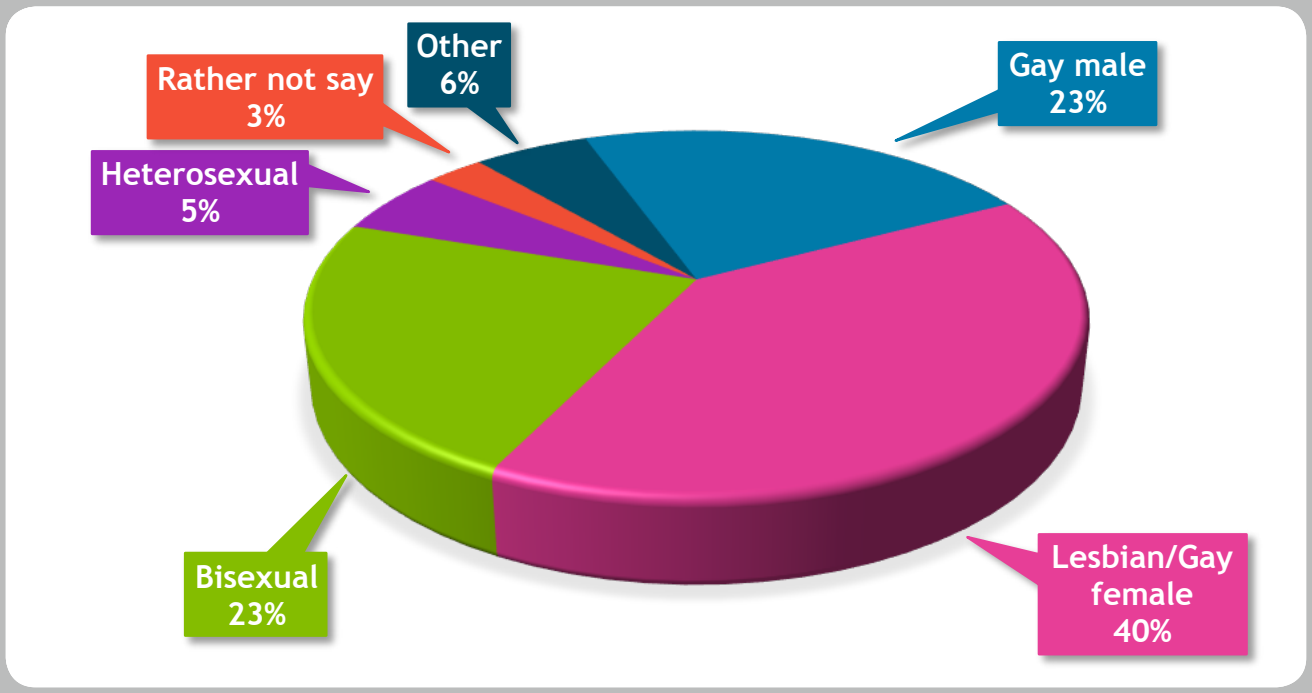
Picture from pixabay.com

The people who replied to our survey

What is your sexual orientation?

We heard from 2 people identifying as heterosexual, 8 identifying as bisexual, 14 identifying as Lesbian/Gay female, and 8 identifying as Gay male.

The respondents were mainly White British, with only two from ethnic minorities. Six reported having a physical disability, and – strikingly – 18 said they had a hidden disability (which could include mental health issues) - see Appendix 1.



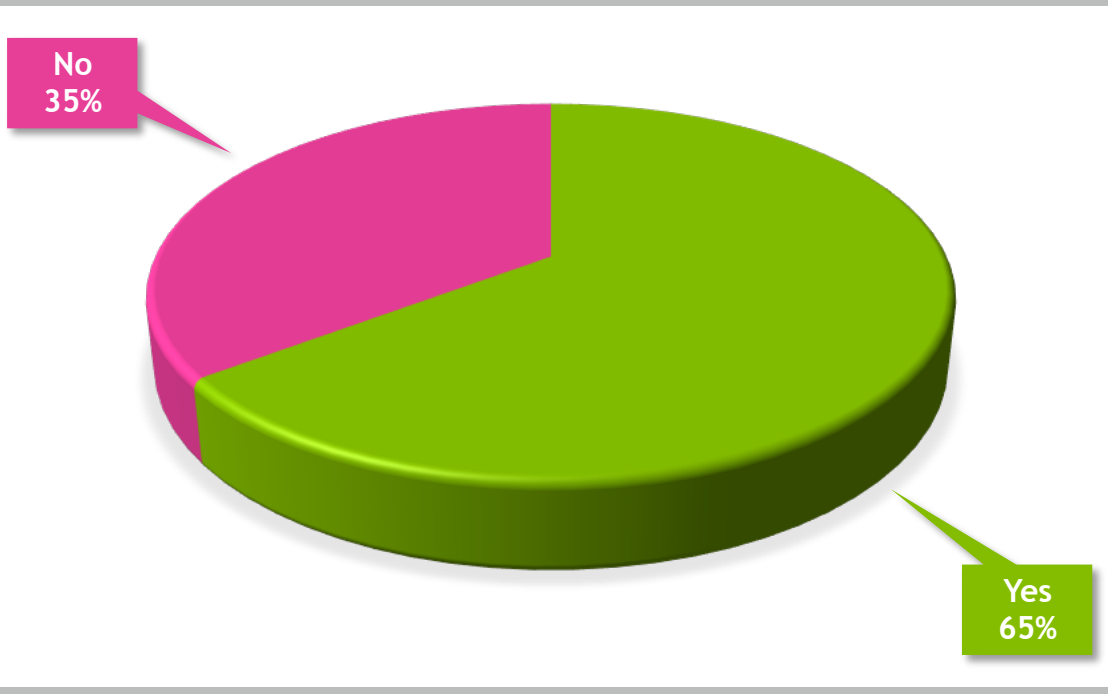
Survey findings

Experiences in GP services

Are you 'out' to your GP about your sexual orientation?

Around two thirds of the respondents told us that they are 'out' to their GP about their sexual orientation. Of those who replied about whether this had made a difference to their relationship with their GP, more than half felt it had made no difference.

We also asked about gender identity (see summary), and 3 transgender people told us that they are 'out' to their GP, and 2 told us that they are not. Of this group, 2 felt being transgender had made no difference to how they are treated, 1 felt treated differently as a result, and another said that things are difficult with their GP as a result.



'I would feel uncomfortable with them knowing I am bi due to the lack of understanding; this is someone who sleeps around.'

The meaning here is unclear, but a common prejudice about people who are bisexual is that they are 'greedy' or 'confused' or must be promiscuous, because of their sexual orientation.

'GP seems to try and link everything to my transition or birth sex.'

Of 10 people who are not 'out' to their GP about sexual orientation and/or gender identity, 4 felt it was not relevant, 5 said it had not come up in conversation, and one replied that they are not sure if their GP is OK about people who are LGBT+.

Experiences as an unpaid carer

Five people told us that they have caring responsibilities for someone else, and none said that they get help from agencies in providing care to another person (although one person did reply to a follow-on question saying that they are open, as an unpaid carer, in letting caring agencies they deal with know their sexual orientation or gender identity.)

We heard that an issue for unpaid carers, particularly where one partner cares for the other, is not being recognised as the person most closely connected to the patient/service user in the NHS and/or social care, and that worrying about this being a problem in future can be very stressful.

Experiences as a person receiving social care

One person told us that they live in supported accommodation or a care home. They said that they are not open there about their gender and sexual identity.

One person told us that they receive care at home from paid carers – and two people replied to the question about being open in this situation. One reply said that everyone knows the person's gender and sexual orientation, the other that some people providing care do.

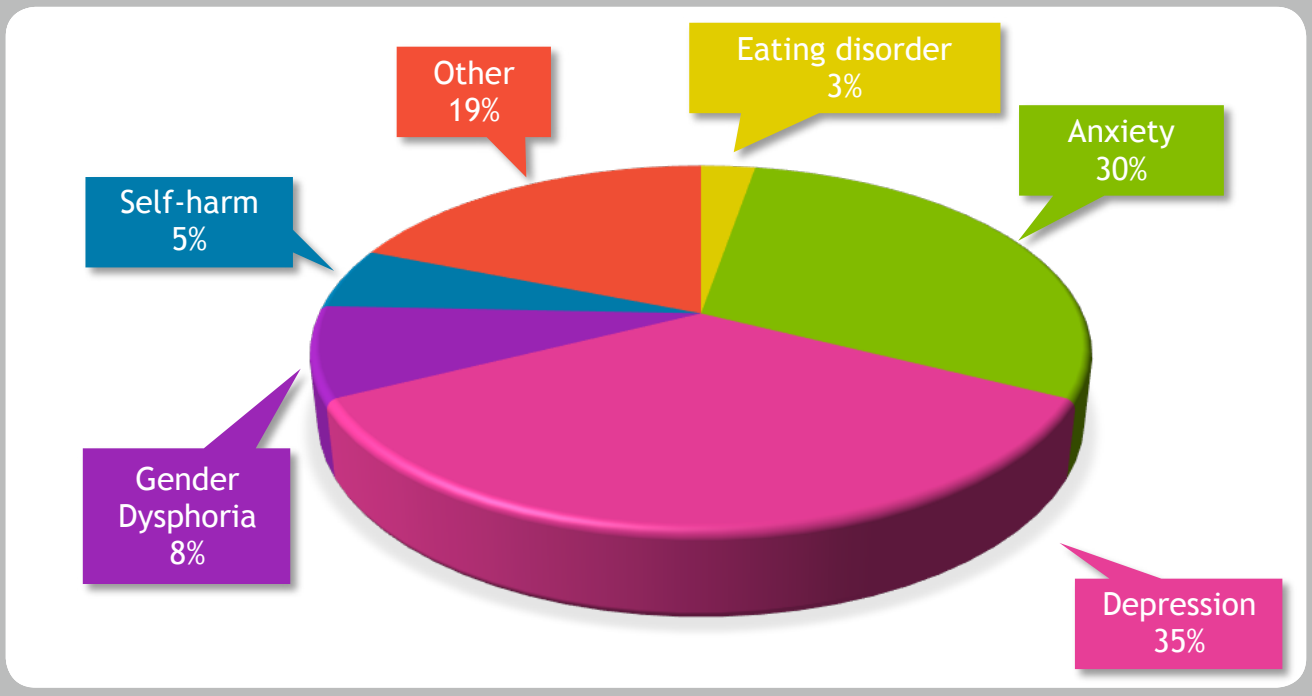
Another person said, 'It doesn't come up really, I am dating at man atm so they assume I am straight I guess.'

Using healthcare services

We asked about receiving treatment in the last 12 months for some conditions that may reflect mental distress or anxiety caused by the prejudice LGBT+ people can experience in their lives. Responses for anxiety and depression were high, given that around 10% of the general population will experience depression at any given time - in this sample 11 out of 35 (31%) reporting anxiety, and 13 (37%) reporting depression. These two conditions may be linked in one person, of course. Other people indicated that they had been treated for eating disorder (1 person), gender dysphoria (3) and self harm (2).

The front cover of a 2013 LGBT Foundation Report[11]

Have you received treatment locally for any of the following in the last 2 years?



We also asked an open question about treatment for other conditions, and people told us:

'Rare pain condition, also see rheumatologist.'

'Severe liver problem.'

'CFS, ADHD.'

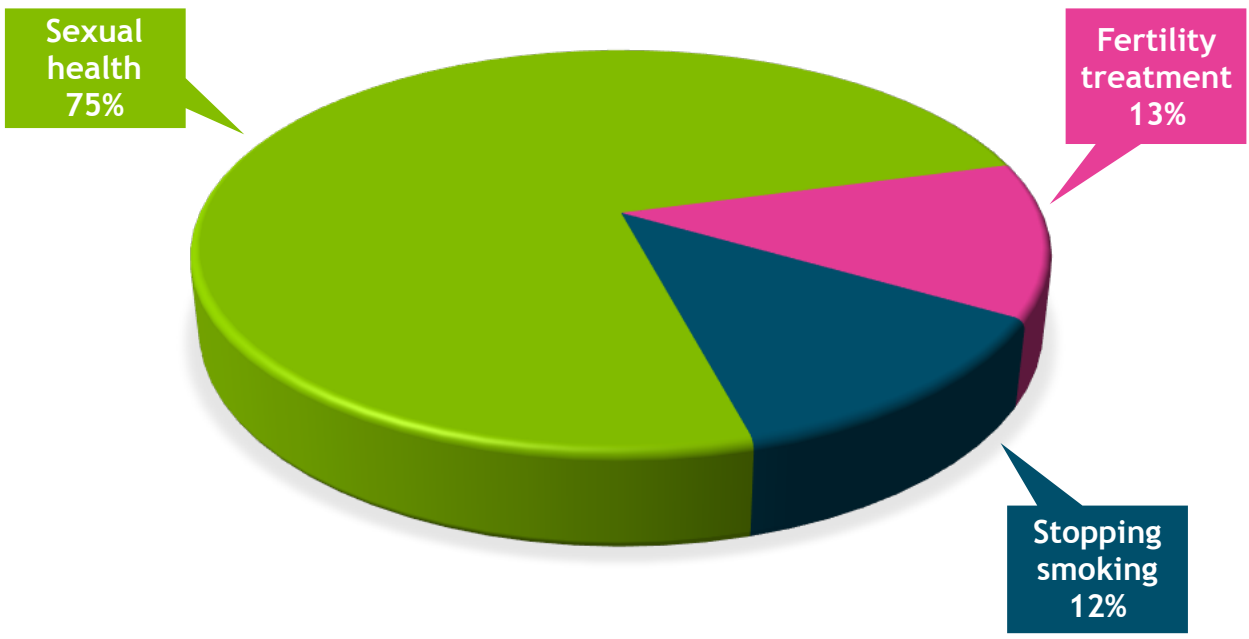
'PTSD.'

'Taking depression pills for 30 years - OK.'

'General messed in the head problems due to surviving child sexual assault and other traumas.'

We asked if people had accessed a number of services that reflect both key public heath priorities and important issues in many lives – sexual health, and fertility. Of the 14 people who replied, 12 had used sexual health services, 2 had used fertility services and 2 had used stop smoking services.

In the last 2 years have accessed any of the services below? Please tick as many as are relevant to you.



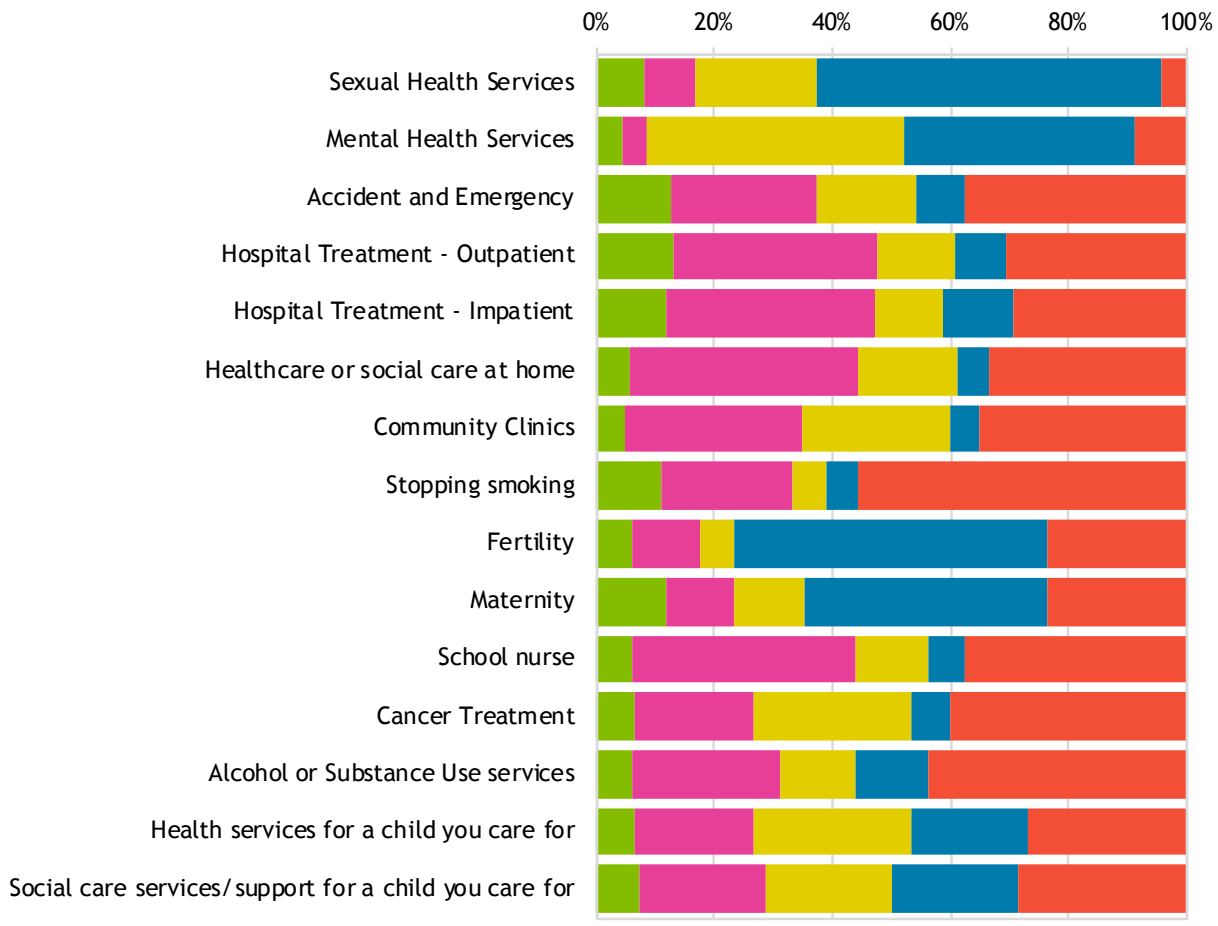
Picture from stock.adobe.com

To disclose or not?

We asked how open people felt they would be able to be when accessing a wide variety of different services that are important for health throughout life, and in exercising the human right to a private and family life (article 8 of the Human Rights Act).

People were most willing to be open in sexual health services, mental health services, with fertility services and maternity services seeing a smaller proportion, but still significant numbers, willing to be 'fairly' or 'very' open.

If you had to access or have accessed any of the services below, how open would you be about your sexual orientation or gemder identity? (Answer as many as you feel could be applicable to you)

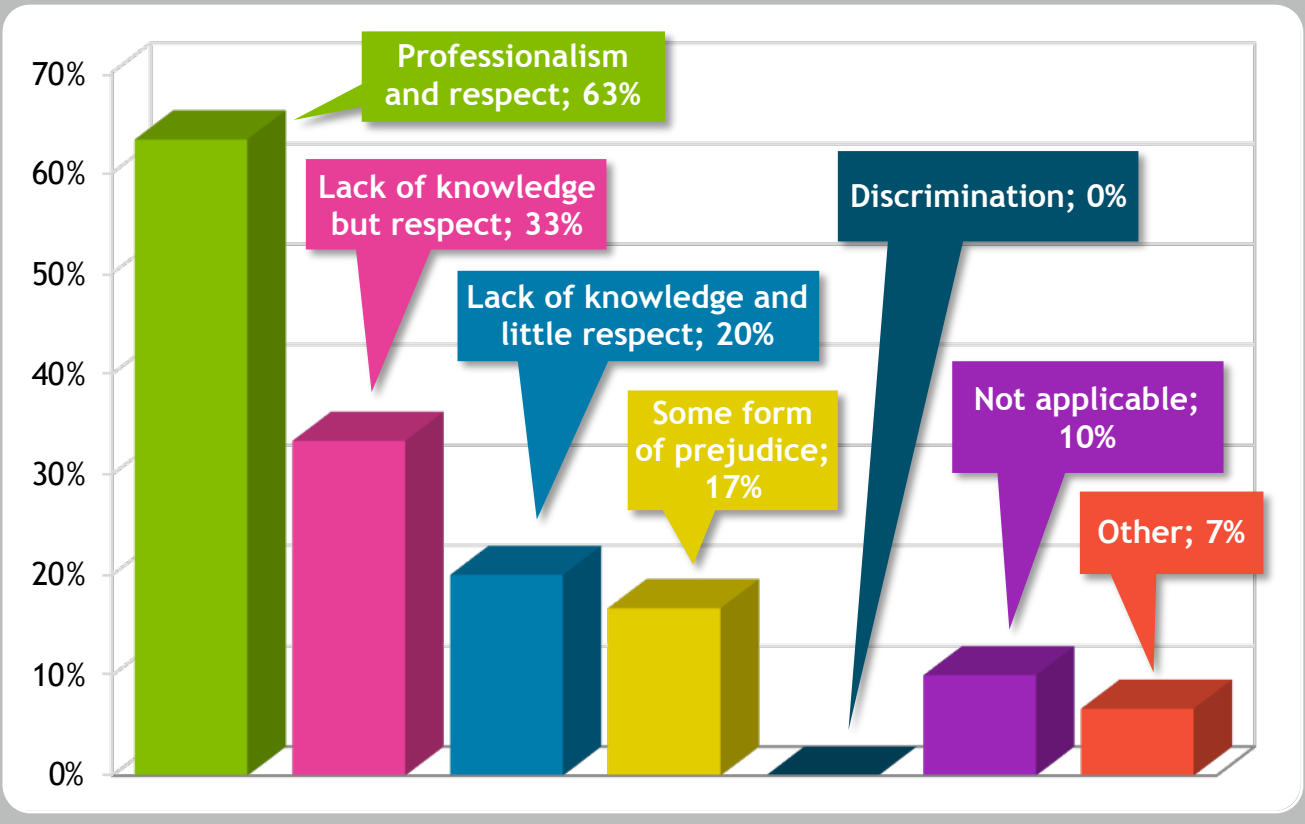


There was less willingness to be open in the A&E Department, hospital treatment as an outpatient, hospital treatment as an inpatient, healthcare or social care at home, stopping smoking services, contact with a school nurse, cancer services and alcohol or substance abuse services. Significant numbers took the view that their gender and/or sexuality is not relevant in these settings.

	Not open at all	Not open unless I have to be	Fairly open	Very open	Sexuality/gender not relevant in my view	Total
Sexual Health Services	8% (2)	8% (2)	21% (5)	58% (14)	4% (1)	24
Mental Health Services	4% (1)	4% (1)	43% (10)	39% (9)	9% (2)	23
Accident and Emergency	13% (3)	25% (6)	17% (4)	8% (2)	38% (9)	24
Hospital Treatment - Outpatient	13% (3)	35% (8)	13% (3)	9% (2)	30% (7)	23
Hospital Treatment - Impatient	12% (2)	35% (6)	12% (2)	12% (2)	29% (5)	17
Healthcare or social care at home	6% (1)	39% (7)	17% (3)	6% (1)	33% (6)	18
Community Clinics	5% (1)	30% (6)	25% (5)	5% (1)	35% (7)	20
Stopping smoking	11% (2)	22% (4)	6% (1)	6% (1)	56% (10)	18
Fertility	6% (1)	12% (2)	6% (1)	53% (9)	24% (4)	17
Maternity	12% (2)	12% (2)	12% (2)	41% (7)	24% (4)	17
School nurse	6% (1)	38% (6)	13% (2)	6% (1)	38% (6)	16
Cancer Treatment	7% (1)	20% (3)	27% (4)	7% (1)	40% (6)	15
Alcohol or Substance Use services	6% (1)	25% (4)	13% (2)	13% (2)	44% (7)	16
Health services for a child you care for	7% (1)	20% (3)	27% (4)	20% (3)	27% (4)	15
Social care services/support for a child you care for	7% (1)	21% (3)	21% (3)	21% (3)	29% (4)	14

While 19 (of 30 respondents) had been met with professionalism and respect when disclosing sexual orientation or gender identity to a health or social care professional in the past, 10 reported lack of knowledge and respect, 6 little knowledge and no respect, and 5 some form of prejudice. One noted that the professional had been 'overly curious'.

If you have disclosed your sexual orientation or gender identity to a health or social care professional in the past, what response have you had from them? You may tick more than one box.



Asked whether they had a negative experience in the last two years when accessing local health and social care services, which they perceived was because of their sexual orientation or gender identity, 27 replied 'no', but 5 people replied 'yes'. This is what they then wrote about their experiences:

'Regular abdominal scan related to gender transition - operator did not read my medical record and assumed I was cisgender male there for prostate scan. I had to explain my whole medical history and current physical condition multiple times. Operator used inappropriate/triggering language. In the end the operator did not even complete the scan conclusively. I told my GP about it later but was told that because it was an outsourced provider I would have to contact them directly to take up any issue with them. I did not feel able to do this.'

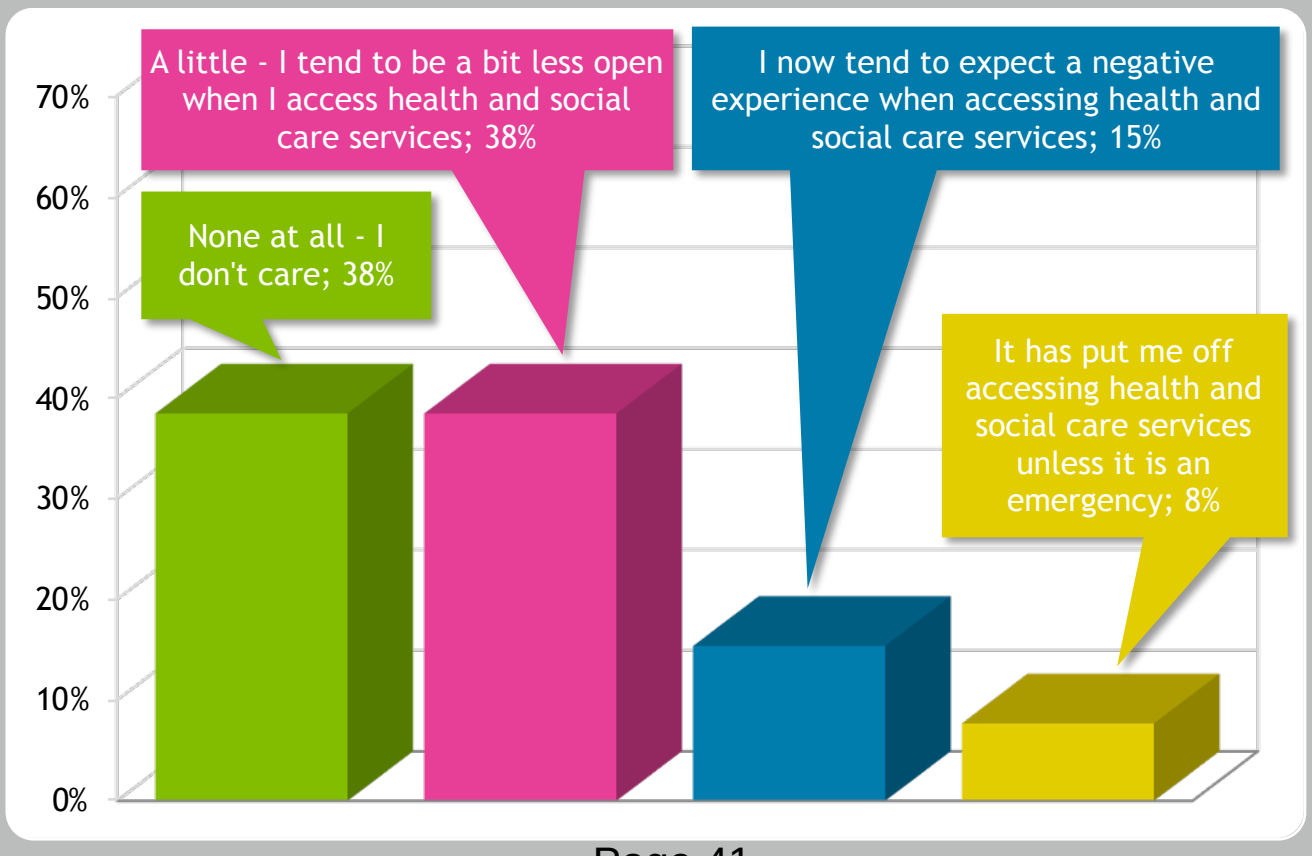
'Advised my midwife/health visitor I was in a same sex relationship and received judgement.'

'Assuming my wife is either a sister or my mother. Questions from GP about contraception. General lack of knowledge about my orientation and therefore making assumptions.'

'While [abroad], I attended a clinic for urethritis and was open about my sexuality. I am in an open marriage. The physician was confused and didn't know how to respond, so he absent-mindedly asked why I wanted to be in an open marriage. It was difficult and made me feel like opening up less to healthcare professionals unless it was relevant.'

Then 8 people told us that a negative experience within the last two years has had some impact on their willingness to access heath and care services in the future. Of these, 5 reported tending to be a bit less open, 2 now tend to expect a negative experience and 1 said they had been put off accessing all except emergency care.

What impact has that negative experience made on you accessing health and social care services in the future?



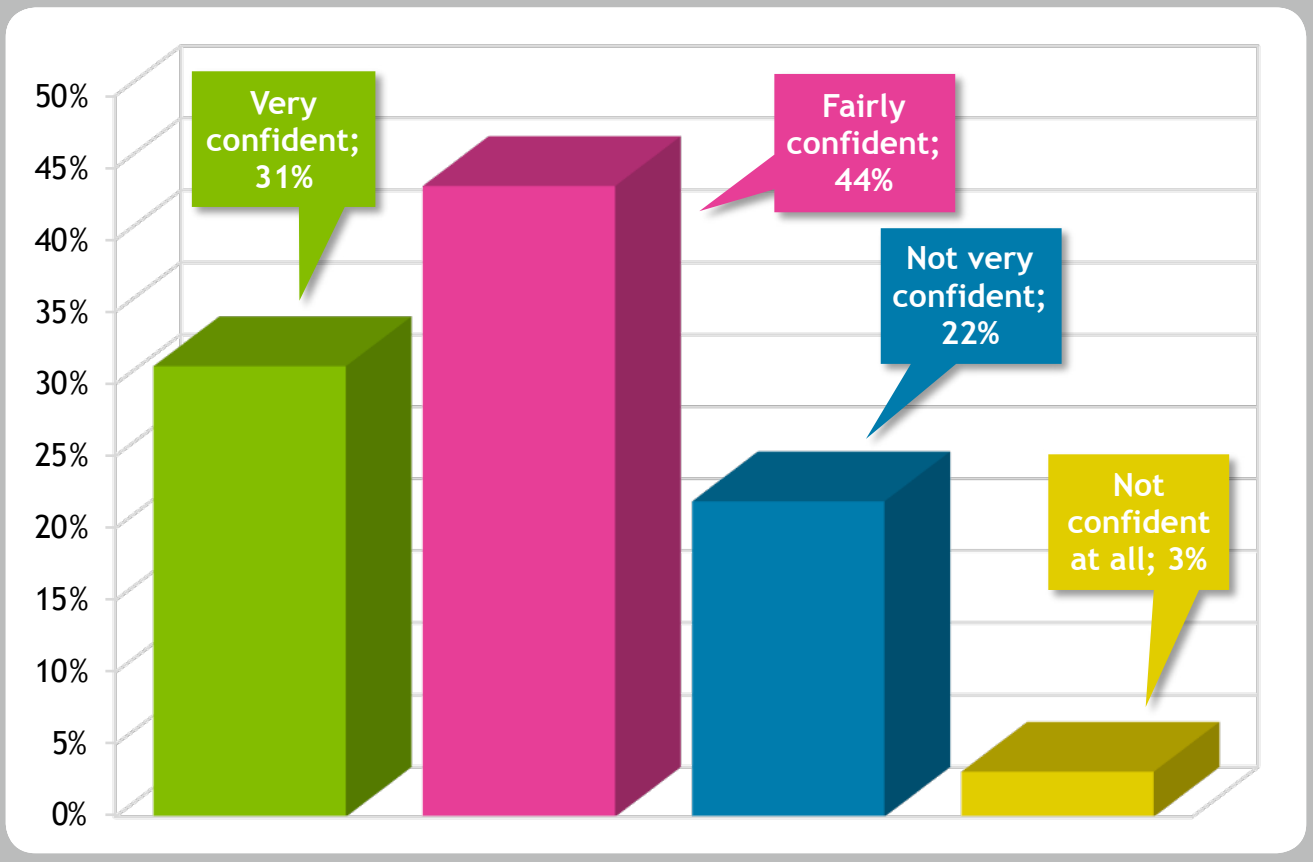
Confidence was high, overall (14 fairly confident and 10 very confident) that in the future health and care professionals would treat them with respect in relation to their sexual orientation or gender identity.

'Some people are very good or at least act professionally, while others are completely ignorant and/or have no idea how to behave, but I have no way of knowing how they will react or what assumptions they will make until I am actually talking to them.'

'I'm sure there are some health care professionals who would respect my orientation, but I have experienced negative treatment from older male doctors based purely on my gender and I doubt that my sexuality would improve that.'

Another indicated that they would feel more confident of this in social care than in health care.

How confident are you that health and social care professionals in the future will treat you with respect because of your sexual orientation or gender identity?



Improvements that could be made to services for LGBT+ services

People told us:

'Be more openly diverse - posters/LGBT+ pins on their lanyards. visual clues so I don't think I'm going to expect judgement for 'coming out'.'

'There isn't a very strong community in Reading so we don't tend to stick up for each other.'

'Greater ease of access to LGBT+ related info, matters and points of contact for any LGBT+ concerns or issues you may wish to raise and address.'

'Refresher training links to overcome loneliness/social isolation.'

'Greater ease of access to LGBT+ related info, matters and points of contact for any LGBT+ concerns or issues you may wish to raise and address.'

'Education to all healthcare professionals about bisexual people - what is means to be bi (we don't all sleep around), and education on sex between women- the risks and what to do about it. When I asked I was told no risks (this is 20 years ago I asked! but I haven't bothered to ask since).'

'More conclusive information on cervical screening for lesbians. This caused some confusion at my GP practice.'

'We need more resources on sexual health for lesbians.'

'More training for medical staff to overcome any weird prejudices they have regarding sexuality and gender. Being asked continually about pregnancy tests when I have a female partner, am female-bodied and have stated multiple times that I will not be conceiving and there is no chance of being pregnant gets very tiring very quickly!'

'Increase awareness/visibility of things that are available.'

'Gay care homes, LGBT awareness for social and healthcare professionals and training.'

Discussion

The survey findings show how important it is not to rely on assumptions about anyone's gender and sexual orientation. Indeed, that it is best not to make any assumptions.

The survey also confirms what is already known from national reports, and local reports in other parts of the Healthwatch network round the country - that knowledge about different possible identities, sexualities and the wide range of partnering and family arrangements that people have is an important part of what any health or care professional should know.

It was disappointing to note that while more than half of respondents had been met with professionalism and respect when disclosing sexual orientation or gender identity to a health or social care professional in the past, a significant number reported lack of knowledge and respect, several 'little knowledge and no respect', and several 'some form of prejudice' (and one noted that a professional had been 'overly curious').

What people said when replying to this survey indicated that respect for people is an important component of feeling safe and understood in services, if people feel it relevant to disclose their gender and/or sexual orientation, which they may not.

It is important to note and understand that, in various situations, some respondents felt that these aspects of themselves were of no immediate relevance. For example, in the hospital A&E Department or when receiving hospital outpatient treatment. There was more of a willingness, in this sample of LGBT+ people, to be open in sexual health and mental health services.

Resources to help with designing services and training staff include:

- local LGBT+ organisations including SupportU[8] - SupportU provides a free service to individuals asking quick questions, including people from local organisations, and also can provide formal training packages
- the national documents and toolkits mentioned below.

Lesbian and Bisexual women

Our survey suggests that better awareness of the healthcare needs of Lesbian and Bisexual women is important – reflecting what is known from reviewing the research evidence and national surveys.

- The LGBT Foundation has useful resources that can inform service commissioners and providers, as well as women, on its Women's Health page[9]
- This film (lasts 3 minutes) explains the findings of a review and analysis of currently published research on Lesbian and Bisexual women's gynaecological conditions.[10] It highlights some of the reasons why these women may experience poor gynaecological health
- This 2013 report[11] by the LGBT Foundation (under its previous name) covers the full range of health issues for Lesbian and Bisexual women
- An evidence-based report[4] just published by Public Health England focuses on Improving the health and wellbeing of Lesbian and Bisexual women, and other women who have sex with women

- A 2015 report from the Equality Network was the first UK wide research report to focus specifically on Bisexual people's experiences of accessing services[12] (female and male bisexual people).

Gay and bisexual men

We did not receive any free-text comments clearly attributable to gay or bisexual men in our survey. Their range of health needs is reflected in this national survey[13] and report from charity Stonewall.

Transgender people

When needing to use services, being transgender is not always the cause, as one of our respondents noted. It is the case, however, that transgender people face barriers to inclusion and access in health and social care that are specific to their situation, as this report[14] from charity Stonewall notes.

Other gender identities and sexual orientations

The health needs of non-binary people (as well as transgender people) are reflected in this commissioning resource document[15] from NHS England.

Getting older

One respondent suggested that 'gay care homes' are needed – the health, care and social needs of LGBT+ people are not always well-met as they age, as this report[16] explains. Sharing memories, photographs, and stories is important for many people as they get older and experience the need for living support, perhaps in relation to dementia or other cognitive impairment, or in relation to the experience of grief when a partner dies.

Feeling safe to do these things is important, and not always straightforward for people who are Lesbian, Gay, Transgender or of other genders or orientations.

The charity Stonewall publishes this guide[17] for health and care services on working with LGB people in older life, based on the findings of a large national survey of people's experiences (published in 2010).

In Manchester, a local Dementia Network[18] has been formed to provide support to LGBT+ people affected by dementia with information, and give them opportunities to help shape future service provision.

The front cover of an Age UK resource[16]

How do our survey findings compare with a larger government study?

We worked with the charity Support U to promote our survey to the LGBT community in Reading and also used social media to target potential respondents. We attracted 35 responses.

The government surveyed 108,000 LGBT people in 2017 and results can be found here: https://www.gov.uk/government/publications/national-lgbt-survey-summary-report[19]

We found similar findings when comparing some of the questions:

Are you 'out' to your GP?

Our survey: 65%

Government survey: More than half had disclosed to a health professional

Have you had a negative experience because of your sexual orientation?

Our survey: 16% said they had experienced some form of prejudice from a health professional following disclosure of their sexual identity

Government survey: at least 16% of survey respondents who accessed or tried to access public health services had a negative experience because of their sexual orientation

Have you accessed services recently for a mental health issue?

Our survey: 31 per cent said they had received treatment for anxiety, and 37 per cent said they had been treated for depression, in the last two years

Government survey: 24% of respondents had accessed mental health services in the 12 months preceding the survey

The government survey led to an LGBT Action Plan[20] published in July 2018, which includes commitments to:

- appointing a national LGBT health adviser to provide leadership on reducing the health inequalities that LGBT people face and awareness of the benefits of asking patients about sexual orientation and gender identity
- improving mental healthcare, including suicide reduction, for LGBT people
- new best practice guidance about the Gender Recognition Act, for GP surgeries and gender identity clinics.

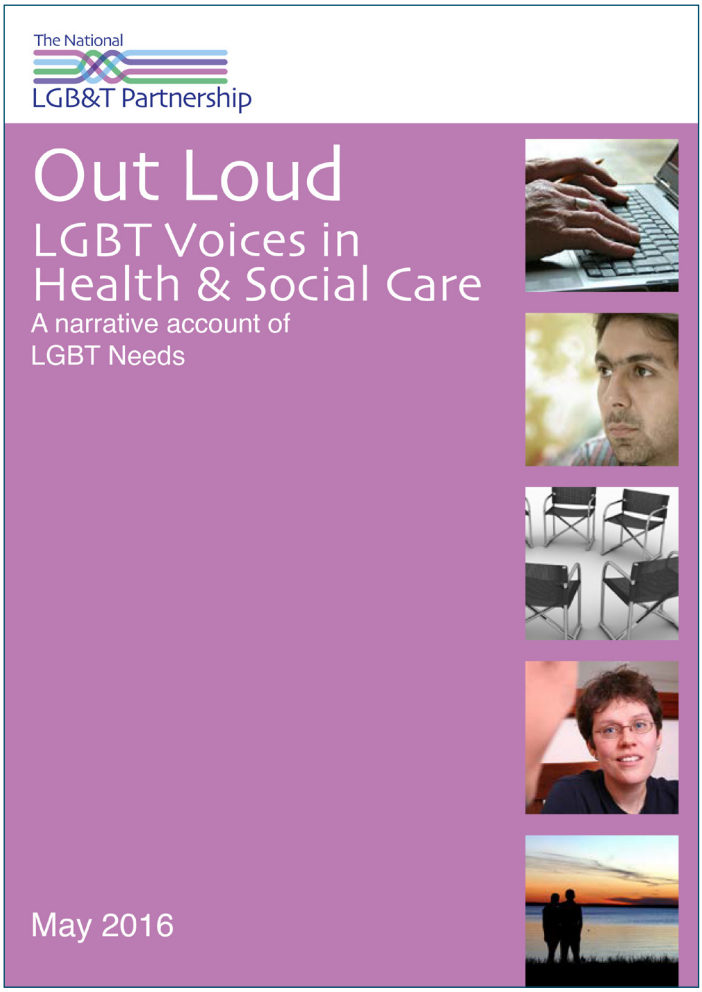
Conclusion and recommendations

We enjoyed working in partnership with SupportU and learned from them. Respondents to the survey suggested a number of improvements that could be made in services which we believe are important, and these are included in our joint recommendations.

Healthwatch Reading and SupportU together recommend

1. NHS and social care services should ensure that the training of their staff is up to date regarding the health needs of LGBT+ people and working with diverse groups. It should take account of the advice given throughout this report, which includes:
    - Do not make judgemental comments
    - Do not ask questions about gender and sexual orientation beyond what they need to know to provide care or help
    - Do not make assumptions about the relationship between any person and the person(s) accompanying them
2. NHS and social care services should take steps to be more clearly welcoming to and respectful of diversity e.g. using posters, LGBT+ pins on their lanyards – and ensure greater ease of access to LGBT+ related information and points of contact for any LGBT+ concerns or issues patients/service users may wish to raise
3. Reading Borough Council should explore supporting social care provision that is sensitive to the needs of LGBT+ people
4. Local commissioners and providers should ensure that they use
    - this national resource[1], published in 2016 by the LGB&T partnership and based on the views of more than 200 people identifying as LGBT+
    - this guide for the NHS[2] and this toolkit[3] from charity Stonewall
    - this Healthwatch Reading report and
    - the other resources mentioned in the discussion section of this report

    to inform the commissioning of LGBT+ inclusive local health and social care services, and staff training in these services.



The front cover of a report by the National LGBT Partnership[1]

Next steps

We know from experience that going out into the community is the most effective way to reach people, and that is what we plan to do next. We will be at Reading Pride in September and look forward to listening to LGBT+ Reading people there and collecting their views about health and social care.

Picture from pixabay.com

Picture from pixabay.com

Picture from SupportU

Your legal rights as a LGBT person when using the NHS

The Equality Act (2010)[21] says you must not be discriminated against because:

- you are heterosexual, gay, lesbian or bisexual
- someone thinks you have a particular sexual orientation (this is known as discrimination by perception)
- you are connected to someone who has a particular sexual orientation (this is known as discrimination by association)

In the Equality Act, sexual orientation includes how you choose to express your sexual orientation, such as through your appearance or the places you visit.

The NHS Constitution (2015)[22] states:

'You have the right not to be unlawfully discriminated against in the provision of NHS services including on grounds of gender, race, disability, age, sexual orientation, religion, belief, gender reassignment, pregnancy and maternity or marital or civil partnership status.'

'You have the right to be treated with dignity and respect, in accordance with your human rights.'

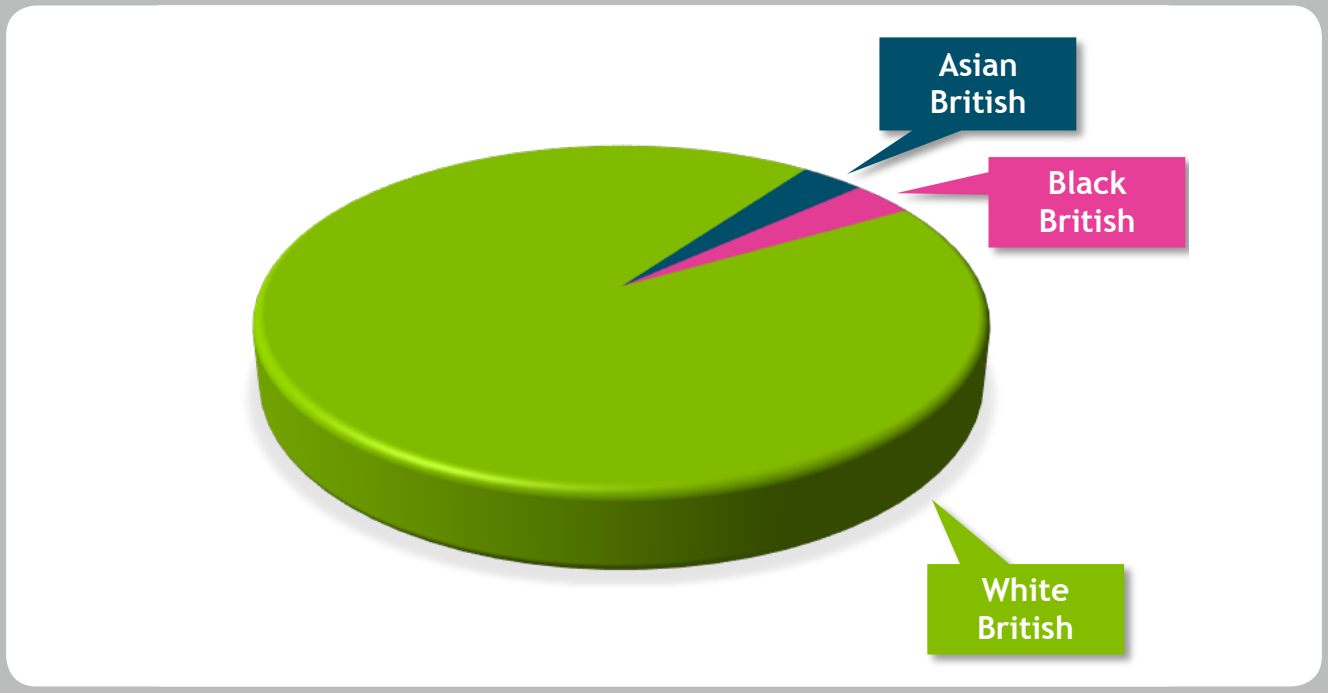
The constitution also states NHS staff 'have a duty not to discriminate against patients or staff and to adhere to equal opportunities and equality and human rights legislation'.

Appendix 1:

About the people who answered the survey

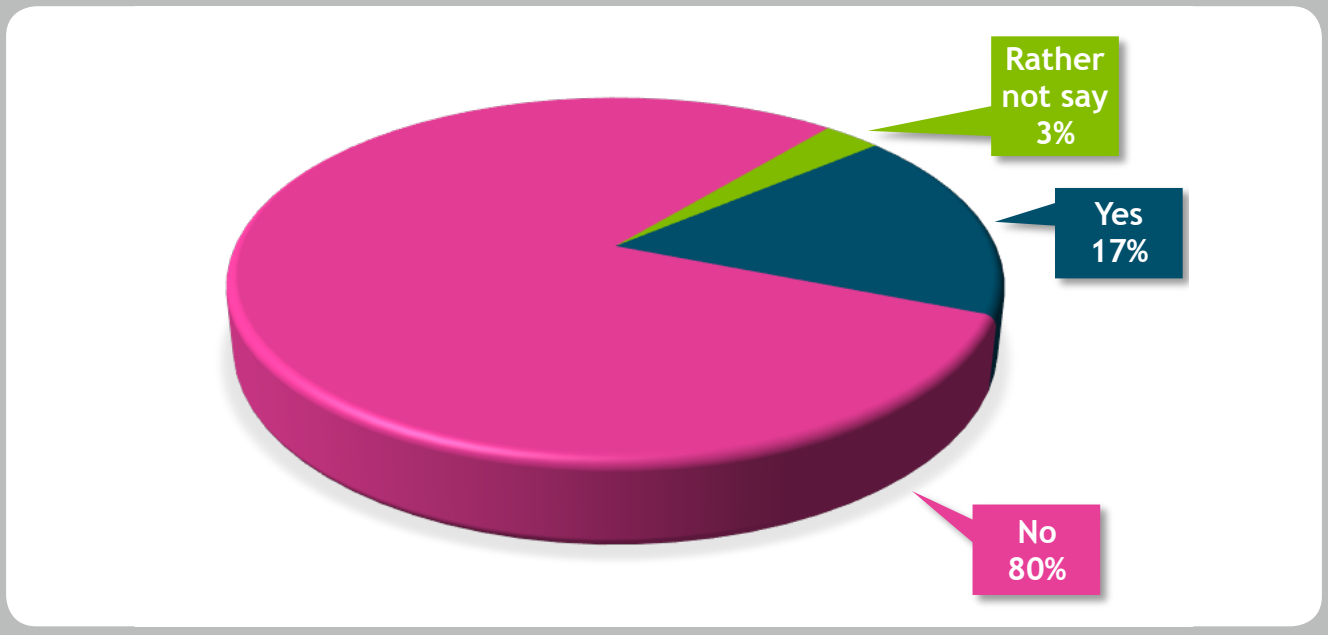
What is your ethnicity?

The respondents were almost all people identifying as White British, two were from ethnic minorities.



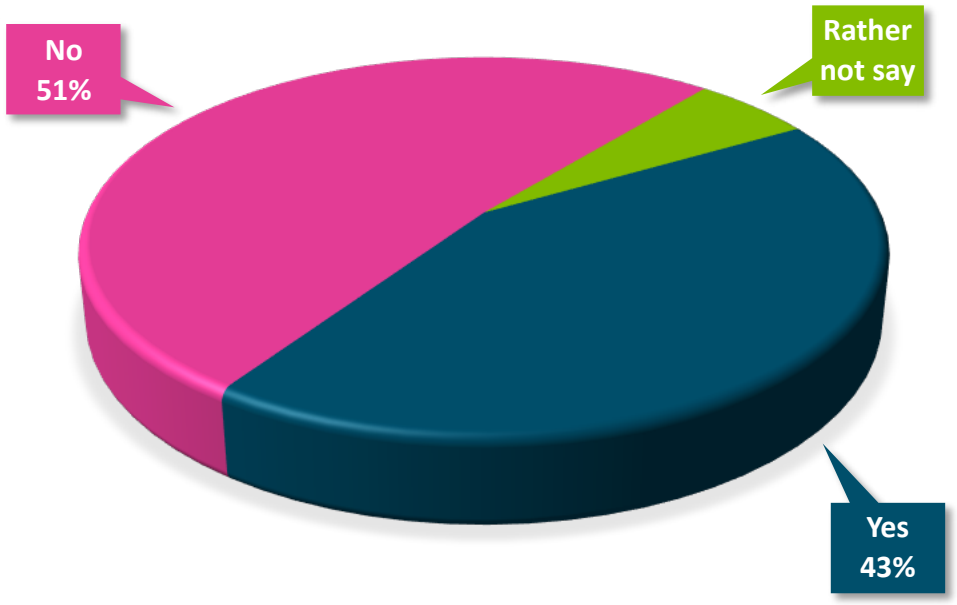
Do you have a physical disability/impairment?

6 people reported having a physical disability



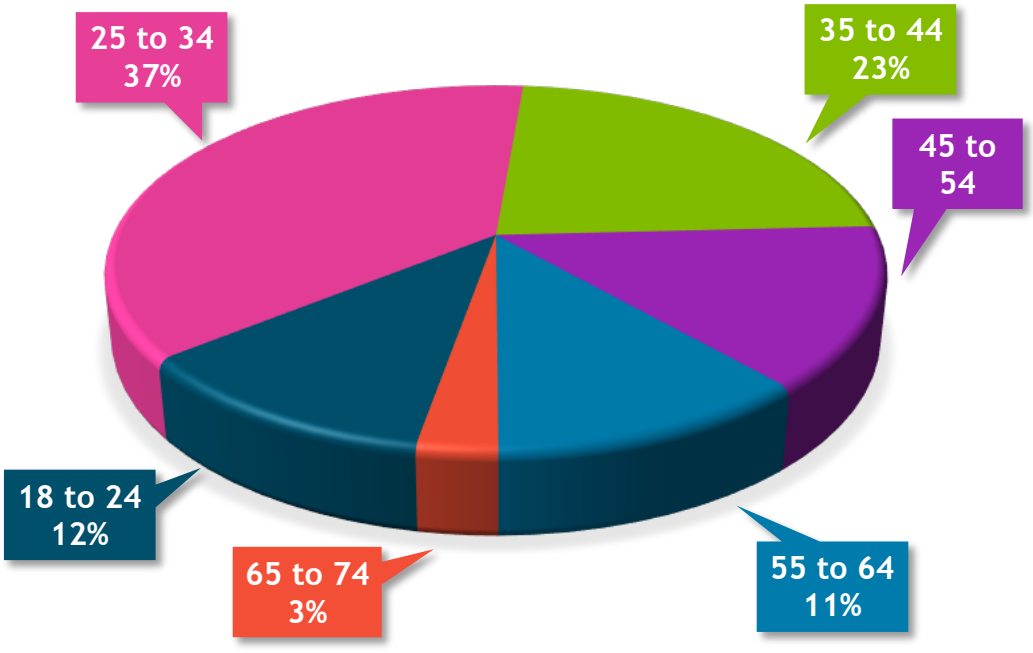
Do you have a hidden disability/impairment?

18 people reported having a hidden disability, which could include mental health issues.



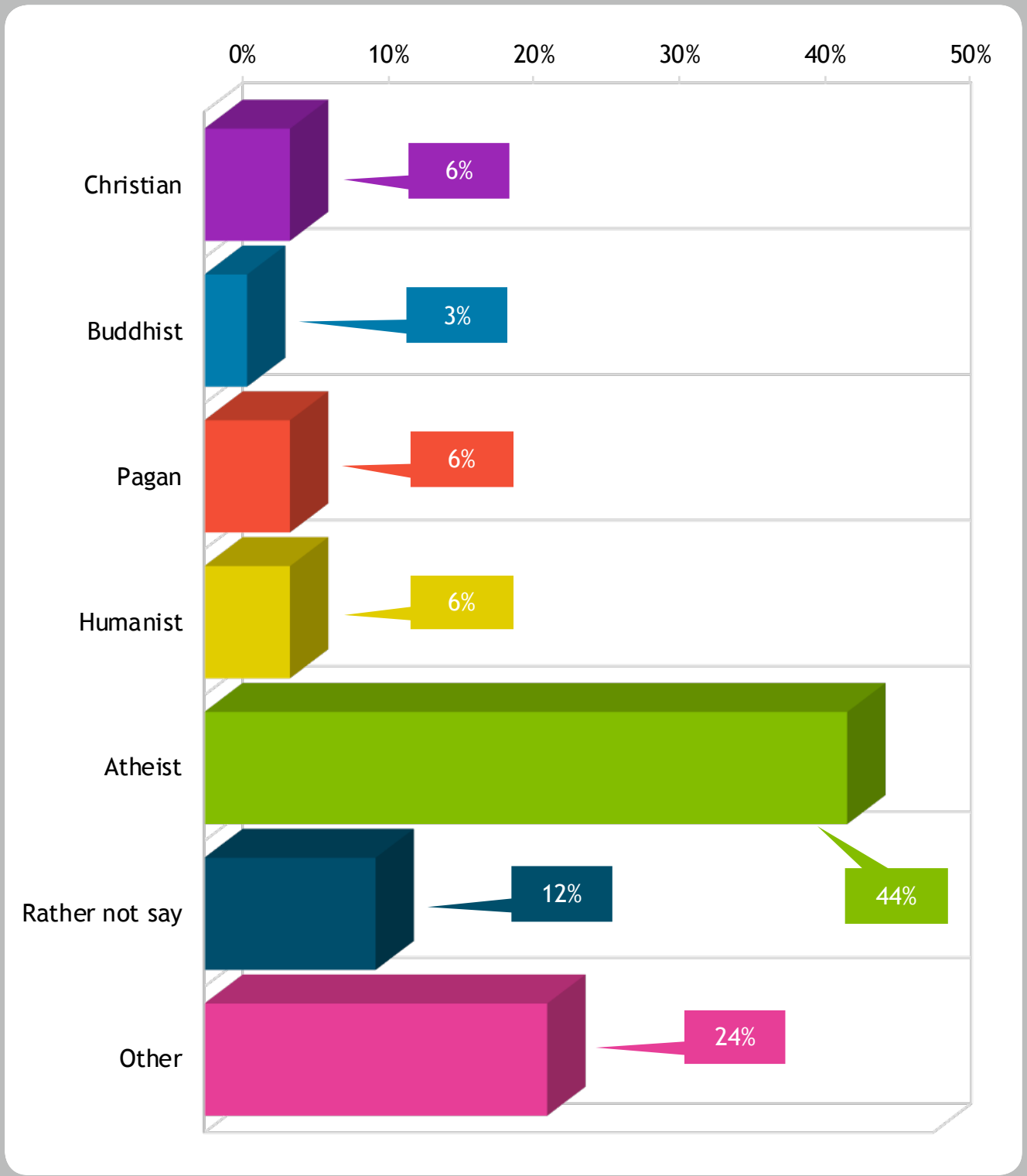
What is your age?

Around half of the respondents are aged 25 to 44



Do you have a religion or faith or other chosen life approach?

Around half describe themselves as atheists



Appendix 2:

The organisations in Reading we contacted by email (or via social media) with the survey link

- ACRE Reading
- Berkshire, Buckinghamshire & Oxfordshire Law Society
- Berkshire Healthcare Foundation Trust
- Ernst & Young
- Environment Agency
- Microsoft
- MyUmbrella
- Office of the Independent Adjudicator for Higher Education
- Reading Football Club
- Reading Youth
- Reading Borough Council
- Reading Pride
- Reading Voluntary Action
- Royal Berkshire Hospital NHS Foundation Trust
- South Central Ambulance Service
- SSE plc
- Thames Valley Police
- Thames Valley Police LGBT+ Association
- Thames Water
- The Oracle Shopping Centre
- University of Reading
- University of Reading LGBT+ Society

References

1 **The National LGB&T Partnership (2016) Out Loud: LGBT Voices in Health and Social Care.**
https://nationallgbtpartnership.org/publications/out-loud/

2 **Stonewall (2012) Sexual Orientations A guide for the NHS**
https://www.stonewall.org.uk/sites/default/files/stonewall-guide-for-the-nhs-web.pdf

3 **Stonewall (2017) Service Delivery Toolkit How to Build an LGBT-inclusive service Step 1 Beginning the Journey**
https://www.stonewall.org.uk/sites/default/files/sdt-step1.pdf

4 **Public Health England (2018) Improving the health and wellbeing of lesbian and bisexual women and other women who have sex with women**
https://assets.publishing.service.gov.uk/government/uploads/system/uploads/attachment_data/file/723557/improving_health_and_wellbeing_LBWSW.pdf

5 **Reading Borough Council Joint Strategic Needs Assessment (JSNA) Lesbian, Gay, Bisexual,& Trans (LGBT) People**
http://www.reading.gov.uk/jsna/lgbt

6 **The National LGB&T Partnership (2016) Public Health Outcomes Framework Companion**
https://nationallgbtpartnership.org/publications/phof/

7 **The National LGB&T Partnership (2016) Public Health Outcomes Framework Companion**
https://nationallgbtpartnershipdotorg.files.wordpress.com/2018/04/lgbt-public-health-outcomes-framework-companion-doc.pdf

8 **SupportU**
http://www.supportu.org.uk

9 **LGBT Foundation Women's Health page**
https://lgbt.foundation/who-we-help/women/general-health

10 **Lesbian and Bisexual women's likelihood of becoming pregnant and gynaecological conditions - filmed summary of: Hodson, Meads and Bewley (2016) Lesbian and Bisexual women's likelihood of becoming pregnant and gynaecological conditions: a systematic review and meta-analysis**
https://vimeo.com/198372354
(see written report at https://obgyn.onlinelibrary.wiley.com/doi/full/10.1111/1471-0528.14449)

11 **LGBT Foundation (2013) Beyond Babies and Breast Cancer - Health care needs of lesbian and bisexual women: an overview of the available evidence**
https://s3-eu-west-1.amazonaws.com/lgbt-media/Files/4d02f34a-74f5-47da-b11a-b78f57b6ee2c/Beyond%2520Babies%2520and%2520Breast%2520Cancer.pdf

12 **Equality Network (2015) Complicated? Bisexual people's experiences and ideas for improving services**
https://www.equality-network.org/resources/publications/bisexual/

13 **Stonewall (2013) Gay and Bisexual Men's Health Survey**
https://www.stonewall.org.uk/sites/default/files/Gay_and_Bisexual_Men_s_Health_Survey__2013_.pdf

14 **Stonewall (2016) Getting it right with your trans service users and customers**
https://www.stonewall.org.uk/sites/default/files/getting_it_right_with_your_trans_service_usersand_customers.pdf

15 **NHS England (2015) Treatment and support of transgender and non-binary people across the health and care sector: Symposium report**
https://www.england.nhs.uk/commissioning/wp-content/uploads/sites/12/2015/09/symposium-report.pdf

16 **Age UK (2017) Meeting the needs of older LGBT people**
https://www.ageuk.org.uk/latest-news/articles/2017/november/meeting-needs-of-older-lgbt/

17 **Stonewall (2012) Working with older lesbian, gay and bisexual people A guides for Care and Support Services**
https://www.stonewall.org.uk/sites/default/files/older_people_final_lo_res.pdf

18 **LGBT Foundation - LGBT Dementia Network - Manchester**
https://lgbt.foundation/events/new-lgbt-dementia-network/5741

19 **Government Equalities Office (2018) LGBT Survey Summary Report**
https://www.gov.uk/government/publications/national-lgbt-survey-summary-report

20 **Government Equalities Office (2018) LGBT Action Plan - Improving the Lives of Lesbian, Gay, Bisexual and Transgender People**
https://www.gov.uk/government/publications/lgbt-action-plan-2018-improving-the-lives-of-lesbian-gay-bisexual-and-transgender-people

21 **Equality and Human Rights Commission**
https://www.equalityhumanrights.com/en/equality-act-2010/what-equality-act

22 **The NHS Constitution (2015)**
https://www.gov.uk/government/publications/the-nhs-constitution-for-england/the-nhs-constitution-for-england

Contact Healthwatch Reading at:
3rd floor, Reading Central Library
Abbey Square, Reading
RG1 3BQ
Telephone 0118 937 2295
Email info@healthwatchreading.co.uk

healthwatch Reading
advice • advocacy • action

NHS
North and West Reading
Clinical Commissioning Group

Reading Borough Council
Working better with you

NHS
South Reading
Clinical Commissioning Group

READING HEALTH AND WELLBEING BOARD

DATE OF MEETING:	**12th October 2018**	**AGENDA ITEM:**	**7**
REPORT TITLE:	**Reading's Drug and Alcohol Consultation on the Commissioning Strategy for Young People and Adults for 2018 to 2022**		
REPORT AUTHOR:	**Sally Andersen**	**TEL:**	**0118 9373244**
JOB TITLE:	**Senior Commissioner Drugs and Alcohol**	**E-MAIL:**	**Sally.andersen@reading.gov.uk**
ORGANISATION:	**Reading Borough Council**		

1. PURPOSE OF REPORT AND EXECUTIVE SUMMARY

1.1 To inform on the consultation outcome of the draft Reading Drug and Alcohol Commissioning Strategy for Young People and Adults from 2018 to 2022.

1.2 Appendix 1 – Reading Drug and Alcohol Commissioning Strategy for Young People and Adults – 2018-2022
Appendix 2 - Reading Drug and Alcohol Commissioning Strategy for Young People and Adults – 2018-2022 Consultation Results

1.3 The Policy Committee on 24 September 2018 noted the consultation results and endorsed the Strategy (Minute 32 refers).

2. RECOMMENDED ACTION

2.1 To note the 8 weeks consultation results of the Reading Drug and Alcohol Commissioning Strategy for Young People and Adults 2018-2022.

2.2 To endorse the Reading Drug and Alcohol Commissioning Strategy for Young People and Adults 2018-2022.

2.2 To note the next steps in the production of the action plan for each of the three priorities and development of service specification.

3. NATIONAL POLICY CONTEXT

3.1 Reading's draft Drug and Alcohol Commissioning Strategy for Young People and Adults – 2018-2022 has been written in line with the Government Drug Strategy 2017, the Governments' Alcohol Strategy 2012 and Reading Health and Wellbeing Strategy 2017-2020.

3.2 Alcohol is the most widely available drug in the UK and is used sensibly by the majority of the population. It is part of our social fabric and a major contributor to the economic vibrancy of the community. Whilst most people do not use drugs, drug misuse can be found across all communities in society. From heroin and crack use among adults, to cannabis use amongst young people, to the use of new psychoactive substances by clubbers, drugs are available and misused by a wide range of people.

Although the number of people using alcohol and taking drugs is reducing nationally and locally, the needs of alcohol and drug users are becoming increasingly complex, and there is a strong link between high risk substance use and deprivation. There is evidence that problems of alcohol and drug dependence are significantly less prevalent in the population working full time than in the unemployed and economically inactive, and many higher risk drinkers come from fractured family backgrounds, with a history of alcohol abuse in the family. The proportion of the population drinking more frequently is most prevalent among less affluent neighbourhoods in Reading. There are also strong links between homelessness, offending and substance misuse, and significantly higher than average prevalence of people who have issues with substance misuse, homelessness and offending behaviours (multiple complex needs).

4. THE PROPOSAL

4.1 Current Position

As drug and alcohol misuse is a cross-cutting issue, it requires a multi-agency response. The draft strategy is one that involves our partners and it covers a wide range of issues such as multiple complex needs, prevention, early intervention, education, training, employment, housing, finances, crime, recovery and support.

A drug and alcohol needs assessment for adults was carried out in December 2016. The findings from the consultation has therefore informed the draft strategy and sets out the key priorities over the next 5 years. Following a period of health and social care partner engagement to develop our draft strategy, three priorities were identified:

Priority 1 - Prevention; reducing the amount of alcohol people drink to safer levels and reducing drug related harm.

Priority 2 - Treatment; Commissioning and delivering high quality drug and alcohol treatment systems.

Priority 3 - Enforcement and Regulation; tackling alcohol and drug related crime and anti-social behaviour.

The Public Health Team ran a public consultation exercise lasting eight weeks from 21st February 2018 to 23rd April 2018. This was to ensure Reading Borough Council and its health and social care partners are focused on appropriate priorities for the period 2018-2022, in responding to the changing needs of people, affected by Drugs and Alcohol.

4.2 Options Proposed

The 'Drug and Alcohol Strategy for Adults and Young People', is intended to set out the broad vision of the Council in terms of what actions are required to put in place a sustainable treatment support system for drug and alcohol use in Reading. The focus is on a health and social care multidisciplinary approach that joins up the different services provided across all agencies partners, which will benefit individuals, families and for society more generally.

The public were invited to comment on whether they agreed with the strategic priorities for Reading. They were also asked to suggest what was needed to achieve each priority. Their response will be used to develop our local action plan in supporting each priority. A total of 91 questionnaires were completed and returned, which represents a good sample size.

The Consultation results:

Priority 1 – Prevention

92.31% agreed with this priority.

Priority 2 – Treatment
93.41% agreed with this priority

Priority 3 – Enforcement and regulation
93.41% agreed with this priority.

It is recommended that the strategy be changed to reflect the views of people and partners involved, and that our local action plan be developed for each of the three priorities with clear performance indicators that demonstrate the numbers that access the services and the effectiveness and best value targets.

Further information - the analysis of the consultation response received is detailed at Appendix 2.

5. CONTRIBUTION TO STRATEGIC AIMS

5.1 The Reading Drug and Alcohol Commissioning Strategy for Young People and Adults – 2018-2022 (Appendix 1) supports the Council's strategic aims '*Safeguarding and protecting those that are most vulnerable'*.

5.2 The Reading Drug and Alcohol Commissioning Strategy for Young People and Adults – 2018-2022 reflects the Health and Wellbeing Strategy 2017-2020 which includes alcohol as a priority; the goal being to reduce the amount people drink to safer levels. The strategy also contributes to the priority "*Supporting people to make healthy life choices".*

5.3 The drug and alcohol strategy 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 specifically addresses these in the following ways:

- Support a change in the community's attitude by supporting and encouraging more responsible drinking.
- Increase awareness, understanding and support the change in lifestyle and attitudes in order to empower and enable individuals to make more positive choices about the role of alcohol and drugs in their lives.
- Ensure individuals understand:
  The health risks associated with drugs and alcohol,
  The consequences using can have on education, employment, relationships, housing and
  The impact the environment where the individual is misusing can have.
- We want to improve people's wellbeing, increase their chances of recovery from drug and alcohol misuse, and help ensure they are safe. We have an ambition for sustained recovery, reducing harm to individuals and the wider community. We see this as being achieved through three themes of activity: prevention, treatment and enforcement.

6. COMMUNITY & STAKEHOLDER ENGAGEMENT

6.1 The Reading Drug and Alcohol Commissioning Strategy for Young People and Adults – 2018-2022 has been prepared with key health and social care partners and an eight week public consultation period took place.

7. EQUALITY IMPACT ASSESSMENT

7.1 The consultation questionnaire included an 'About You' section which included gathering equality data. This information has been included in the consultation results analysis (Appendix 2).

7.2 An equality impact assessment regarding any potential changes to the treatment service from 2019/20 will need to be completed as part of the procurement process for a new service.

8. LEGAL IMPLICATIONS

8.1 Local authorities' statutory responsibilities for public health services are set out in the Health and Social Care Act 2012 (subsequently referred to as the '2012 Act'). As of 1 April 2013, Local Authority duty is to improve public health through mandated and non-mandated functions. Whilst drugs and alcohol is a non-mandated service, the Public Health grant condition state local authorities must have regard to the need to improve the take up of, and outcomes from, its drug and alcohol misuse treatment services.

9. FINANCIAL IMPLICATIONS

9.1 Drug and alcohol treatment services are funded from the Public Health Budget. The funding included for these services in 2018-19 is £1.95m. The grant in both 2018-19 and 2019-20 continue to be subject to conditions, including a ring-fence requiring local authorities to use the grant exclusively for public health activity.

9.2 From 2019/20, the drug and alcohol treatment budget will reduce by 8% across 2 years until 2020/21. A reduction in funding may influence a change in demand for the service, however this is considered to be a low risk at 4% reduction per year. Numbers in specialist treatment for alcohol were 181 (2017/18). Those that successfully completed alcohol treatment were 81 (Reading 44.7%, England 38.7%) Numbers in specialist treatment for opiate drug misuse were 580 (2016). Those that successfully complete drug misuse treatment (opiate) were 59 (Reading 9.2% England 6.7%). Numbers in specialist treatment for non-opiates were 98 (2016). Those that successfully completed drug misuse treatment for non-opiates were 53 (54.4% Reading, 34.7% England). Services will seek to enable service users to reduce their dependency and will focus on those that are most in need.

9.3 The Council remains aware of the need to ensure that drug and alcohol services are provide a safe, fit for purpose, quality service. With this in mind the Council intends to minimise the risks on other Council services (Children and Families, Adult Social Care, Housing and Neighbourhoods) as well as cost to the wider legal (crime) and health (spread of blood borne virus, HIV) system through the minimal budget reduction despite the fact the Public Health grant from Central government has been reduced overall by 3.9%.

9.4 In October 2015, the Government announced proposals for local councils to be 100% funded by locally raised revenue by 2020. Under these proposals, top-up grants from central government will be phased out by 2020. Instead, the current position is that local authorities will be expected to use their business rates to fund a number of services and grants; Public Health grant (ring-fence to be maintained until 2019-20). The detail around the proposal to use business rates is still under consideration at national level.

10. SUPPORTING PAPERS

10.1 Appendix 1 – Reading Drug and Alcohol Commissioning Strategy for Young People and Adults – 2018-2022

Appendix 2 - Reading Drug and Alcohol Commissioning Strategy for Young People and Adults – 2018-2022 Consultation Results

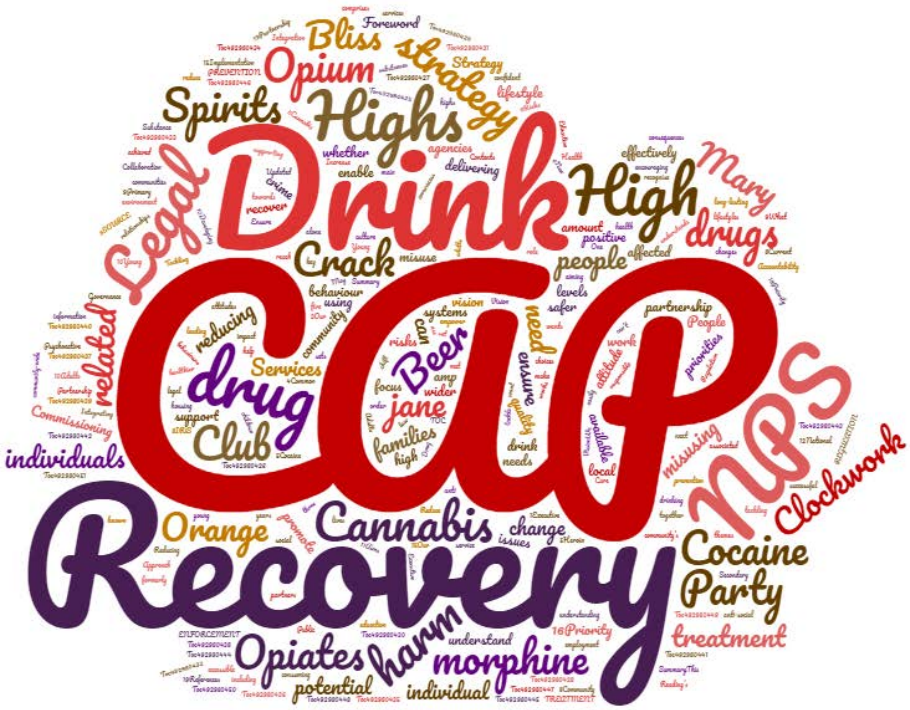
Wellbeing Team

Reading Borough Council
Working better with you

January 2018

Reading Drug and Alcohol Commissioning Strategy for Young People and Adults

2018 – 2022



Foreword

This strategy sets out Readings' approach to tackling drug and alcohol related problems, both of which can be inextricably linked to health inequalities. The pattern of drug and alcohol use is changing so now is the ideal time to create a new drugs and alcohol Strategy for young people and adults with all partners.

The early preventative treatment of drug and alcohol misuse will hopefully avoid damaging longer term dependency and ultimately prove much more efficient and effective. The sheer size of alcohol misuse should make it a priority and so this is where we believe we should be targeting our work, whilst continuing to offer support and interventions for drugs misuse. It is evident that treating and managing drug and alcohol is complex. It is also clear that the challenges we are facing cannot be addressed by any one agency or individual alone.

Problematic drug and alcohol use is associated with poor living conditions, unemployment, domestic abuse, ill-health and safeguarding concerns. There are new substances, such as 'legal highs'; new supply routes including the internet and 'head shops'; and new patterns of use and problems associated with more established substances, including problems with heroin and alcohol becoming more common among older people. We need to respond to these challenges, and be aware that this area never stands still.

We want to improve people's wellbeing, increase their chances of recovery from drug and alcohol misuse, and help ensure they are safe. We have an ambition for sustained recovery, reducing harm to individuals and the wider community. We see this as being achieved through three themes of activity: prevention, treatment and enforcement. While the strategy presents our three priorities for Reading, the details of how we will tackle these issues will be contained within three action plans – one for each of the three priorities.

In the face of mounting cuts to the council's health budget, now more than ever we need to focus our limited resources in the areas that will have the most impact. This strategy is a step towards having a constructive and responsive approach to bring partners together to transform health and wellbeing in Reading; prevent drug and alcohol misuse, and support people to recover and to build healthy, fulfilled lives.

We hope that you find this strategy informative and focused on the right priorities to deliver results. I would like to take this opportunity to thank everyone for their invaluable contributions to the development of this strategy.

Councillor Graeme Hoskin

Contents

Executive Summary

This strategy sets out Reading's drug and alcohol related vision and priorities for the next five years.

The key focus is to reduce the harm, or potential harm, that misusing drugs and alcohol has on the individual, families and the wider community. We need to ensure that treatment services are available and accessible to support those who need them to recover effectively. Education and information needs to be easily available.

We understand the work set out in this strategy can only be achieved in successful partnership with all agencies in Reading.

This strategy comprises three main 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.

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.

Reading wants to promote a culture shift to promote a positive change in the attitude and behaviours towards alcohol harm and drug misuse. We need to:

- Support a change in the community's attitude by supporting and encouraging more responsible drinking.
- Increase awareness, understanding and support the change in lifestyle and attitudes in order to empower and enable individuals to make more positive choices about the role of alcohol and drugs in their lives.
- Ensure individuals understand:
    - the health risks associated with drugs and alcohol
    - the consequences using can have on education, employment, relationships, housing and
    - the impact the environment where the individual is misusing can have.

Our Vision

We recognise that, to ensure long-lasting changes in lifestyles, we need to work with individuals, families, communities and other partners. One service alone can't tackle all the issues.

Our vision is to:

> *"Reduce the harm, or potential harm, that misusing alcohol and drugs has on the individual, families and the wider community. We want 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"*

We are aiming for a local partnership that works together effectively to ensure that it understands drug and alcohol use in Reading, and is confident that local needs for prevention and treatment are being met.

Common drugs, the risks and the law

The most commonly used drugs, such as cannabis, opiates and crack cocaine, are illegal. Uncontrolled New Psychoactive Substances (also called NPS, 'legal highs' or 'club drugs') are relatively easily available.

Cannabis

Details	Risks	Law
Most commonly used drug but use is falling according to Europe's drug agency (EMCDDA) report. Sedating and hallucinogenic – heightens senses. People may feel: ▪ Relaxed, happy, giggly and/or talkative ▪ Hungry (AKA the munchies)	People may feel light headed, faint, sick (AKA a whitey) Can cause anxiety, suspicion, paranoia	Class B drug Penalties: ▪ Up to 5 years in jail for possession ▪ Up to 14 years in jail + unlimited fine for selling or giving away.

Heroin

Details	Risks	Law
Made from morphine, extracted from opium poppy Around for hundreds of years Originally used to treat pain, sleeplessness and diahorrea Used by clubbers as "chill out" drug – small dose gives a heightened sense of wellbeing, larger doses relaxes/causes drowsiness	▪ Can cause dizziness and vomiting ▪ Highly addictive ▪ Injecting/sharing needles can spread HIV and Hepatitis C and damage veins, cause ulcers, abscess and blood clots ▪ Respiratory depression, can lead to death.	Class A drug Penalties: ▪ up to 7 years in jail and/or an unlimited fine for possession ▪ up to life in jail and/or an unlimited fine for selling or giving away.

Cocaine

Details	Risks	Law
Powder (AKA coke), freebase and crack cocaine are powerful stimulants, with short-lived effects. Different forms for snorting, smoking and injecting Speeds up the mind and body	Addictive. Users crave more and more so can get expensive Heavy users may turn to heroin to dampen cravings High doses cause convulsions, heart attack/heart failure Higher risk of overdose/side effects if mixed with other drugs or alcohol. Mixing cocaine and alcohol produces cocaethylene which is toxic Snorting can cause breathing problems and destroy nose cartilage White heroin may be snorted by mistake – this can be fatal Makes people feel depressed and run down and can lead to serious anxiety, paranoia and panic attacks. Increases mental health problems. May damage unborn babies or cause miscarriage Injecting drugs has high risk of overdose. Speedballing (injecting a mix of cocaine and other drugs) can be fatal. Injecting/sharing needles can: ▪ spread HIV and Hepatitis C ▪ damage veins, cause ulcers, abscess and blood clots	Class A drug. Penalties: ▪ up to 7 years in jail and/or an unlimited fine for possession ▪ up to life in jail and/or an unlimited fine for selling or giving away.

New Psychoactive Substance (NPS) *(formerly known as legal highs)*

Details	Risks	Law
Stimulant NPS (brand named include Clockwork Orange', 'Bliss', 'Mary Jane)	▪ Not enough known about potency or effects if mixed with other drugs/alcohol ▪ Ingredients may not be as listed ▪ Over confidence and risk taking ▪ Can cause anxiety, panic, confusion, paranoia, and psychosis ▪ Lowers immunity and strains the heart and nervous system ▪ Linked to poisoning and death ▪ Can feel low for a while once stopped	Since Spring 2016 it is illegal to produce, supply or import NPS. Punishments range from a prohibition notice, which is a formal warning, to 7 years in prison.

Details	Risks	Law
Downers or sedative NPS	▪ Reduced inhibitions, concentration and slows reactions ▪ cause lethargy and forgetfulness ▪ can affect balance - increases risks of accidents ▪ has caused unconsciousness, coma and death, particularly when mixed with alcohol and/or with other downer drugs. ▪ Causes anxiety anxious once stopped, ▪ Heavy users may get severe withdrawal syndrome which is dangerous and requires medical treatment	
Psychedelic or hallucinogenic NPS (act like LSD, magic mushrooms, ketamine and methoxetamine	▪ Cause confusion, panic and strong hallucinatory reactions (‘bad trips’), ▪ Can affect judgement and cause erratic careless or dangerous behaviour which can lead to a serious injury or self-harm.	
Synthetic cannabinoids	▪ Life-threatening in large doses. ▪ Can affect the nervous system leading to seizures, fast heart rate, high blood pressure, sweating, increased body temperature, ▪ Can make people feel agitated and combative (ready to fight).	

More detailed information on these and other drugs is available online - see www.talk-to-frank.com

Alcohol and the risks

New guidelines published by the Government in January 2016 state there is no safe level for drinking alcohol and that to reduce risks to health both men and women should drink no more than 14 units spread evenly throughout each week.

Alcohol can:

- increase the risk of certain diseases and health problems; it's a causal factor in more than 60 medical conditions which include mouth, throat, stomach, liver and breast cancers, heart disease, stroke, cirrhosis, pancreatitis, liver disease etc.
- affect behaviour and risk taking in the short term
- Have a negative effect on relationships, work and personal safety.

Alcohol use is sometimes classified as

- 'RISKY' - drinking at a level that may cause physical or emotional harm, or cause problems in a person's life in some other way
- 'HARMFUL' - drinking at a level that has already led to harm or
- 'DEPENDENT' -heavy drinking where the person has become physically dependent on alcohol and will require detoxification to stop using safely.

Current Services in Reading

We have a number services to treat and support drug and alcohol users.

SOURCE

SOURCE is a specialist drug & alcohol service (provided by Reading Borough Council) working with young people under 18 years old (or up to 25 if they are vulnerable adults) or have LDD. SOURCE is jointly funded by Public Health, Children's Service and the Police and Crime Commissioner.

The service offers:

- Confidential assessments of young person's drug/ alcohol use including legal highs.
- Links to substitute prescribing services
- Care plans to address drug and alcohol issues
- One to one sessions based on individual learning styles
- Help to access healthcare services in the community
- Signposting to young person's services such as CSE, YES, Young Carers etc.
- Stop Smoking Services
- C-card registration

SOURCE also offers:

- support for families of drug users
- Specialist training, consultation and resource library for professionals

IRiS Reading (Integrating Recovery in Services)

IRIS Reading (provided by Cranstoun in partnership with Inclusion) was commissioned by Reading's Drug and Alcohol team in 2014. The service is funded via Public Health and the Police and Crime Commissioner.

It provides an integrated drug and alcohol treatment service for local residents which includes:

- Assessment & referral
- Routes through to all other IRIS services
- Access to substitute prescribing
- Pre-detox support
- Peer support
- Harm reduction
- Health improvement
- Screening & vaccination
- Housing Support
- Needle exchange
- Acupuncture
- Relaxation

At the end of August 2016:

- 755 people engaged in treatment with specialist drug and alcohol services.
- 183 said alcohol caused them the most problems
- 420 said heroin caused them the most problems
- 380 had a prescription to help them manage symptoms of withdrawal from opiates.

Community Alcohol Partnership (CAP)

Public Health and Trading Standards jointly fund the CAP which sits within Reading Borough Council. The CAP focuses on education, enforcement, public perception, communication, diversionary activity and evaluation in Reading across all schools and in the community amongst retailers.

CAP aims to develop a culture where:

- Adults and young people drink responsibly
- Young people under the age of 18 are only able to access alcohol under responsible and informed supervision
- Safe consumption limits are understood and
- Parents understand the impact of alcohol and are aware of the influence their drinking can have on their children.

Primary and Secondary Care Services

- Local GPs offer IBA (Identification and Brief Advice) to patients and can signpost to specialist support if required.
- Pharmacies offer supervised consumption and needle exchange
- Prospect Park Hospital provides an alcohol detox service (referrals only)
- Royal Berkshire Hospital treats high risk alcohol patients (Sidmouth Ward) and treats emergencies (like overdose) are accessed via A&E.

What are the issues in Reading?

Young People

Young people receiving interventions for substance misuse have a range of vulnerabilities that require specialist support and intervention.

Those in treatment often say they:

- are/were victims of domestic violence
- have contracted a sexually transmitted infection
- have experienced sexual exploitation.

And are more likely to:

- not be in education, employment or training and
- be in contact with the youth justice systems.

Between April 2016 and March 2017, 33 young people were engaged with structured treatment with SOURCE (our young people's drug and alcohol service), of whom 19 presented to treatment during the year. While this number is small, it reflects the most complex cases who:

- have a range of social and emotional needs and
- are mainly referred by the Youth Offenders Team (YOT) and specialist schools catering for children who are excluded/at risk of exclusion (Figure 1).

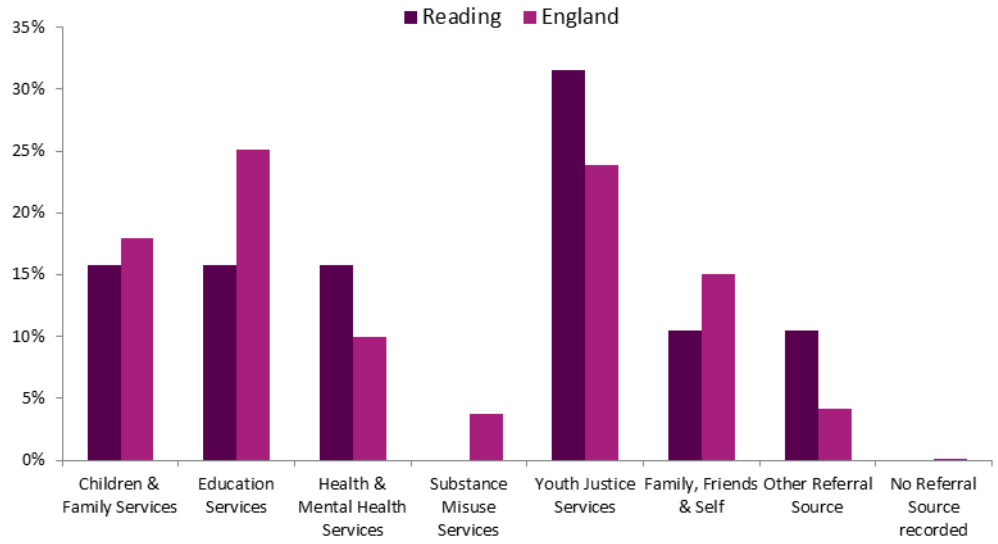


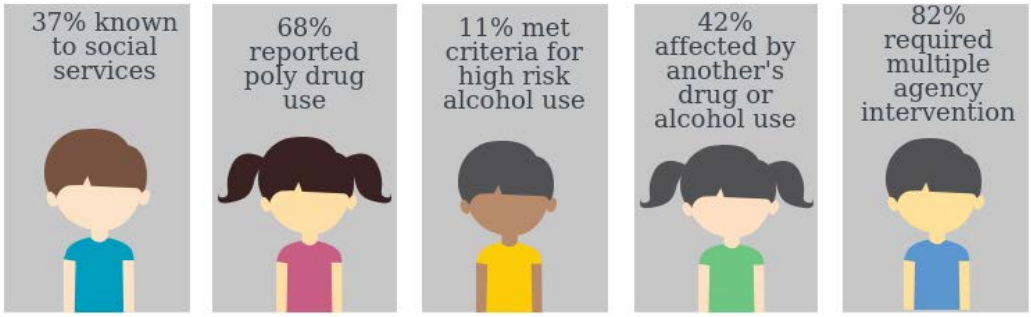
Figure 1: % Referrals of young people to drug or alcohol treatment by source (2016/17)[1]

Several indicators suggest that young people who presented to drug and alcohol treatment in Reading in the last year may have had more complex needs than may have been seen elsewhere.

- Of the 19 new presentations in 2016/17, 8 (37% of the total) were either the subject of a child protection plan, or were classified as a looked after child or a child in need, compared to a national figure of 25%.

[1] National Drug Treatment Monitoring System

- 68% of new presentations in Reading reported poly drug use and 11% met criteria for high risk alcohol use, compared to 59% and 2% of new presentations nationally.
- 42% of new presentations in Reading reported that they were affected by another person's substance use, compared to 23% nationally.
- An analysis of interventions delivered shows that 82% of those receiving structured treatment in 2016/17 required interventions from multiple agencies, compared to 56% nationally.
- Young people in Reading spend considerably more time in treatment (an average of 34.78 weeks in 2015/16) compared to the national average (24.53 weeks) [1]



Information and advice for young people

Source provides information sessions in schools and youth clubs.

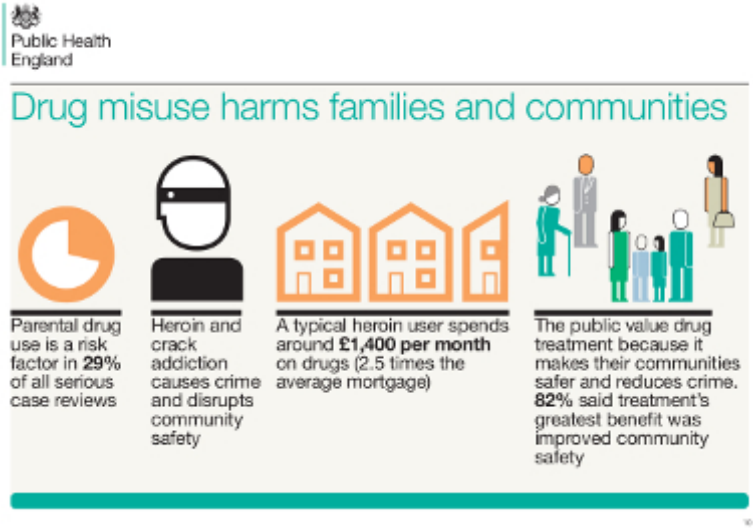
The Community Alcohol Partnership (CAP) provides focussed education sessions and workshops.

Adults

Locally the numbers of drug-related admissions and drug-related deaths are proportionally smaller than those related to alcohol use. Illegal drug use is less prevalent than heavy alcohol use and is associated with fewer acute adverse reactions. However, those who do use illegal drugs, particularly heroin and crack cocaine, typically experience a myriad of physical and psychological health and social problems which require interventions from a range of providers.

People who misuse drugs (especially opiates and crack cocaine) place an enormous strain on their children and families which can have a serious negative impact on their long-term health and well-being.

Reading has a high rate of deaths caused by drug use (6.1 per 100,000 – equivalent to between 10 and 11 deaths in Reading each year. This compares to a rate of 3.9 per 100,000 in England). Those at highest risk are long-term heroin users, especially men *(ref PHOF,)*



An estimated 1,111 people in Reading are regular heroin users *(ref http://www.nta.nhs.uk/facts-prevalence.aspx),* of which some 616 (51%) engaged with specialist treatment last year (16/17), compared to 56% of heroin users nationally. Almost 10% of heroin and other opiate drug users in treatment in Reading left treatment free of dependence in 2016/17, compared to 7% nationally.

Drugs and alcohol misuse are significant causes of both violent and acquisitive crime. Acquisitive crime, often associated with drug use, fell to a low level in 2015, but increased in 2016 and 2017 (Figure X). A locally commissioned evaluation of Opiate Substitution Therapy (OST) for offenders suggested that OST in Reading was successful in helping entrenched offenders stop or reduce their offending and suggested that greater support for homeless offenders may help to increase effectiveness.

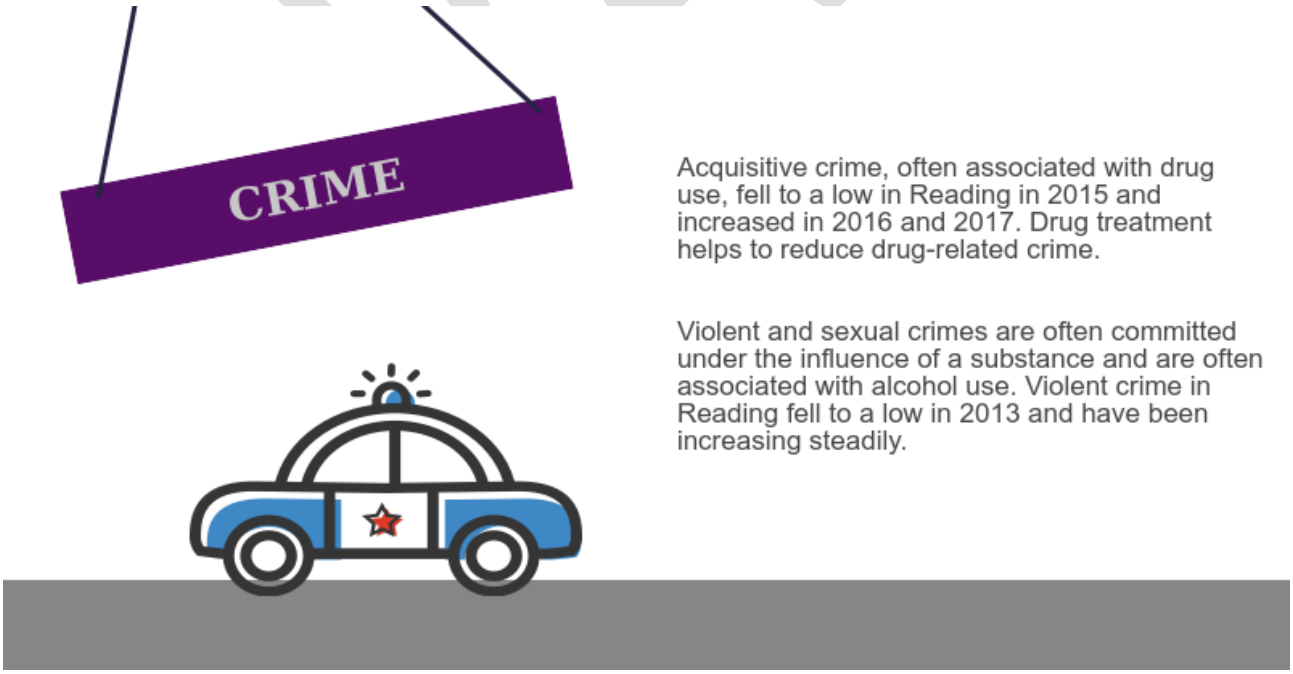
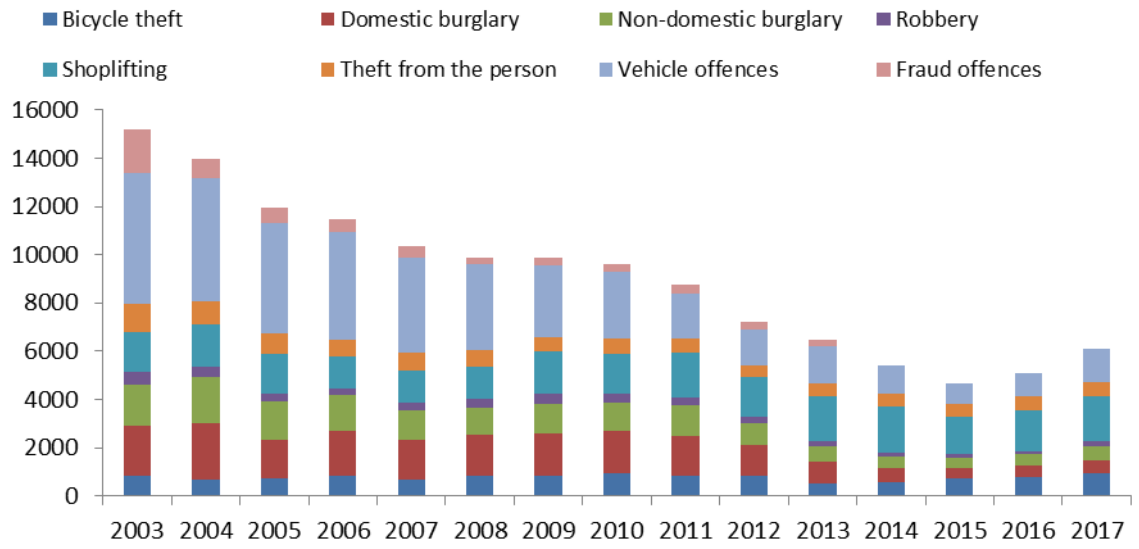


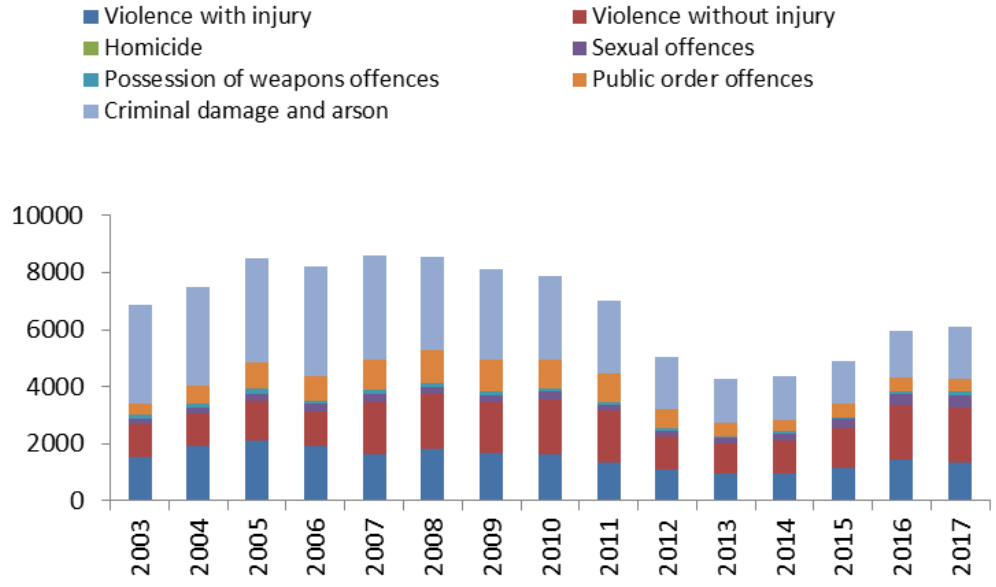
Figure X: Recorded Crime in Reading 2003-2017 – Acquisitive crime types



Source: Police Recorded Crime Statistics

Alcohol use is more commonly associated with "psychopharmalogical crime", or crimes committed while under the influence of a substance. These may include violent and sexual offences, including those involving domestic abuse. The level of violent crime in Reading fell to a low in 2013, but increased steadily until 2016, and has remained stable in 2017.

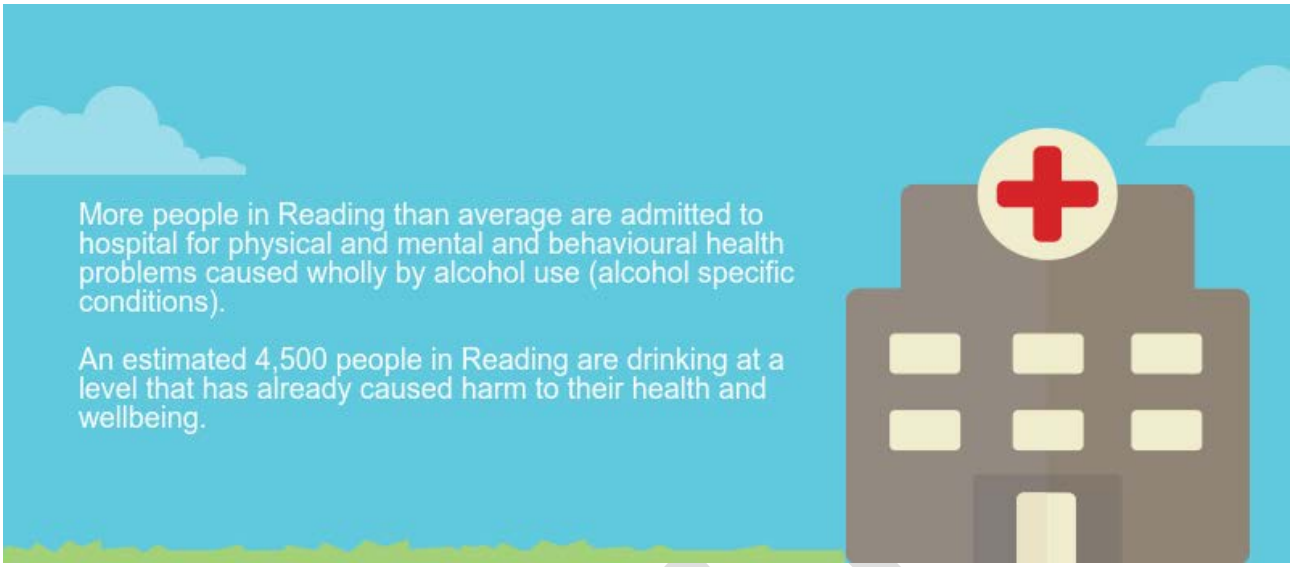
Figure X: Recorded Crime in Reading 2003-2017 – Violent and sexual crime types



Source: Police Recorded Crime Statistics

Statistics on mortality and admissions to hospital related to alcohol suggest that more people in Reading than average are suffering from health problems caused by alcohol,

especially alcohol specific conditions (those caused wholly by alcohol use) and mental and behavioural conditions.



Alcohol misuse, mainly in the adult population, is a far greater problem than drug use in Reading (as elsewhere) mainly because of the sheer number of people who drink alcohol in our society (a very large majority) and the increasing proportion who do so in ways that risk injuring their health.

Based on national self-reported drinking levels against the current guidelines we estimate:

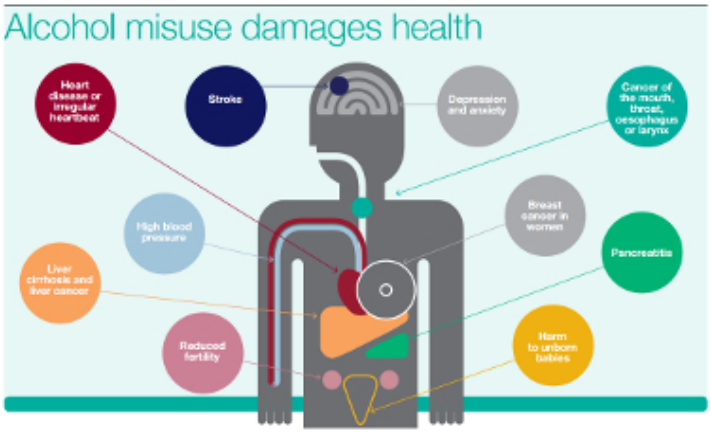
- at least 30,000 residents drink at a level that could harm their health or wellbeing
- 4,500 are drinking to levels that have already harmed their health or wellbeing

As research shows that people significantly under-report their drinking, we can infer that people's true drinking levels are higher than this.

Reading has high rates of alcohol-specific mortality in men

Between 2013 and 2015 the estimated:

- rate of deaths in men caused by a disease wholly attributable to alcohol was 24.2 per 100,000 population significantly worse than the England average (15.9) and other areas with similar levels of deprivation (14.3)[2]
- The rate for all persons in Reading (14.1 per 100.000) was significantly worse than the combined rate in other areas with similar levels of deprivation (10.3 per 100,000) The rate was also worse than the rate for all England (11.5 per 100,000), although in the most recent period the difference was not large enough to be statistically robust.



Source: Public Health England

[2] IMD 2010

These rates indicate a significant population who have been drinking heavily and persistently over the past 10-30 years.

Liver disease is one of the major causes of mortality and morbidity in England with deaths reaching record levels having risen by 20% in the last decade.

Aims of this strategy

We aim to:

- Reduce harm from alcohol and drug use in the Borough
- Minimise harm and negative effects to the wider population
- Encourage and promote recovery for dependent drug and alcohol users.
- To engage all partners to streamline efforts and use resources effectively.

Developing this strategy

This strategy has been informed by internal and external data and evidence, including:

- The National Drugs Strategy 2010 –"Reducing Demand, Restricting Supply, Building Recovery: Supporting People to Live a Drug Free Life"
- The National Drugs Strategy 2017
- The National Alcohol Strategy 2012
- Reading's Joint Strategic Needs Assessment (JSNA) and the
- Health & Wellbeing Strategy 2017-20.

National Drug Strategy 2017

The National Drugs Strategy 2010 set out the Government's approach to tackling drugs.

It focused on recovery* as well as reducing the harms caused from drugs and alcohol. The two key overarching aims of the 2010 strategy were to:

- Reduce illicit and other harmful drug use and
- Increase the numbers recovering from their dependence

The National Drugs Strategy 2017 moves another step forward clearly setting the expectations for action from a wide range of partners, including those in education, health, safeguarding, criminal justice, housing and employment. The new strategy expands on the 2010's two overarching aims to reduce demand, restrict supply, build recovery and take global action.

What is recovery?

*Recovery is a process more so than an end state and means different things to different people. Recovery is the best way to summarise the benefits to physical, mental and social health. This could mean anything from support with managing money and debt, ability to access and sustain accommodation, employment and training and having the capacity to build healthy relationships including parenting. We have used the definition within the 2010 Drugs Strategy

"Recovery involves three overarching principles – wellbeing, citizenship, and freedom from dependence. It is an individual, person-centred journey, as opposed to an end state, and one that will mean different things to different people."

This means recovery is much wider than just being free from dependence on drugs and alcohol. It is about having a safe place to live, a job, friends and a place in society.

National Alcohol Strategy 2012

The National Alcohol Strategy 2012 set out the Government's approach to addressing alcohol. The outcomes are to support:

- A change in behaviour so that people think it is not acceptable to drink in ways that could cause harm to themselves or others;
- A reduction in the amount of alcohol-fuelled violent crime;
- A reduction in the number of adults drinking above the NHS guidelines;
- A reduction in the number of people "binge drinking;
- A reduction in the number of alcohol-related deaths; and
- A sustained reduction in both the numbers of 11-15 year olds drinking alcohol and the amounts consumed.

Reading's Joint Strategic Needs Assessment (JSNA)

The JSNA provides data and evidence about the needs of the local population, including:

- an estimate of the number of people likely to benefit from support or treatment to reduce alcohol use
- information, evidence and best practice around about interventions

Reading's Health and Wellbeing Strategy 2017-2022

The HWB Strategy sets out how the Health and Wellbeing Board plans to realise its vision for 'a healthier Reading' and meet its key objectives to:

- Promote and improve the health and wellbeing of the people of Reading
- Reduce health inequalities; and
- Promote the integration of services.

The strategy has identified eight priorities - Priority five is focused on Alcohol and "to reduce the amount of alcohol people drink to safer levels".

Public Health Outcomes Framework (PHOF)

We will use PHOF indicators for health improvement to measure the progress of this strategy. People are helped to live healthy lifestyles, make healthy choices and reduce health inequalities

2.15 Drug and alcohol treatment completion and drug misuse deaths
Definition: The number of drug users that left drug treatment successfully (free of drug dependence) who do not then re-present to treatment again within six months as a proportion of the total number in treatment.

2.16 Adults with substance misuse treatment need who fully engage in community-based structure treatment following release from prison

2.18 Alcohol related admissions to hospital

This strategy will also contribute to:

1.13 Levels of offending and re-offending (Definition: Percentage of offenders that re-offend from a rolling 12 month cohort)

1.11 Domestic violence rates

4.06 Under 75 mortality rate from liver disease

Reading's Drug and Alcohol Needs Assessment, January 2016

On 22 January 2016 the Health and Wellbeing Board endorsed a report into the needs of local resident in relation to drug and alcohol use. The report found:

- Current resources are primarily targeted at drug treatment, particularly opioid substitution therapy (the prescribing of an opiate substitute, like Methadone or Subutex, to reduce the effects of withdrawal from illicit opiate drugs (like heroin) and help to reduce risks to the individual and enable them to maintain a safe and functional lifestyle).
- Around 500 heroin users are in treatment at any one time (roughly half of the total number of people estimated to use heroin in the Borough).
- Although these numbers are relatively small, the use of heroin and other drugs is often related to a variety of significant and very complex problems and the needs of this vulnerable group are high.
- The number of people using alcohol at potentially harmful levels is much greater, but the number receiving structured treatment is much smaller.
- We estimate around 30,000 residents drink at a level that could harm their health or have a negative effect on their work or personal relationships, and around 4,500 people whose drinking has already caused them some physical, emotional or social harm but only 100-150 people are in treatment for alcohol misuse in Reading at any one time. This apparent disparity is likely to reflect in part both more modest treatment and support needs of many alcohol users, as well as the nature of clinical treatment that can be provided for alcohol use (usually detoxification).
- Alcohol users, particularly those whose use would be classified as 'risky' rather than 'harmful' or clinically dependent, may be offered a short, practical and motivational discussion about their drinking at their GP surgery or by another professional.
- The high rates of liver disease and other alcohol-related mortality suggest that more support is needed locally to help people to reduce their alcohol use.
- The number of people, including young people, who engage with drug services for help with use of cannabis, cocaine and New Psychotic Substances is very small.
- Prevention activity, mainly delivered in focussed sessions in schools and youth clubs, is limited.

The report recommended a revised approach to drug and alcohol services that:

- puts greater emphasis on the problems of alcohol misuse at all ages;
- puts greater emphasis on prevention, particularly targeting of 0-18 year olds, with specialist family support in place for children at risk;
- ensures that health and social care and criminal justice services work together effectively;
- enables and encourages frontline staff in all sectors to do more to identify people at risk of harm from drug and alcohol use, and to provide a brief intervention or refer for specialist treatment where appropriate; and
- enables partners to take account of the cumulative impact of drug and alcohol use in strategic planning and delivery of services.

Visit www/reading.gov.uk/JSNA for more details.

Partnership Approach - Collaboration and Integration

Drug and alcohol misuse has a huge impact on the individual, their families, the children and our community.

No single organisation can tackle these issues alone.

The responsibility for prevention of Drug and Alcohol misuse is shared between the Council, CCGs, Hospital Trust, Primary Care Providers, Housing, the Police, probation services, voluntary organisations, faith groups, those in recovery and many others.

We must work in partnership to :

- Improve the health and wellbeing of individuals who misuse drugs and alcohol. This will link in with The Health and Wellbeing Strategy objectives.
- Improve successful completions from drug and alcohol – ensure our treatment services are improving, responsive and available in Reading.
- Ensure vulnerable families & children receive timely and appropriate drug and alcohol support
- Reduce crime, domestic violence abuse and anti-social behaviour

We need robust joint working arrangements between organisations and must work as a partnership to achieve these objectives.

We must share our expertise and manage clients to ensure they have the best possible outcomes and can fulfil a drug and alcohol free lifestyle.

Implementation, Governance and Accountability

Reading's strategic priorities, target outcomes and actions to deliver this strategy will be set out in our Drug and Alcohol Strategy Action Plan.

We will be accountable to the:

- Health and Wellbeing Board
- Clinical Commissioning Groups and
- Community Safety Partnership

and will report on progress against targets and developments to reduce offending behaviours, tackle drug and alcohol misuse as well as achieving successful completions.

These governing groups will be responsible for signing off the Strategy and the management and signing off of the actions.

We have identified three key priorities for this strategy:

- 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.

We will review the drug and alcohol strategy annually so that it is responsive to emerging needs.

The Drug and Alcohol Strategy Action Plan will assign responsibility and timeframes for actions so that progress can be monitored.

Key milestones in achieving the strategic priorities provide a framework to ensure that the drug and alcohol strategy and the action plan are robust.

The drug and alcohol Strategy 2018-2022 will contribute to the service priorities set out in the Council's Corporate Plan 2016-19:

• Safeguarding and protecting those that are most vulnerable

• Providing the best life through education, early help and healthy living

Our priorities

In Reading, we want to enable individuals affected by drug and alcohol misuse to recover and reach their potential in leading a healthier lifestyle. We aim to reduce harm to those at risk, empower those who are addicted or dependent to recover.

Through consultation with local partners, we plan to address and commit to addressing 3 priorities of Prevention, Treatment and Enforcement and Regulation.

Priority 1: PREVENTION - Reducing the amount of alcohol people drink to safer levels & reducing drug related harm

We want our communities to be getting the right information and advice on drugs and alcohol. The promotion of positive and responsible behaviours around drug and alcohol misuse is crucial, enabling individuals to make informed choices.

This is particularly important for young people and includes education around any subsequent behaviour that follows the consumption of drugs or alcohol, for example, offending, risky sexual behaviour, exclusion from school, loss of employment and benefits.

We must ensure the community understands the consequences their drug and alcohol use can have on others, specifically the effects on children and young people viewing such activities.

We also know that drug and alcohol service users tend to have numerous contacts with a range of other health care services. These include GP, A&E departments, other acute wards as well as the ambulance services. We want to work more closely with primary care and social services teams (Multi-Agency Safeguarding Hub, Early Years, Long term care teams, social workers) to capture drug and alcohol misusers to ensure that we can deliver the safest and most efficient appropriate treatment.

Every contact counts and our strategy aims to ensure that the first point of contact for our drug and alcohol misusers is positive, informative, supportive and that staff have the right skills to engage positively and effectively.

We want to achieve:

- Reduce the health, social and economic harms caused by alcohol harm and

drug misuse, for both the individual user and wider society

- A shift in culture to promote positive alcohol lifestyle choices and a reduction in drug misuse
- More people to be able to receive support at an appropriate level to address risky, harmful and dependent use of alcohol.
- Make services more accessible; reduce stigma of alcoholism so people feel able to seek help and get the help they need.
- Encourage uptake in training in screening and brief interventions for frontline practitioners.
- Fewer alcohol related admissions to hospital and a reduction in alcohol and drug related harm.
- More people to receive support around co-existing mental health and drug and alcohol issues.
- Awareness of the risks of using drug and alcohol amongst all groups including lesbian and gay communities, ethnic minority groups, parents and carers, voluntary sector.

To achieve this, we will:

- Work together, regularly reviewing the needs of the local community and benchmarking local investment and performance.
- Provide good quality treatment for alcohol users that is evidence-based and recovery-focused and that enables individuals to improve their health and wellbeing.
- Promote knowledge and change behaviour by promoting understanding of the risks of using drugs and alcohol and by embedding screening and brief intervention in primary care, social care and criminal justice settings, housing and environmental health contacts.
- Increase number of audit c/brief interventions delivered in primary care.
- Review existing interventions and develop a robust multi agency model to reduce alcohol-related hospital admissions.
- Work with schools to target prevention campaigns as well as Parents about drinking behaviours and their consequences.
- Work closely with schools to support their delivery of drug and alcohol awareness programmes.
- Develop and implement a programme of communication in line with national campaigns, using social media, around drug and alcohol misuse
- Develop a rolling training programme for all agencies and Partners in Reading; drug and alcohol awareness, naloxone training, suicide prevention training
- Promote drug and alcohol awareness training to specific targeted groups including lesbian and gay communities and ethnic minority groups.
- Promote positive and responsible behaviours around alcohol and drug misuse including any subsequent behaviour that follows for example offending, risky sexual behaviours, exclusion from school or termination from work and benefits.
- Work in partnership with mental health services to improve interventions around co-existing mental health and drug and alcohol issues.

Priority 2: TREATMENT -Commissioning and delivering high quality drug and alcohol treatment systems

The misuse of drugs and alcohol can have a detrimental effect on a person's health and wider wellbeing. It is accountable for poor health outcomes, health inequalities and significant demands on the resources of many public services.

Around 600 opiate users engage with local specialist adult drug treatment services each year. Many have very complex needs and engage in risky behaviour, causing harm to themselves, their children and other family members and the wider community.

As more people are identified as requiring treatment for drug and alcohol misuse, treatment providers and partners need to ensure their services meet their needs. Due to the ever changing environment, increased pressures on individuals and the new emerging trends for alcohol and drug users of all ages, there is the need to enhance these treatment systems to ensure continued delivery of high quality, fit for purpose services.

Re-balancing existing resources to address the unmet needs of alcohol users while managing the risks to the opiate using population will be a considerable challenge for Reading in the coming years.

We aim to:

- Re-tender drug and alcohol treatment services to manage the emerging needs of alcohol users
- Ensure those exiting treatment are free of alcohol and drug dependence, do not re-present at treatment services and are effectively reintegrated into society
- Reduce the numbers of drug related deaths; identify, appropriate interventions, prevention and training activities around the prevention of drug related deaths including the provision of take home naloxone.
- Reduce the risks of suicide
- Reduce the availability of illegal drugs and access to New Psychoactive substances
- Improve pathways between partner services; i.e. housing, probation, prisons, voluntary organisations, GPs, A&E and hospital wards
- Improve pathways for those with mental health issues; co-existing and dual diagnosis.

To achieve this we will:

- Specialist treatment providers need to ensure their services are meeting the needs of Reading. We live in a changing environment with increasing peer pressure, pressure on individuals and the new emerging psychoactive substances, that specialist treatment providers need to enhance their services to continue delivering high quality fit for purpose services.
- Review drug related deaths on a quarterly basis via the Substance Misuse Death Overview Panel as well as monitoring national information. The Panel will develop a mechanism for ‘learning the lessons’ and for the rapid dissemination of recommendations around the prevention of deaths.
- Disseminate Naloxone alongside overdose training to service users, their families and other agencies to prevent drug related deaths.
- Improve services via a trained workforce to highlight the dangers and harmful effects of drugs and alcohol on families and children.

- Improve relationships e.g. facilitating joint training & joint induction arrangements and communications between Specialist treatment services and the mental health services to put in place timely and effective pathways for those individuals with co-existing and dual diagnosis needs. Commissioners need to link up commissioning strategies and priorities as well as contract manage jointly to effectively manage clients.
- Develop effective information and intelligence sharing across the partnership.

Priority 3: ENFORCEMENT & REGULATION - Tackling alcohol and drug related crime and anti-social behaviour

Illicit drug use and alcohol consumption is also a significant contributory factor in relation to a wide range of crime, disorder and anti-social behaviour for adults and young people.

We want to ensure alcohol is sold and consumed responsibly in Reading and continue to disrupt the supply of drugs into Reading through effective enforcement.

We aim to:

- Reduce violence and crime associated with drugs and alcohol
- A community free of alcohol related violence in homes and in public places, especially the town centre
- Improve measures aimed at reducing access to counterfeit and illegal alcohol
- Reduce the availability of illegal drugs
- Reduce street drinking
- Reduce 'county line' dealing –this is described as when an individual, or more frequently a group, establishes and operates a telephone number in an area outside of their normal locality in order to sell drugs directly to users at street level.

To achieve this we will:

- 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
- Drugs and alcohol are often linked to violence, burglary, domestic violence and disturbances. We need to improve a partnership approach to tackle drug and alcohol related issues associated with town centres and other trouble areas.
- Conduct a local criminal justice needs assessment to look at this cohort in more detail and develop tailored services to meet local need.
- Develop effective information and intelligence sharing across the partners, identifying where current crimes are taking place and known availability of alcohol and drugs in order to develop effective responses and improve current engagement with treatment services to improve referral pathways.
- Enforce laws on underage sales of alcohol and reduce the availability of illegal drugs.

References

This strategy references a number of documents:

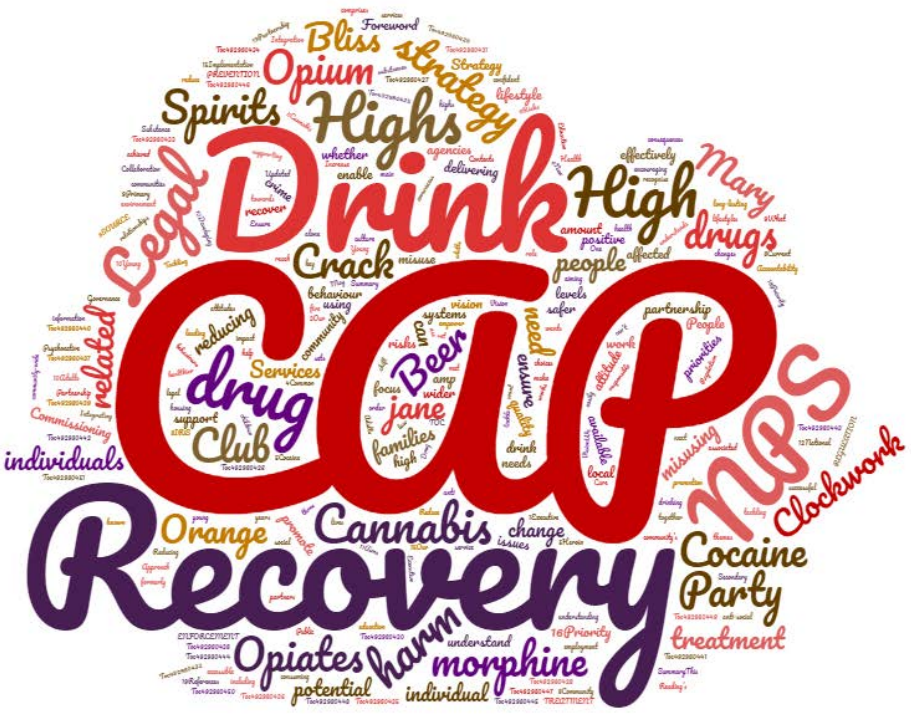
- Government Alcohol Strategy, 2012
- Government Drug Strategy, 2010
- Government Drugs Strategy 2017
- Reading Drug and Alcohol Health Needs Assessment, 2016
- Reading Community Safety Partnership Strategy 2016
- Reading Health and Wellbeing Strategy 2016
- Reading Joint Strategic Needs Assessment
- Public Health Outcomes Framework

Wellbeing Team

Reading Drug and Alcohol Commissioning Strategy for Young People and Adults

2018 – 2022

CONSULTATION RESULTS



Executive Summary

Following a period of stakeholder engagement to develop a draft strategy, the Public Health Team ran a public consultation for 8 weeks between 21st February 2018 to 23rd April 2018. This was to ensure Reading Borough Council and its partners are focused on the right priorities for the period 2018-2022.

The strategy comprised of three main 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.

Feedback was supportive of the 3 priorities. There were general comments submitted on how we should tackle each of these priorities in more detail.

Background

Reading Public Health lead for drugs and alcohol began drafting the strategy in June 2017 for a period of 3 months. During this period, all key partners were consulted with on a one to one or group session basis to gather the views of priorities for Reading.

A Reading Needs Assessment was completed in Jan 2016. The recommendations from this report and the Reading Health & Wellbeing Strategy 2017-2020; *Priority 3: Reducing the amount of alcohol people drink to safer levels* has also taken into consideration.

The Government published the Drug strategy 2017, this sets out how the government and its partners, at local, national and international levels, will take new action to tackle drug misuse and the harms it causes.

All partners welcomed the opportunity to be involved in the development of the Reading Drug and Alcohol Commissioning Strategy for Young People and Adults2018-22 at an early stage. This has shaped the draft strategy prior to a formal consultation period in 2018.

All partners and service users from adult and young people have expressed a view to taking part in further workshops after the consultation has closed and the strategy finalised to develop a long term action plan to address the priorities.

What we consulted on

Public Health consulted with key partners on the issues presenting each service.

We then consulted with the wider public as to whether they agreed with the three priorities identified;

Priority 1 - Prevention; reducing the amount of alcohol people drink to safer levels and reducing drug related harm.

Priority 2 - Treatment; Commissioning and delivering high quality drug and alcohol treatment systems

Priority 3 - Enforcement and Regulation; tackling alcohol and drug related crime and anti-social behaviour.

We asked the public for comments on whether they believed any other priorities should be considered.

How we consulted

Public Health lead for drug and alcohol consulted with key partners for the priorities for Reading. Meetings to discuss the drug and alcohol issues in Reading took place with the following partners;

IRIS Reading Specialist Adult treatment service
Source
Homeless forum
Salvation Army
Hamble Court
Launchpad
St Mungos
Reading Voluntary Action
Health and Wellbeing Team
Housing Commissioners
Community Safety Partnership
Childrens, Mental health and Maternity Board (CMMV Board)
Community Alcohol Partnership
Licensing and Trading Standards
CCG Representatives
Probation
Thames Valley Police
Substance Misuse Overview Panel
Berkshire West mental health Group

The formal consultation on the strategies 3 priorities ran from 21st February 2018 to 23rd April 2018. It was an open public consultation, aimed at all members of the community as well as Partner organisations and community voluntary organisations.

The public were invited to comment on whether they agreed with the draft strategy priorities for Reading. They were also asked to suggest what was needed to achieve each priority. These answers will be used to develop an Action Plan to support each priority.

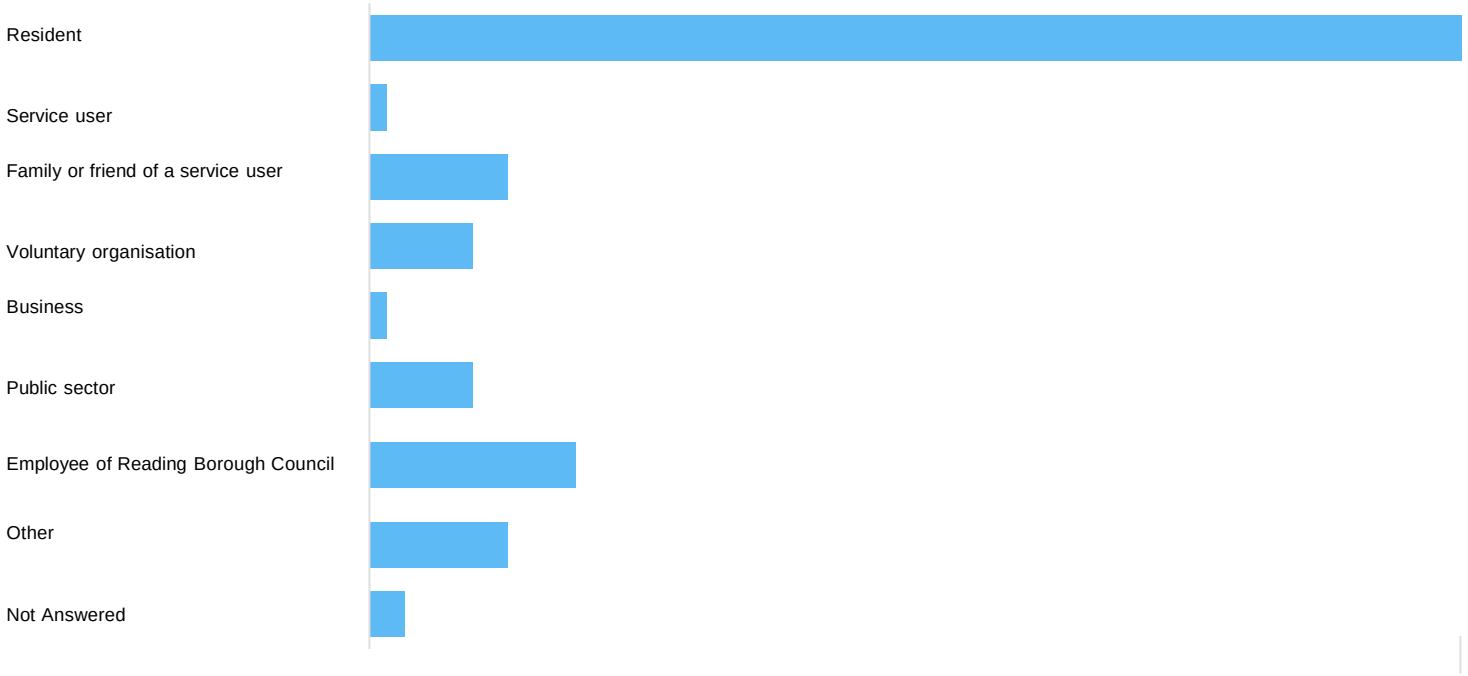
The consultation questionnaire was available on the Council's website and in paper copy on request. A press release was issued at the start and during the consultation.

Who responded

A total of 91 questionnaires were returned.

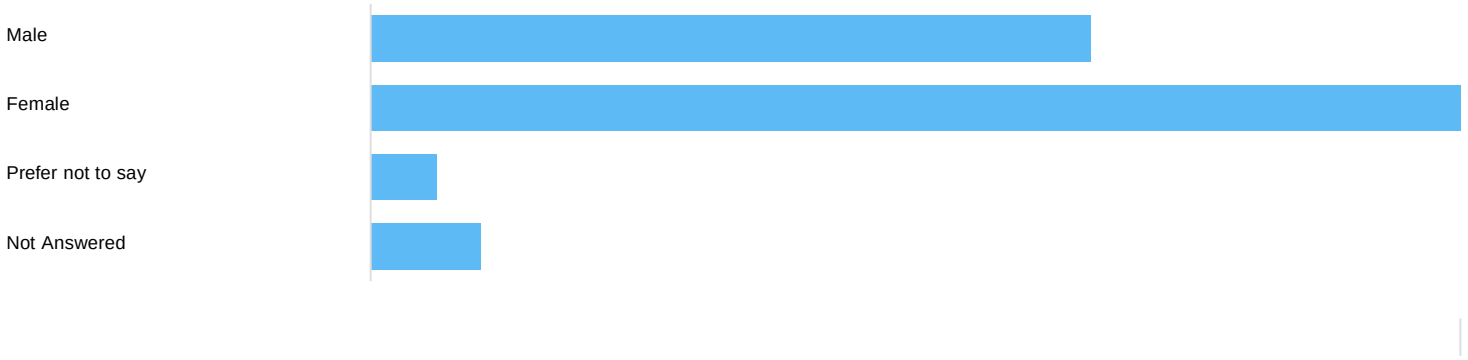
More detailed demographic analysis is available only from those who responded to the consultation by returning a questionnaire and completing the 'about you' questions – which were optional.

ABOUT YOU

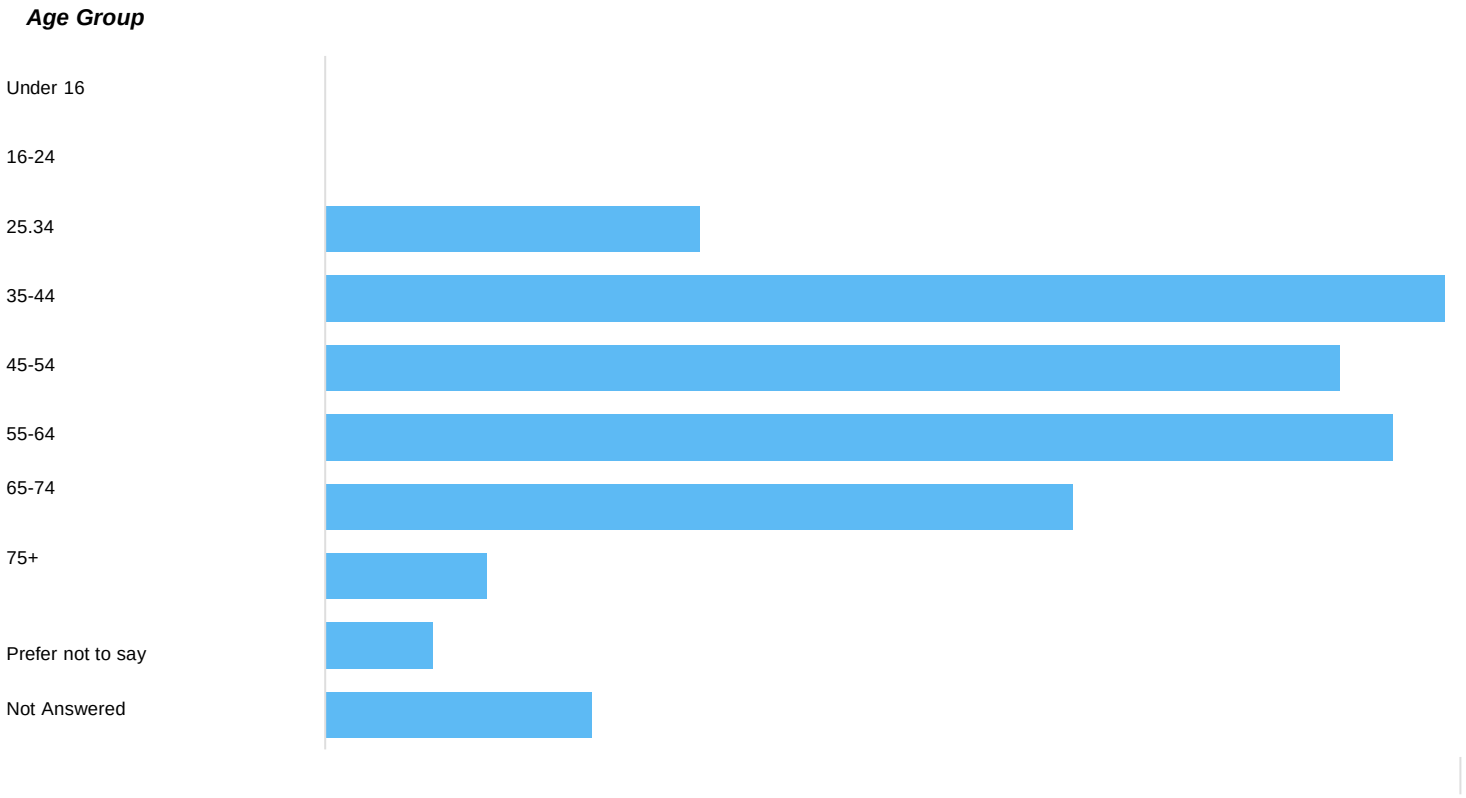


70% of respondents were residents.

GENDER



54.95% of respondents who identified by gender were female and 36.26% male.



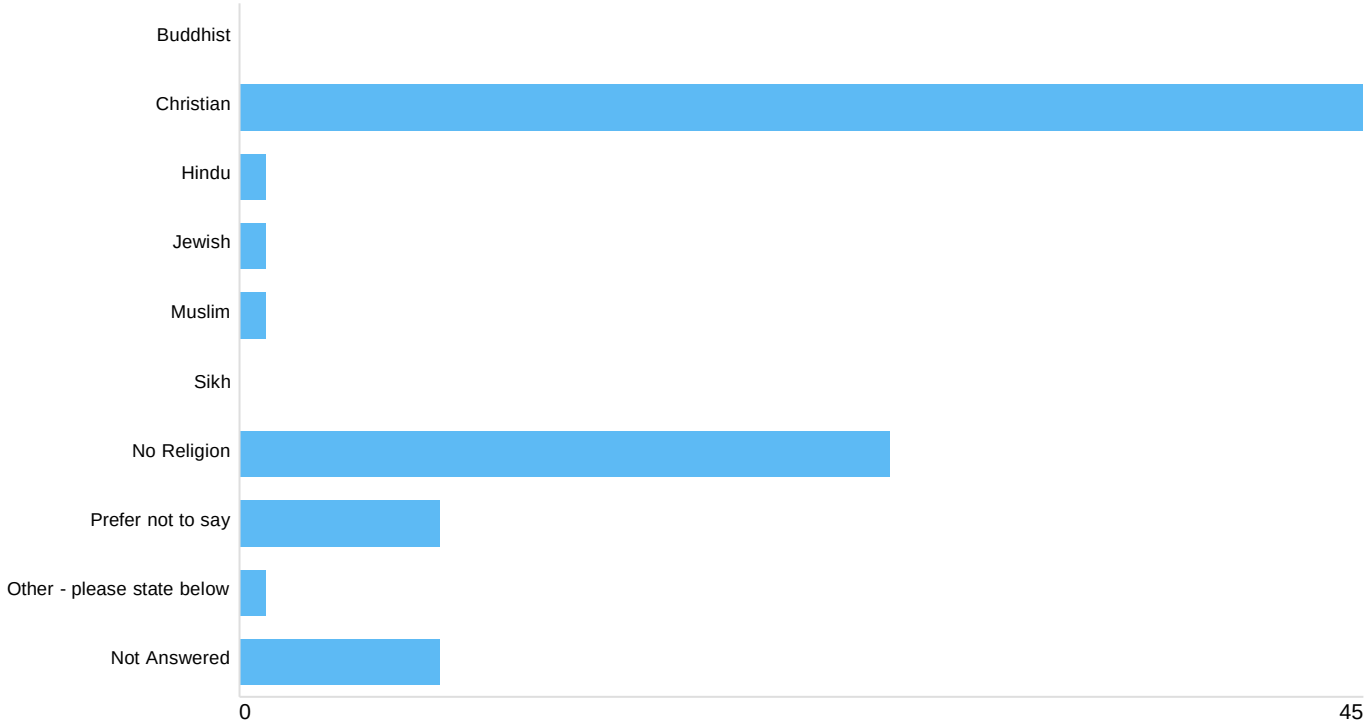
Questionnaires were returned by a range of people. There were no questionnaires from the 0-24 age group. It was verbally reported that the strategy was not user friendly for young people, however, it was suggested that young people would like to be involved with the action plan to look at how they can be more involved in taking forward the priorities for Reading. The youth cabinet in particular would be keen to work in this area.

Ethnicity

Three quarters of questionnaires (75.82%) were returned by people who identified as White British.

Option	Total	Percent
White - British	69	75.82%
White - Irish	1	1.10%
White - Gypsy or Irish Traveller	0	0%
White - Any other White background (Please specify below)	5	5.49%
Mixed - White and Black Caribbean	0	0%
Mixed - White & Black African	0	0%
Mixed - White & Asian	0	0%
Mixed - Any other Mixed background (Please specify below)	1	1.10%
Asian or Asian British - Indian	2	2.20%
Asian or Asian British - Pakistani	1	1.10%
Asian or Asian British - Bangladeshi	0	0%
Asian or Asian British - Chinese	0	0%
Asian or Asian British - Any other Asian background (Please specify below)	0	0%
Black or Black British - African	0	0%
Black or Black British - Caribbean	0	0%
Black or Black British - Any other black background (Please specify below)	0	0%
Other ethnic group - Arab	0	0%
Other ethnic group - Any other ethnic group (Please specify below)	1	1.10%
Prefer not to say	5	5.49%
Don't know	1	1.10%
Not Answered	5	5.49%

Religion



Consultation feedback

Priority 1: PREVENTION - Reducing the amount of alcohol people drink to safer levels & reducing drug related harm

"Prevention needs to have a multi-agency collaborative approach and needs to be fully supported by prevention strategies aimed at different age groups"

Question 1: Do you agree with this priority?

Yes	No	Not answered
84 Responses	6 Responses	1 Response
92.31%	6.593%	1.099%

Question 2: Would you like to add further comments or suggestions?

Yes	No	Not answered
49 responses		
53.8%		

Priority 1 – a range of comments included;

Housing/ rough sleeping/ begging

- Robust policing and the local authority discouraging street sleeping and begging.
- It was suggested the Council should house individuals somewhere where drugs and substances are less readily available (i.e. not on the Oxford Road) as a preventative measure.

Education

- Needs to be accessible, accurate, meaningful and contextual.
- Advertise information on support & helplines available.
- Detailed information for schools to be more readily available to be able to signpost young people.
- Education for families to be able to support their children.
- Communication plan – how and who accountable to?
- A lack of specialists to come and run sessions/ workshops with our students.
- Don't just rely on schools to get the messages out – use outreach, radio etc.

Businesses

- There is a role for businesses in our communities

Young people

- Need to include Young people with disabilities.
- Ask a young person who has experiences of substance/ alcohol misuse and have now tackled their difficulties, to promote healthy behaviours to others/ peers.

- More work with young people on healthy choices and peer pressure

Community Pharmacies

- Community Pharmacies could help the prevention agenda

Drugs

- Availability of recreational drugs (via Amazon, Schpock apps). Prevent or criminalise this activity.
- Known network of drug dealers are operating in Reading. Disable the use of phone boxes for people to call in for the drugs.
- Police to assess drug abuse in drivers is key, tools and manning needs to be available.
- Remove the supply of drugs – continual reporting through 111 has not removed drug dealers from the streets.

Alcohol

- Changing the fashion of drinks, less bars aimed at Young people.
- More communication coverage on alcohol related admissions
- Enforce the one can ban along Oxford Road. Street drinking is not being enforced in Reading.
- Police and other authorities to have a no tolerance attitude towards these people who are spoiling central Reading (Non drinking zones).
- Support for bar staff to refuse selling alcohol to customers.
- Providing family members with information about their local Al-Anon groups will help prevent further damage being caused to the families. Please see website: www.al-anon.org.uk
- Better monitoring of licences being given out to supply alcohol.

Co-occurring issues

- More recognition of the work needed for co-occurring issues (Substance misuse and MH).

Other

- Prevention needs to have a multi-agency collaborative approach and needs to be fully supported by prevention strategies aimed at different age groups.
- Enabling people to take more responsibility for their behaviour.
- To tackle cultural issues by having a new approach; changing the drug and alcohol scene. To consider some of the initiatives taking place abroad to interrupt the existing environments that support addicts.
- Investigate the causes of these problems and proper social responses.
- Better protection for neighbourhoods for those affected by drug/ alcohol use/ noise. Process to complain is stressful.
- In-reach service needed at RBH ED. No specialist Drug and Alcohol workers at BHFT Psychological Medicine Service (Mental Health Liaison).
- Training for GPS to support the prevention agenda; IBA and drug screening.

Priority 2: TREATMENT -Commissioning and delivering high quality drug and alcohol treatment systems

"Interventions will need to remain as high quality and reflect the emerging and current trends within Reading. By continuing this investment it improves outcomes for residents and their family and the wider community"

Question 3: Do you agree with this priority?

Yes	No	Not answered
85 responses	6 responses	0 responses
93.41%	6.593%	0%

Question 4: Would you like to add further comments or suggestions?

Yes	No	Not answered
42 responses		
46.2%		

Priority 1 – a range of comments included;

Recovery rates

- Agree about most drugs and alcohol but opiate addiction has incredibly low recovery treatment rates 8%. Other solutions are needed at a national level especially

Prevention

- This area is very grey. There appears to be non-existent treatment or help if the user is continuing with their substance abuse. No one wants to help until either they have stopped using or something major has happened. There is no proactive prevention to stop the user and their family/ friends imploding.
- Treatment is a great priority however we also at this stage need to work hard to prevent any further alcohol use. This means engaging with services such as IRIS at the earliest possible stage and first presentation. An alcohol support nurse role would be ideal for acute admissions but also as a support beacon for those who are being discharged home.
- Prioritising treatment in my opinion makes it 'ok' to start the abuse. I would much rather any resource here was focused on education of those not using drugs currently and preventing people ever needing treatment
- Why do you not emphasise the need for personal responsibility for misuse rather than just taking a default view common everywhere, that the system needs to provide services to deal with the problem and this needs to be funded by taxpayers of course.
- Treatment as early as possible is preferable to leaving it as late as possible.
- Such people misusing alcohol and/or non-prescription drugs cost the NHS vast amounts of money and time. These people ought to be educated in PERSONAL RESPONSIBILITY and SELF DISCIPLINE.
- Improved advertising/ information so people affected know what services are available to them.

Treatment

- Treatment need to be longer term to ensure there is sustained change, and not quick-fix programmes which end in 6 weeks
- Treatments are effective, but root causes are often ignored so the chances of the situation repeating are sadly very likely. Follow-up strategies are critical- what to do after the treatment.
- Treatment should include harm reduction and if appropriate maintenance elements. Treatment has social, psychological, physical & medicinal dimensions. This needs to be aligned with better provision of mental health services
- High quality service delivery is required - a more responsive service (for scripting), and the homelessness and lack of supported housing adds to the problems.
- There should be more support to set things up prior to release from prison to prevent reoffending and relapse.
- There is very little choice for what type of treatment that can be received.
- Feedback from GPs:
  • There is a need for a common, consistent approach to Alcohol Detoxification.
  • There is a need for a common approach to opiate and benzodiazepine management
- In reach services to the Royal Berkshire Hospital to work with the range of health professionals and projects already in place e.g. into wards including Sidmouth Ward, Cardiology Wards and the teams who provide inpatient and outpatient care/management to people with issues related to substance misuse and alcohol.
- Frequent Attenders to A&E project has been successful in reducing attendances of identified cohort by 46% - that group have identified improving drug and alcohol misuse services an opportunity – the specialist treatment service is a good but more is needed.
- Providing interventions and treatment for alcohol and drug users is important to meet the needs of Reading residents. These interventions will need to remain as high quality and reflect the emerging and current trends within Reading. By continuing this investment it improves outcomes for residents and their family and the wider community.
- Treatment for moderate and dependant drug and alcohol users' needs to be readily available within the community to prevent avoidable deaths and improve the health choices of those using substances. Partners across housing, probation, mental health and social care should be knowledgeable about what treatment options are available in Reading and work jointly to address the needs of those that require treatment services to support individuals to build their recovery capital and complete treatment successfully.
- There is a need for a common approach to opiate and benzodiazepine management.
- Better communication between secondary care primary care and community treatment services.
- Include prescription drug use

<u>Financial</u>

- Knock on effects of cut backs
- I am afraid that I do not agree that council taxpayers money should be used for this purpose, it is after all for a majority of these people a lifestyle choice.
- More central government funding is needed.

<u>Wider family impact</u>

- There needs to be something in treatment about wider family impact - particularly where the person in treatment is responsible for the care/support (either full or part time) for children. Whilst this may fall under prevention and is a part of the awareness raising - for young people and those caring for people with addiction, there is something about supporting them with resilience.
- Support for families of addicts

Detox

- Alcohol detox treatment at Prospect Park needs reviewing. It should not sit alongside people with acute mental distress.
- There is a need for a common, consistent approach to Alcohol detoxification

Location

- The treatment service is in the centre of 'DRUG DEALING and STREET DRINKERS ALLEY'.
- Around ANY CARE or RECOVERY CENTRE area- you need a ZeRO TOLERANCE ZONE. The community that it sits in is being inundated with this problem right in a RESIDENTIAL NEIGHBOURHOOD!

Pharmacies

- Community pharmacies already provide a valuable service supervising methadone/ subutex prescriptions and offering a needle exchange service. They could also be commissioned to provide Hepatitis testing and treatment services and also HiV testing.The pharmacies could work more collaboratively with other treatment agencies and TVPS and this would be more likely if there were opportunities to learn and share together.

Young people service

- Need an agency specifically aimed at prevention in school aged children - 13-18. There is a high use of cannabis users within our schools, and with this being a gate way drug an agency to come in and support schools and the students would be greatly received. Our Permanent Exclusions are increasingly significantly for having drugs/drug paraphernalia on their person whilst in school.
- A lot of our students are coming into college/ leaving college during the day to smoke weed. This has a detrimental effect on their behaviour, learning and therefore their future aspirations. We need help with what can be done to stop this.

Parents

- More treatment for parents who misuse, to support children living wither their parents.

Supply

- Ultimately the drug problem will not significantly reduce unless some UK government control of supply is established such as in Portugal.

Criminal justice

- In 2013 TVP commissioned a drug and alcohol service to work in custody suites across the county. The aim of this was to reduce substance misuse through offending and our team worked with offenders in custody, referring them to services and requiring those to tested positive for heroine and cocaine to attend treatment. This service was excellent and the statistics show that from 2013-2015 the rates of acquisition based crime, fuelled by addiction lowered considerably. However the police stopped funding for this service in 2015 as deemed too expensive. The figures of crime subsequently have risen from 2015 onwards.
- More money and resources should be put into the direct work done with those arrested for crimes involving addiction.

Other

- I suggest that the NHS is the correct owner for the treatment of all long-term conditions. They will, one hopes, use evidence to design effective treatment regimes which keep pace with changing requirements. I do, however, think that our LA, on our behalf, could be looking creatively at "treating" the environment in which these problems surface. We have, for instance, lots of homeless people and beggars on our streets.

Priority 3: ENFORCEMENT & REGULATION - Tackling alcohol and drug related crime and anti-social behaviour

"This links to the perception of crime and making people feeling safe within the community. Disrupting supply reduces availability and can contribute to the prevention message. Promoting responsible behaviour and reducing anti-social behaviour"

Question 5: Do you agree with this priority?

Yes	No	Not answered
85 responses	4	2
93.41%	4.396%	2.198%

Question 6: Would you like to add further comments or suggestions?

Yes	No	Not answered
42 responses		
46.2%		

Priority 3 – a range of comments included;

Other

- This is just the surface problem. You need to address the root cause to prevent the issue.
- Should be priority one. This is a huge problem and enforcing it would prevent a lot of the other issues.

- Please remember that addicts are also victims and are often exploited in many ways. Whilst they may go on to commit crime and become a problem within their community, they rarely make a conscious decision for this to be the case. They did not choose to be an addict. A balance between treatment and sustained change Vs the public interest to prosecute needs to be finely tuned. Focus of drug related crime and anti-social behaviour should be aimed at the dealers first and foremost.
- This activity should form part of the 'prevention' strategy
- We need a better and more co-ordinated operational strategic governance framework in Berkshire to analyse the data and intelligence we have.

Retailers/ Licensing

- Stop small retailers selling to known homeless, addicts or those clearly under the influence of alcohol. For this to happen, shop workers and owners need more support to be able to say "no" to known, difficult customers.
- Stronger LICENSING RULES in PROBLEM areas- will help.
- An increased minimum price on a unit of alcohol would help - but realise this is a government decision. Also, is there any way to decrease the huge amounts of alcohol made available in supermarkets for the Reading Festival?!
- More places need to be available to socialise without alcohol being the main centre of stage.

Legalise it

- The war against drugs is lost. The best thing we can do now is to legalise these substances and try to remove the criminal element that is wreaking havoc on our streets.

Enforcement

- Needs to be consistent enforcement of a whole host of issues by council, police and public including begging aggressive begging, shoplifting, anti-social behaviour, open drug dealing and injecting in town centre, fly tipping of detritus used by street population
- Reduce the amount of drugs that come into Reading
- Concern at the rising level of drug use in the town centre, including our communal car park.
- Disrupting drug supply tends to make it more expensive rather not less available. I believe drug use relies on income from begging and begging should therefore be restricted in the town centre.
- There should be a ban on drinking in the street apart from just outside pubs and bars.
- Tough ENFORCEMENT is the answer
- Anything that can be done to reduce crime, disorder and anti-social behaviour would be very welcome. Our town centre should be a place for everyone to enjoy and feel relaxed in the daytime and evenings. Unfortunately, as in many of our towns and cities, older people are deterred from going out in the evenings the evenings for theatre/cinema/meals etc. because of the alarming sight of, mainly young people , who have obviously had too much alcohol. I would have thought pub landlords have a responsibility to refuse to serve patrons who demonstrate excess alcohol consumption.
- More spot checks on known drug user properties, as well as working with neighbourhood watch committees.

- As well as active enforcement a strategy to decriminalise drug use and supply through pharmacies in parallel with seeking out and arresting the illegal supply chain is needed to eventually get the drugs problem under control.
- An absolute must. But not just in the town centre. Dealers are smart and use the peripheral areas such as Tilehurst.
- Once charged the courts need to do their part and enforce sentences.
- The police need to be more visible on the streets especially where drug dealers are known to operate.
- Additional resource required to aid enforcement effectively.
- Criminal enforcement (as the main approach) has had little effective impact, and can in itself cause damage to people's lives that can outweigh the impact of substances.
- Enforcement and regulation has undoubtedly a role, though can be used to simplify complex issues and fail to understand the drivers around substance initiation and continued use
- County lines, cuckooing, sexual exploitation adults and children, violence towards and between the vulnerable are big issues.
- This links to the perception of crime and making people feeling safe within the community. Disrupting supply reduces availability and can contribute to the prevention message. Promoting responsible behaviour and reducing anti-social behaviour.
- Working in partnership with the local police to protect vulnerable adults, who due to their substance use, are often abused physically, sexually, emotionally and financially needs to also form part of the enforcement. It is not just simply the case of enforcement for those who are battling addiction to reduce crimes associated with their substance use. A balanced and comprehensive approach is required which should include the police working with social care and health services on the ground to gather intelligence to support the disruption of emerging supply markets and offer supportive interventions that build confidence in the community to tackle the negative effects of drug & alcohol use on Reading communities.
- A stronger police presence is needed in all areas of Reading, including PCSO / community officers, who are very welcome in our neighbourhoods, and who can oversee areas that younger children use. This requires additional funding which should come through central government funds and taxes.
- There needs to be better communication links with Bullingdon Prison and practices.

<u>Education</u>

- I think educating the population of Reading is required. The signs, in areas used for begging, explained that giving money did not solve but supported the problem. It suggested generous residents should give to charities working in the area.
- Readings secondary school rate for Permanent Exclusions are increasing with drug and crime related incidents, to include gang related crimes.
- We would LOVE for police to come and do regular drug searches on our students and just have a greater presence and greater penalties for carrying.

Question 7: Are there any other priorities you feel should be included?

Yes	No	Not answered
43 responses	40	5 responses
49.43%	45.98%	5.75%

Q8 Other than issues already included within the 3 priorities, comments included:

- The public and residents near to areas of treatment centres and supported housing also need consideration when plans relating to ASB and substance misuse are designed. For instance, placing IRiS in the middle of (1) a residential street and (2) in the middle of a high drug crime area would have benefited from residents advice.
- Better services for people with substance misuse who have additional needs like learning disabilities, ASD and mental health
- Follow up is the critical part of treatment/ recovery
- Extend CCTV across Reading
- There is a need for a unified IT system. Connected Care could support this.
- Support for families/ carers

Q9 – Any further comments

- More diversionary activities – alternatives to alcohol
- What proportion of funding will be spent on alcohol prevention, compared with tackling drug misuse? Agree that alcohol is a bigger problem but how much do you have to take away from drug services?
- There needs to be a specific agency for this ever increasing issue amongst our young people, to include family support, knowledge and awareness, misuse support and gang affiliation.
- Prevention needs to begin as early as possible - we should not underestimate how young some children are when they become aware of substance misuses, especially alcohol.
- Treatment needs to be individual, less pathway-orientated and more focused on individual need
- Pursuit of criminal activity needs to be targeted at suppliers and dealers, criminalising addicts is not working which is why dealers are targeting younger and less obvious victims to draw into the world of supplying, dealing and running.
- The first sentence of the 'vision' is really weird. What is wrong with "Reduce the harm that alcohol and drugs have on the individual, families ...etc". "Potential harm", "misusing" I don't understand why those words are there!!
- There must be a recognition in the strategy of the interdependence of the trio of housing / mental health / and D&A problems.
- After-care in the community is another area where individually are left much to themselves and peer support.
- Where in Reading do you go for a night out without alcohol? Where do young people go? This sort of infrastructure needs nurturing by Reading Council.
- Central Government appears to be ignoring any evidence base. Local government should not repeat this.
- You should look to empower the people of the town to help prevent and educate

- More police on the streets, walking the beat. When reporting drug selling details, no action or follow up happens.
- In order for the strategy to be effective and outcome focussed, joint KPIs that support a wide range of health and social care strategic plans and work to support people to make better lifestyle choices and receive the support they require to build recovery and sustain it is required. Many health and social care services in Reading are working to improve the health & wellbeing outcomes of individuals and communities, this strategy can provide a clear direction for Reading to remain a top performing area on the PHOF with continued support from cross departmental joint working.
- Education and prevention in primary care and brief intervention training

End of Life – starting the conversation

Janette Searle,
RBC Wellbeing Team

Sandeep Nandhra-Gourlay,
Sunrise Senior Living

SUNRISE
SENIOR LIVING

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Deaths each year

- Each year, around 480,000 people die in England. This is predicted to increase to 550,000 by 2035.5
- 1,107 Reading residents died in 2016.

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Place of death (2016)

Place of death	Reading	IMD 4th less deprived LAs	England
Hospital	51.3	45.5	46.9
Home	23.9	22.7	23.5
Care home	15.2	23.5	21.8
Hospice	7.3	6.0	5.7
Other places	2.3	2.2	2.2

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Ambitions for Palliative and End of Life Care: a national framework for local action 2015 - 2020

- Each person is seen as an individual
- Each person gets fair access to care
- Maximising comfort and wellbeing
- Care is co-ordinated
- All staff are prepared to care
- Each community is prepared to help

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What's important to me

- Independent review into choices available about end of life care.
- Issues which people would like a choice about included:
  - Place of death
  - Pain control
  - Involvement of family and others close to the person nearing end of life
- It all starts with finding out what's important to the person at end of life.

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Our Commitment to you for end of life care (July 2016)

Government response to *What's important to me* was a commitment to support people approaching the end of their lives to:

- have honest discussions with care professionals about their needs and preferences
- make informed choices about their care
- develop and document a personalised care plan
- discuss their personalised care plans with care professionals
- involve their family, carers and those important to them in all aspects of their care as much as they want
- know who to contact for help and advice at any time.

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Dying Matters

A national coalition to help people talk about death

Information available on the site covers being with someone when they die, facts about funerals, personal stories, reviews of books covering death and bereavement

www.dyingmatters.org/

Leaflets available include

- *Five things to do before I die* - Information to help you think about the plans you might like to make before you die.
- *Remember when we…* - Tips on starting a conservation with someone you know about their end-of-life wishes
- *Being there* - Top tips for what to say and so when someone has been bereaved

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Dying Matters Week 2016

The ‘Big Conversation’ at St Laurence Church

- RBC End of Life Champion, Rachel Eden
- Berkshire West CCGs
- Citizen’s Advice
- A local law firm to talk about wills and lasting power of attorney
- a hospice chaplain
- Around one dozen information and advice stalls run by local support organisations and charities

However, only 37 people attended

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Dying to Talk 2017

A series of smaller community-based conversations covering topics such as legal and financial issues, organ donation and funeral planning.

Events included

- a slot on Reading's community radio station
- open day at the crematorium
- drop in sessions for cake and a chat about Dying Matters
- planning sessions with the Duchess of Kent hospice
- BBQ at the Sunrise Home in Sonning
- event at the RISC café, hosted by the Utulivu Women's Group.

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Dying Matters Week 2018

- Sue Ryder hospice promotion @ The Oracle
- BLAST FM shows around Dying Matters, linking with Thames Valley TV
- Sue Ryder Forget-Me-Not walk at Englefield Estate
- Open morning at Reading Crematorium with talk
- Reading Film Theatre showing of ‘That Good Night’
- Cllr Eden’s cuppa and chat in Whitley ward
- Dexter-Montage fund-raising quiz for Daisy’s Dream
- Talk on the psychology of death @ Reading University
- Sue Ryder talk on community support

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SUNRISE®
SENIOR LIVING

Our approach

- We offer a personalised service which values the individual at every stage.
- This includes End of Life, and we try to start planning with individual residents from Day One.
- Conversations are led by specialist End of Life / Palliative Care nursing staff.
- We involve the resident, their family, the GP and faith leaders where appropriate.
- Plans are reviewed – when the time is right, so as to bring reassurance and not cause distress.

The Challenges

- Thinking about End of Life may raise various big questions:
  - What will happen to my family?
  - What will happen to my pet?
  - What about funeral costs?
  - Will I get pain relief?
  - Will I die alone?
- It’s a big subject, and planning needs to be broken down

Why it matters

- People matter at every stage of life – including their final months, weeks and days
- Planning can do so much to improve things – but people often need help to get started
- Trained staff can pick the right moment and the right words

Talkback ‘Matters’ sessions

Talkback has been supporting adults in Reading with learning disabilities and/or autism for over 10 years. This has included community meetings to help people explore their understanding, feelings and views.

In 2016, Talkback invited people to consider what was important to them in terms of wellbeing

- Most welcomed the opportunity to talk about death and dying
- Many had struggled to find a space to consider these issues before.

In 2018, Talkback ran a special Matters session as part of Dying Matters Week

- People again said it was good to be allowed to talk about this. They welcomed support to deal with something ‘messy’.

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Addressing the strategic challenges of the urgent and emergency care system from an end of life perspective (Feb 17)

- Organised by the End of Life Networks for Thames Valley, Wessex and the South West
- Included talks from NHS England officials outlining government expectations on palliative care, plus a range of clinicians including Pangbourne GP Dr Barbara Barrie, a Thames Valley end of life champion.
- Around 120 people attended, mostly professionals or academics.

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The Importance of End of Life Planning (Mar 17)

- Organised by Balmore Park Surgery's Patient Participation Group (PPG) organised this event to give local people information about end of life planning.
- Speakers included a GP from Balmore Park Surgery, and representatives from Duchess of Kent House (hospice), a solicitor, a funeral home, and Age UK Reading. A question and answer session was also included after the talks.
- Reached 86 members of the public, 57% who are registered at Balmore Park Surgery. In total, people from 10 different Reading GP surgeries attended.

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Health and social care

- ReSPECT stands for Recommended Summary Plan for Emergency Care and Treatment. ReSPECT is a PROCESS and a FORM. It creates a personalised recommendation for your clinical care in emergency situations where you are not able to make decisions or express your wishes.

- Work is underway to establish this process locally, commencing with roll out across the Royal Berkshire Hospital Foundation Trust

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Local organisations

- Duchess of Kent Hospice - 15-bed inpatient or day hospice for adults run by Sue Ryder. Specialist nursing teams also provide advice and support to people in their own homes.
- Naomi House Children's Hospice - respite and hospice care for children and young people
- MacMillan - cancer information & support
- Alzheimers Society – dementia information & support
- Carers Hub – information, advice and support for those providing unpaid care

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Bereavement support

- The Listening Place at Tilehurst Methodist Church - bereavement support for everyone, regardless of religion or beliefs.
- Cruse Bereavement Care - face-to-face, telephone, email and website support for people who have been bereaved
- Daisy's Dream - support for bereaved children
- Rosie's Rainbow Fund - bereavement counselling to families who have lost a child, and music therapy
- AB Walker have a bereavement team and you do not need to use them for the funeral in order to access their free services for either a group bereavement course (the Link) or individual counselling.

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Useful websites

- Reading Services Guide
- NHS Choices
- Sue Ryder online community
- Alzheimers Society, especially factsheets section
- Berkshire West Clinical Commissioning Groups

The short film ‘Molly’s Story’ is intended to offer a starting point for families wanting to discuss end of life care with their health and social care teams

www.youtube.com/watch?v=nSZLucUnMcI

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READING HEALTH AND WELLBEING BOARD

DATE OF MEETING:	**12th October 2018**	**AGENDA ITEM:**	**9**
REPORT TITLE:	**A Proposed New Model for Reading's Joint Strategic Needs Assessment**		
REPORT AUTHOR:	**Marion Gibbon**	**TEL:**	0118 9374538
JOB TITLE:	**Interim Consultant in Public Health**	**E-MAIL:**	**marion.gibbon@reading.gov.uk**
ORGANISATION:	**Reading Borough Council**		

1. PURPOSE OF REPORT AND EXECUTIVE SUMMARY

1.1 The report provides a summary of the proposed new model for Reading's Joint Strategic Needs Assessment (JSNA) comprising:

- an online, digital source of data to describe the demography and wider determinants of health of the Reading population that is user-friendly and configurable by the user;
- a repository for detailed, service specific needs assessments carried out by internal and external partners with support from Wellbeing officers; and
- improved engagement with local research, especially qualitative and participatory research that captures user voice.

1.2 Appendix 1 – Presentation of a proposed new model for Reading's JSNA

2. RECOMMENDED ACTION

2.1 That the Health & Wellbeing Board authorises officers to progress the development of Reading's Joint Strategic Needs Assessment in line with the new model described in this report.

3. POLICY CONTEXT

3.1 Preparing a JSNA, in partnership with local Clinical Commissioning Groups (CCGs), is a legal requirement for local authorities. Under the Local Government and Public Involvement in Health Act (2007) and the Health and Social Care Act (2012), Reading Borough Council has a legal duty to prepare a JSNA and a strategy for meeting the needs described in the assessment (the Health and Wellbeing Strategy) in partnership with its partner CCG.

4. THE PROPOSAL

4.1 Current Position.

4.1.1 Reading's current JSNA consists of a large (70+) number of separate sections. Each section was originally produced by an officer from the Council's Wellbeing team, liaising with colleagues from other services as appropriate. A lead officer within the Council is

required to review and update the content of each section on an annual basis. The updated content must be reviewed by a member of the Wellbeing team and signed off by Reading's Public Health Consultant before it is published online.

4.1.2 This model has presented a number of challenges.

- The process requires a large amount of officer time, both from within the Wellbeing team and from internal partners. There are a large number of JSNA sections, which are difficult to keep up-to-date, especially where resources are reducing and where there are competing priorities.
- The process can involve duplication. Some teams and services produce needs analyses to support their own commissioning and strategic activities as well as having to produce JSNA content.
- The JSNA process is not effective at involving health partners and often does not take account of the multiple geographies in which partners operate.
- JSNA sections are produced by different authors with different knowledge and specialisms. As a result, the separate sections are sometimes inconsistent in their depth of analysis and detail. As they are usually produced in 'silo', they not always appropriately connected to other relevant sections.
- The current format lacks visual and interactive content to engage users and doesn't make effective use of digital technologies or publicly available data.
- The current format lacks a mechanism for providing an overarching 'big picture' of Reading and its population.
- There is currently no consistent approach to articulating user voice through the JSNA, despite some active local forums, an effective Local Healthwatch Service and the availability of research by other local organisations.

4.2 Options Proposed.

4.2.1 The proposed new model for Reading's JSNA is designed to introduce a more cohesive and efficient approach to assessing the needs of the local population.

4.2.2 The key elements of the proposed model are:

- an online, digital source of data on the demography and wider determinants of health of the Reading population that is user-friendly and configurable by the user;
- a repository for detailed, service specific needs assessments carried out by internal and external partners with support from Wellbeing officers; and
- improved engagement with local research, especially qualitative and participatory research that captures user voice.

4.2.3 Several options for the online element are being considered. These include:

- providing links to publicly available information published by Public Health England (PHE);
- using free report-building tools available through the Local Government Association (LGA);
- using APIs (Application Programming Interfaces) with a data visualisation tool (such as Tableau) or a new website development; and
- Subscribing to a web-based resource, such as OCSI's Local Insights; Grant Thornton's Place Analytics and Geowise's Instant Atlas.

These are described further in the presentation in Appendix 1.

4.2.4 Under the proposed model, the production of JSNA content will align with needs assessments that are already carried out by the Council and its partners as part of developing strategy and commissioning services. The Wellbeing team will work cooperatively with others to support the production of needs analyses that will support commissioning activity and take into account vulnerabilities and inequalities in the population. The completed needs analyses will then be included and published online as JSNA content.

4.2.5 **Next steps**. Options within the proposed model outlined here will be presented to Reading's Public Health Board (PH Board) in October 2018. The PH Board will be asked to discuss the proposed model and its implementation and:

- agree a preferred option for the digital, online element;
- agree how the new model will be funded (through the Public Health Grant or other means); and
- agree how the implementation of the new model will be overseen (e.g. through the establishment of a separate Steering Group).

4.2.6 Four of the other Public Health teams across Berkshire have also identified similar challenges and have begun working with the Public Health Services for Berkshire team to develop a 'shared vision' for JSNA across Berkshire. Key elements of the shared vision will be automation of data updates and streamlining of JSNA content. A joint approach may offer an opportunity for greater efficiencies and access to a wider pool of resources and skills.

4.3 Other Options Considered

4.3.1 Continuing to produce updates Reading's JSNA in line with the current model is not recommended for the reasons outlined in paragraph 4.1.2.

4.3.2 The implementation of a 'Population Health Management' approach throughout the local Integrated Care System (ICS), focusing on intelligence and analysis to develop an understanding of the health and wellbeing needs of the population, suggests that CCGs and other NHS organisations may have similar interests both to the Berkshire 'shared vision' and Reading's proposed model for JSNA. The model proposed here is likely to allow for alignment with the ICS approach. Delaying an immediate decision on the Reading JSNA model could allow this to be checked more thoroughly, but is unlikely to confer sufficient advantages to merit the delay.

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

5.1 The JSNA contributes to the Health and Wellbeing Strategy by providing a basis on which to identify the health and wellbeing needs of the population. This proposed model is designed to introduce a more cohesive and efficient approach to assessing those needs.

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 specifically addresses these in the following ways:

- Improving the quality of information available to form the basis of effective commissioning and strategic planning across all service areas.
- Providing resources that support greater understanding of needs of vulnerable adults and children, and carers.
- Better links with local qualitative research provide an opportunity for service user voices to be articulated and taken into account.

6. COMMUNITY & STAKEHOLDER ENGAGEMENT

6.1 The Wellbeing team has been involved in ongoing informal discussions with partner organisations about the proposed model and has taken part in workshops to discuss and develop the Berkshire 'shared model' and review potential digital solutions.

6.2 Further consultation and engagement between Wellbeing officers and partner organisations will help to set out plans for supporting the production of service specific needs analyses.

7. EQUALITY IMPACT ASSESSMENT

7.1 An Equality Impact Assessment is not required in relation to the proposal to adopt a new model for JSNA. No groups are expected to be disproportionately affected by adopting a new, more effective and efficient approach. We hope that by engaging better with local research groups, including our local Healthwatch, that the new model will enable us to take into account perspectives of members of the population who may not always be well-represented.

8. LEGAL IMPLICATIONS

8.1 Not applicable

9. FINANCIAL IMPLICATIONS

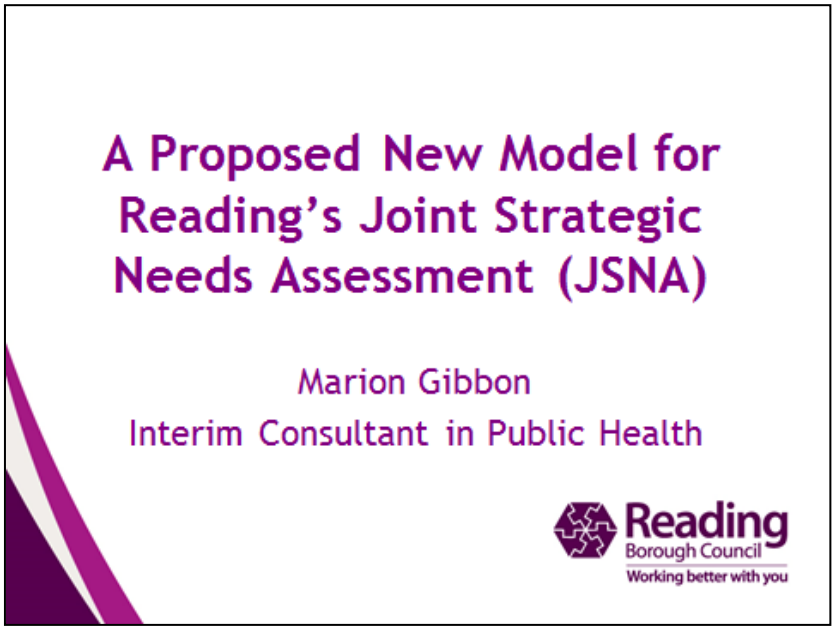
9.1 Implementation of the digital element of the proposed model will be discussed further by the Public Health Board. Value for money and financial risk for each of the options has been considered (see Appendix 1) and will be taken into account before a preferred option is selected.

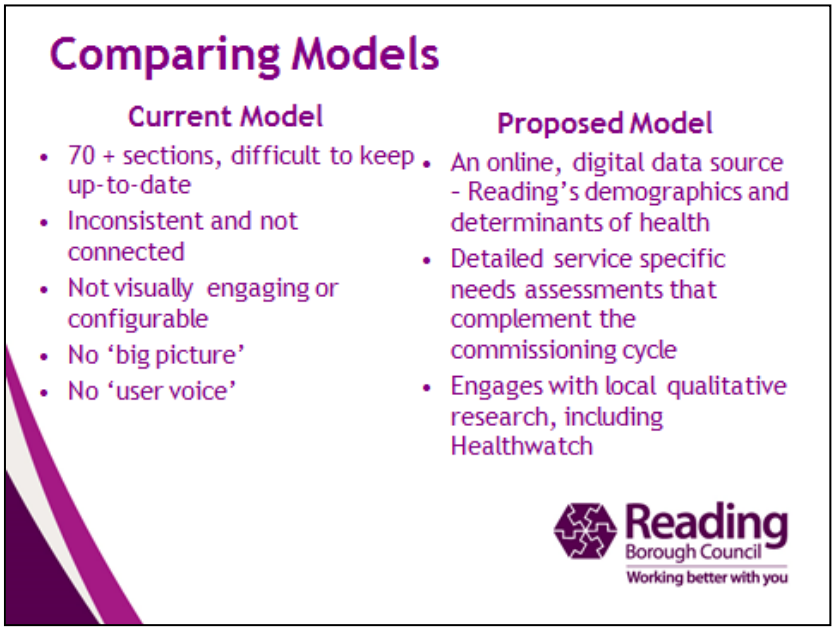
10. BACKGROUND PAPERS

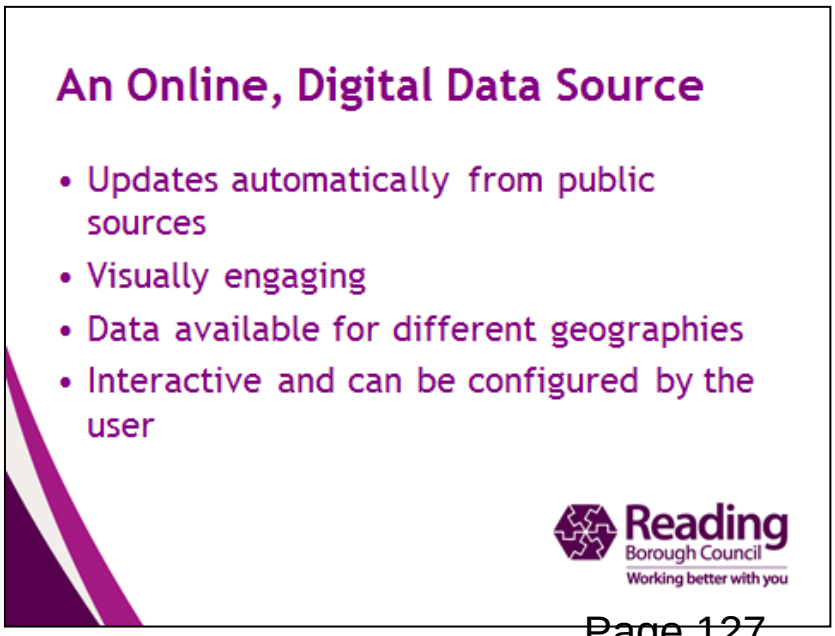
10.1 Health and Social Care Act, 2012 https://www.legislation.gov.uk/ukpga/2012/7/contents

10.2 Local Government and Public Involvement in Health Act, 2007 https://www.legislation.gov.uk/ukpga/2007/28/contents

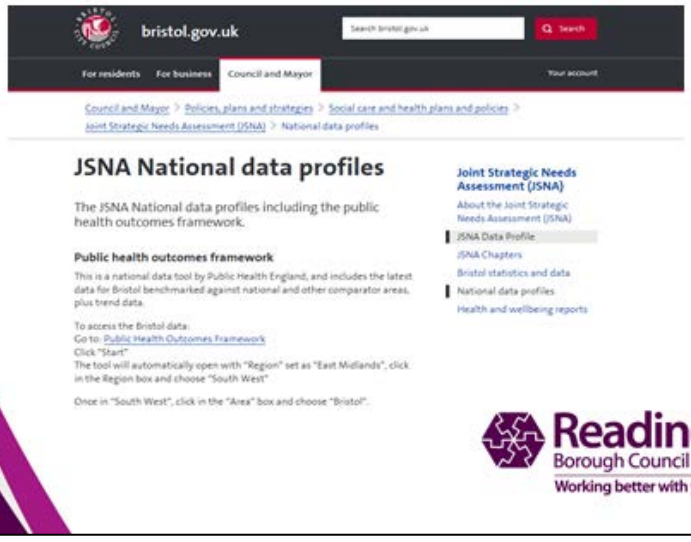
Appendix 1 – Presentation of a proposed new model for Reading's JSNA







Link to publicly available information



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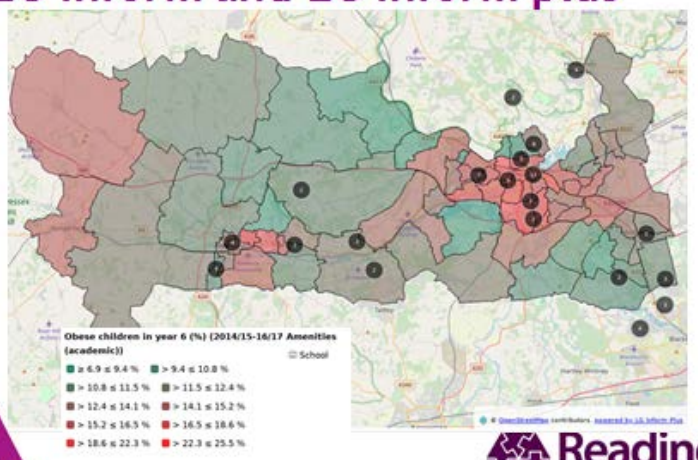
LG Inform and LG Inform plus



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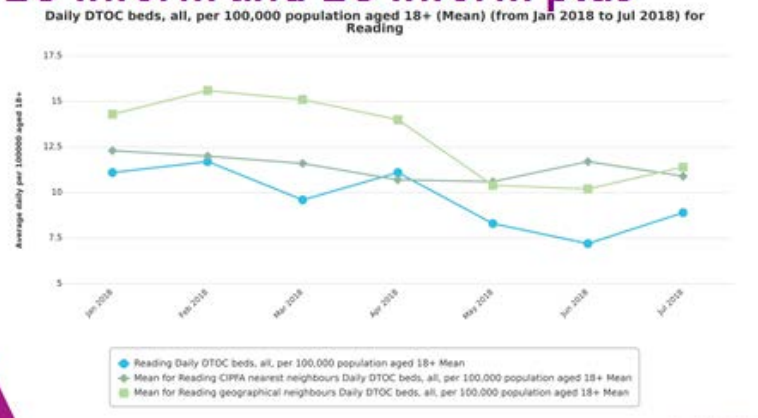

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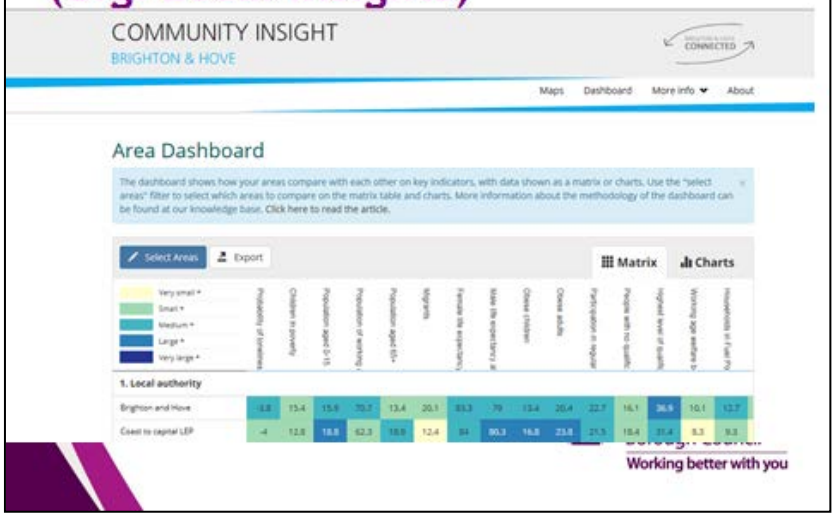
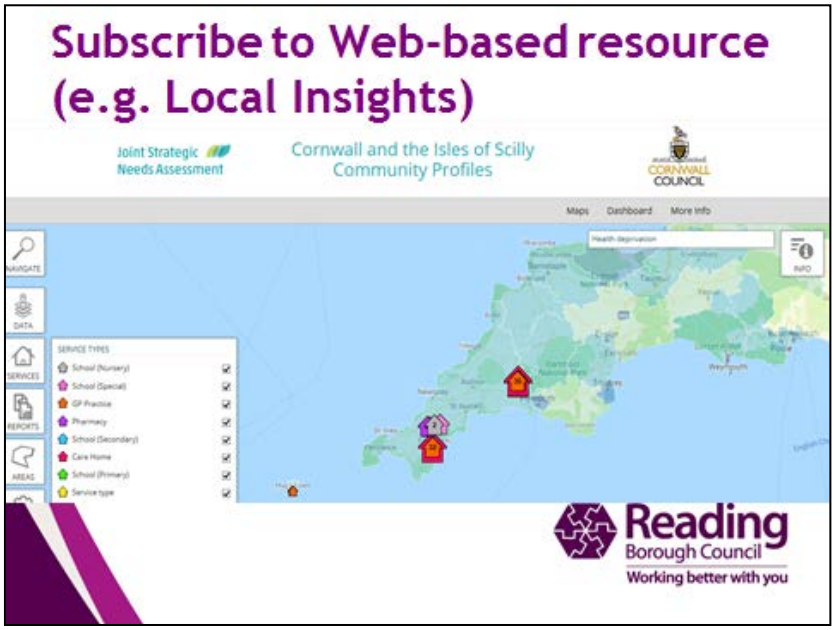
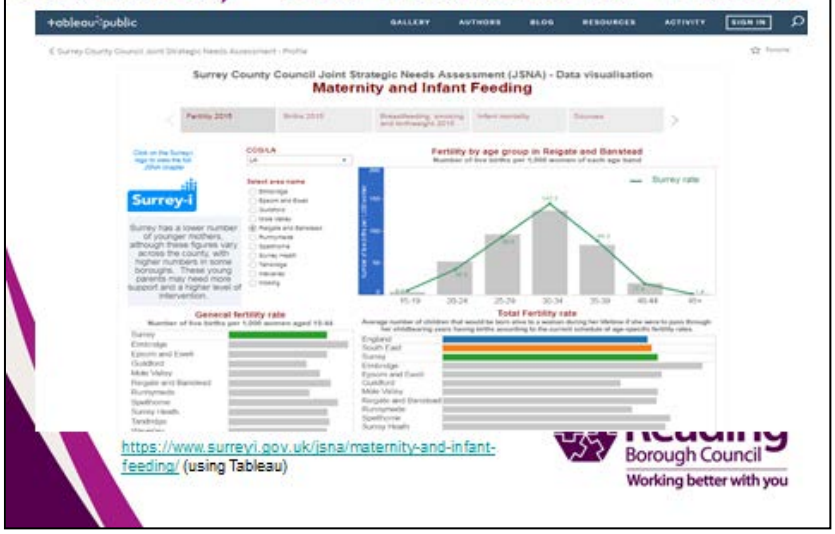
Subscribe to Web-based resource (e.g. Local Insights)



Subscribe to Web-based resource (e.g. Local Insights)



API (an automatic feed of data from a public data source) + Data Visualisation or Website



An Online, Digital Data Source - Evaluating the options

	Links to public data sources	LG Inform/LG Inform Plus	Subscribe to web-based resource	API + Data Visualisation or Website
Automatic updates	Yes	Yes	Yes	Yes
Visually engaging	No	Partly	Yes	Yes
Different geographies	Yes (on separate sites)	Partly	Yes	Yes
Interactive	No	No	Yes	Yes
Cost	Free	Free	££	££££

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Service specific needs assessments

Collecting evidence about population and their needs is a part of the commissioning cycle

Local Government Association, 2018 https://www.local.gov.uk/sites/default/files/documents/LGA_11%20127_A%20councillor%27s%20workbook%20on%20the%20commissioning%20of%20services_June%202018.pdf

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Service specific needs assessments

- Wellbeing team will work collaboratively with its internal and external partners as part of developing strategy and commissioning services
- Inequalities and wider determinants of health taken into account in wider commissioning and planning
- Jointly produced needs analysis published as JSNA content

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Engages with local qualitative research

- Healthwatch reports will be included as part of the JSNA, making sure they are taken into account in planning and commissioning of services
- Including reports from local participatory research - Whitley4Real, Participation Lab http://blogs.reading.ac.uk/participation-lab/files/2018/08/Picture2.png
- And other third sector partners - http://rva.org.uk/article/rvas-report-on-youth-isolation-and-loneliness-in-reading/

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READING HEALTH AND WELLBEING BOARD

DATE OF MEETING:	**12th OCTOBER 2018**	**AGENDA ITEM:**	**10**
REPORT TITLE:	**INFLUENZA [FLU] PLAN UPDATE 2018**		
REPORT AUTHOR:	**JO JEFFERIES**	**TEL:**	**01344 352745**
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ORGANISATION:	**PUBLIC HEALTH SERVICES FOR BERKSHIRE**		

1. PURPOSE OF REPORT AND EXECUTIVE SUMMARY

1.1 This paper is to update the Health and Wellbeing Board on the performance of the influenza (flu) vaccine campaign in winter 2017-18 to summarise lessons learned and to inform the board of changes to the national flu programme for the coming 2018-19 flu season and how these will be implemented locally.

1.2 Appendices:
Appendix 1 – National Flu Programme Letter 201819
Appendix 2 – Berkshire seasonal influenza vaccine campaign 201718 final report
Appendix 3 – Berkshire flu planning workshop report and recommendations
Appendix 4 – Reading Borough Council draft communication plan 201819

2. RECOMMENDED ACTION

2.1 Agree and endorse the multi-agency approach

2.2 Seek assurance that respective organisations are taking steps to fulfil their responsibilities as set out in the national flu plan.

2.3 Be flu champions – take every opportunity to promote the vaccine and debunk myths

2.4 Lead by example, take up the offer of a vaccine where eligible.

3. BACKGROUND

Seasonal flu is a key factor in NHS winter pressures. The National Flu Plan (see National letter – Appendix 1) aims to reduce the impact of flu in the population through a series of complementary measures. Flu vaccination is commissioned by NHS England for groups at increased risk of severe disease or death should they contract flu.

Key aims of the immunisation programme in 2017-18 were to;

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

among people 65 years and over, at least 55% among clinical risk groups and 75% among healthcare workers

2017-18 was a challenging flu season, contributing to winter pressures on health and care services. The PHE report, 'Surveillance of influenza and other respiratory viruses in the UK: Winter 2017 to 2018 released on 24 May 2018, indicated that; in the 2017 to 2018 season, moderate to high levels of influenza activity were observed in the UK with co-circulation of influenza B and influenza A(H3), which is different to 2016-17 where H3N2 predominated. Indicators for GP consultation for flu-like illness in and out of hours and for NHS 111 calls were at higher levels than in 2016-17, patterns of activity were similar peaking in week 52 and peak admissions rates of influenza to hospital and intensive care were higher than seen in the previous 6 seasons.

4. MULTI-AGENCY APPROACH

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

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

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

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

Actions taken in 2017-18 as part of this approach included but were not limited to;

- Development of local authority and CCG flu plans based on a shared approach across the in the West of Berkshire
- Participation in a twice-monthly Thames Valley Flu teleconferences led by NHS England to share flu data, best practice and ability to raise concerns with representation locally
- Participation in monthly Berkshire West Flu Action Group with representation from CCGs, NHS providers and local authority public health to monitor progress against flu plans, review uptake of the flu vaccination, assess the impact of flu activity and share good practice or concerns which could then be escalated.
- The public health team supported the BHFT schools immunisation team to engage with those schools where initial engagement was less effective
- Providers also signed up to the 'Health and Wellbeing of Staff' CQUIN which includes staff flu vaccination uptake
- In the West of Berkshire the CCG Quality Team / CCG flu lead supported low performing GP practices with practice visits and / or communications
- A flu communication pack was shared with all care homes
- Ensuring a consistent communication approach across the health and care economy by linking with the national flu campaign as well local alignment of communications between the local public health and the CCG communication teams.
- Use of targeted social media approaches to promote flu vaccination

- A collaborative approach to the management of of flu outbreaks in closed settings such as care and nursing homes, Berkshire West CCGs commissioned a specific service to undertake risk-assessment and provide antiviral medication for treatment of flu and to prevent further spread to vulnerable residents
- Working with local partners and community and voluntary groups to promote flu vaccine – this included Talkback UK's *Being as Healthy* group, Older People's Working Group, Family Information Services etc.

See Appendix 2 - Berkshire seasonal influenza vaccine campaign 201718 final report for full details.

4.1 LOCAL UPTAKE 2017-18

In 2017-18 uptake of vaccine among GP-registered patients in Berkshire was generally similar to or higher than in 2016-17. After observing an increase in uptake in 2016-17, uptake in Slough was slightly reduced in the 2017-18 flu season, with the exception of over 65's where uptake was slightly higher.

- **Patients in clinical risk groups** – uptake was reduced by between 0.9% and 3.1% in this group, with the exception of RBWM and West Berkshire where uptake was similar to the previous season. Nationally uptake was very similar to the previous season.
- **Over 65s** – Increased uptake of flu vaccine was observed in all Local Authorities within Berkshire. Uptake in West Berkshire reached 77.6%, exceeding the national 75% uptake ambition
- **Pregnant Women** – In line with the national picture, uptake in this group was increased compared to 2016-17 with the exception of Slough where a reduction in uptake of 4.9% was observed. Bracknell Forest exceeded the national ambition of 55%, achieving 57% uptake.
- **Children aged 2 and 3** – Uptake in two year olds increased in Reading, West Berkshire Wokingham and RBWM, but decreased slightly in Slough. A reduction was also observed in Bracknell Forest compared to the previous season. The uptake ambition was not reached in any local authority in Berkshire or nationally (3.9% increase resulting in 42.9% uptake). Among three year olds modest increases in uptake were observed in Bracknell Forest, West Berkshire and Wokingham, with small decreases observed in Reading and RBWM. Slough experienced a larger decrease in uptake. All areas with the exception of Reading and Slough achieved a higher uptake than the national figure of 44.2%
- **Children in school years 0- 4** – this programme was again highly successful in Berkshire, the uptake ambition of 40% was exceeded in all local authorities reaching as high as 80% in at least one area.
- **Healthcare workers** – Uptake among NHS staff increased compared to the 2016-17 season in all local Trusts with the exception of Berkshire Healthcare Foundation Trust, where uptake was slightly recued on the previous season despite more vaccines being given. Uptake in local NHS Trusts ranged from 62.6%-72.1%

4.2 LEARNING FROM 2017-18 SEASON

- Local Authority public health teams actively promoted flu vaccination to eligible groups using a range of channels and worked with commissioners and providers during the season to identify issues. Whilst uptake among school children was good, uptake in other risk groups remains below the desired level; this is in line with other areas of the country.

- There remains considerable variation in uptake between GP practices, There is scope to improve communicating vaccine uptake to practices throughout the flu season and to improve the way patients are invited for vaccination.

- Myths and misconceptions regarding vaccines remain an important barrier to uptake. Other barriers may include variation in access to GP flu clinics, lack of health literacy and inclusion of porcine element in the children's vaccine making it inappropriate for some groups.

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

- Despite introduction of an NHS funded flu vaccine offer for frontline social care staff in nursing and residential care, local intelligence suggest uptake in this group remained low.

- Locally, CCGs and their commissioned providers responded well to flu outbreaks in care homes and closed settings following development and implementation of flu outbreak plans. Close partnership working proved key to the success of this approach and closer working at the planning stage is warranted for future success.

5. CHANGES FOR THE 2018-19 FLU SEASON

The higher burden of H3N2 among elderly people together with the lower VE of vaccines against this sub-type support the need for more effective interventions[1] and the UK Joint Committee on Vaccination and Immunisation has advised that use of adjuvanted trivalent inactivated vaccines (TIV) in those aged 65 years and older would be both more effective and cost-effective than the non-adjuvanted trivalent or quadrivalent vaccines currently in use[2].

In February 2018, NHS England wrote to GP Practice and Community Pharmacies advising that they should offer:

- adjuvanted trivalent vaccine (aTIV) for all 65s and over
- quadrivalent vaccine (QIV) for those age 18 to 64 at risk

Nasal vaccine will continue to be offered to healthy children aged 2 and above.

Nationally, groups eligible for vaccination are similar to previous years, with the addition of children in school year 5 to the school-aged programme. It has been confirmed that care home/nursing home/domiciliary care workers caring for vulnerable residents at risk from influenza are also eligible for a free flu vaccine again in 2017-18. In addition, this offer has also been extended to hospice workers. The eligible groups and where they can access their vaccine are shown below.

Target Group	GP	Pharmacy	Maternity	School	Workplace
Aged under 65 'at risk'	√	√			
Pregnant women	√	√	√		
Eligible children aged 2-3 years	√				
Eligible children in Reception to school year 5				√	
Aged 65 years and over	√	√			

[1] https://assets.publishing.service.gov.uk/government/uploads/system/uploads/attachment_data/file/641162/Influenza_vaccine_effectiveness_in_primary_care_1617_final.pdf

[2] https://www.gov.uk/government/publications/flu-vaccination-supporting-data-for-adult-vaccines/summary-of-data-to-support-the-choice-of-influenza-vaccination-for-adults-in-primary-care

Carers	√	√			
NHS Healthcare workers		√			√
Frontline care home/nursing home/domicillary care workers and hospice workers	√	√			

6. LOCAL FLU PLAN FOR 2018-19

A successful flu planning workshop took place on 8th June at the Open Learning Centre, Bracknell – see Appendix 3 for further details. This was well attended by a range of stakeholders from across Berkshire and sought to being together plans for provision and promotion of flu vaccine and preparing and responding to flu outbreaks. Following the workshop, the Shared Pubic Health Team developed a high level Berkshire Flu Plan which enabled Reading's Public Health and Wellbeing team to create a local flu action plan for the 2018-19 season. Reading Borough Council currently have a draft communication plan – see Appendix 4.

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Department of Health & Social Care

Public Health England

NHS England

26 March 2018

Dear colleague,

The national flu immunisation programme 2018/19

This letter (flu letter: no. 1) provides information about which patients and children are eligible for vaccination in the flu immunisation programme for 2018/19. A second letter will follow in late spring with information about frontline healthcare workers and social care workers.

Eligibility

1. In 2018/19 the one change in eligibility is the extension to an additional cohort of children, those in school year 5. Therefore, in 2018/19 the following are eligible for flu vaccination:

- all children aged two to nine (but not ten years or older) on 31 August 2018
- all primary school-aged children in former primary school pilot areas
- those aged six months to under 65 years in clinical risk groups
- pregnant women
- those aged 65 years and over
- those in long-stay residential care homes
- carers

2. In addition, vaccination is recommended for frontline health and social care workers (see letter no.2 to follow)

National flu immunisation priorities

3. The last season's higher level of flu activity is an important reminder that flu can have a significant impact and is highly unpredictable. This year saw record flu vaccination levels, with nearly one and a half million more people getting the vaccination than last year. We should strive to further improve vaccine uptake rates in all eligible cohorts next year.

PHE Gateway Ref: 2017863
NHS England Gateway Ref: 07808

4. NHS England has already written to GPs, community pharmacies and Clinical Commissioning Groups to confirm that the most effective flu vaccines for the population should be ordered, for the 2018/19 flu season. Based on the advice of the Joint Committee on Vaccination and Immunisation (JCVI), providers should offer:

- **the adjuvanted trivalent vaccine (aTIV) for all 65s and over.** NHS England has recommended that the adjuvanted trivalent influenza vaccine (aTIV) be made available to all those aged 65 and over in 2018/19. This is the most effective vaccine currently available for this group. This reflects current JCVI advice and Green Book guidance published in December 2017 by Public Health England (PHE). Note: JCVI considers aTIV to be more effective and cost-effective than the non adjuvanted vaccines currently in use in the elderly (including quadrivalent vaccine (QIV)).
- **the quadrivalent vaccine (QIV) for 18 – under 65s at risk.** NHS England has recommended that adults aged 18 to under 65 in clinical at-risk groups are offered the quadrivalent influenza vaccine (QIV) which protects against four strains of flu. This reflects current JCVI advice and Green Book guidance that was updated in October 2017 on the basis of cost-effectiveness data produced by PHE.

5. The live attenuated influenza vaccine (LAIV) used for the children's programme is also quadrivalent. We ask that increased effort is given to the vaccination of preschool children as uptake is not as high as in schools. The effectiveness of LAIV offered to children is good; furthermore children under the age of five years old have the highest rate of hospital admissions for flu of all age groups. Improving uptake in these children and children with an underlying clinical risk factor will provide individual protection as well as helping to protect the wider community.

Vaccine uptake ambitions

6. Vaccine uptake ambitions for 2018/19 are similar to previous years. The long-term ambition for eligible adults is a minimum 75% uptake rate is achieved, as recommended by the World Health Organization. In the case of at risk groups the ambition is an interim one because current uptake is some way from 75%.

7. As a key objective in the children's programme is to maximise reduction of flu transmission, in addition to individual protection, the ambition beyond 2018/19 will be based on levels of vaccine uptake needed to achieve this impact. The proposed ambitions are different for the preschool and school-aged children as achieving higher uptake in general practice is more challenging than in schools.

Table 1: Vaccine uptake ambitions in 2018/19

Eligible groups	Uptake ambition
Routine programme	
Aged 65 years and over	**75%**, reflecting the World Health Organization (WHO) target for this group.
Aged under 65 'at risk', including pregnant women	**At least 55% in all clinical risk groups*,** and maintaining higher rates where those have already been achieved. Ultimately the aim is to achieve at least a 75% uptake in these groups given their increased risk of morbidity and mortality from flu.
Children's programme	
Preschool children aged 2 and 3 years old	**At least 48%** with most practices aiming to achieve higher.
School aged children (in reception class & years 1 to 5)	**An average of at least 65%** to be attained by every provider across all years.

* interim ambition

8. Providers should actively invite 100% of eligible individuals (e.g. by letter, email, phone call, text) and ensure uptake is as high as possible. Providers and commissioners will be required, if asked, to demonstrate that such an offer has been made. The benefits of the vaccine among all recommended groups should be communicated and vaccination made as easily accessible as possible.

Timing

9. Although the enhanced service specification for flu includes payment for vaccines given up until 31 March 2019, vaccination, using the most effective vaccine, should be given as soon as possible to provide protection before flu starts to circulate. Ideally vaccination should be completed by the end of November.

10. In general it is appropriate to still offer vaccination to eligible patients at any subsequent point in the flu season, even if they present late for vaccination. This can be particularly important if it is a late flu season or when newly at risk

patients present, such as pregnant women who may have not been pregnant at the beginning of the vaccination period. The decision to vaccinate should take into account the level of flu-like illness in the community, bearing in mind that the immune response to vaccination takes about two weeks to develop fully.

11. It should be noted that for the children's programme, LAIV has a short shelf life and there will only be limited availability of vaccine late in the season.

Conclusion

12. We thank everyone for their hard work in supporting the programme and the significant contribution this makes to reducing illness and death from flu. Flu is a major cause of harm to individuals and a key factor in NHS winter pressures. Preventing flu infection through vaccination also contributes to preventing secondary bacterial infections such as pneumonia. This can help reduce the need for antibiotics and contribute towards preventing antibiotic resistance.

13. We encourage you to look at the National Institute for Health and Care Excellence (NICE) guidelines on increasing flu vaccination uptake which will be published shortly.

14. This Annual Flu Letter has the support of the Chief Pharmaceutical Officer, the Chief Nursing Officer and the Chief Nurse.

Yours sincerely,

Professor Dame Sally C Davies
Department of Health & Social Care, Chief Medical Officer

Professor Paul Cosford
Public Health England, Medical Director and Director for Health Protection

Professor Stephen Powis
NHS England, National Medical Director

Links to other key documents

Document	Web link
Green Book Influenza Chapter	www.gov.uk/government/publications/influenza-the-green-book-chapter-19
National Institute for Health and Care Excellence (NICE) guidelines on increasing flu vaccine uptake	www.NICE.org.uk
NHS England Public Health Functions Agreement 2018/19 (known as Section 7A agreement)	www.england.nhs.uk/commissioning/pub-hlth-res/
NHS England enhanced service specification (For GP providers)	www.england.nhs.uk/commissioning/gp-contract/
Community Pharmacy Seasonal Influenza Vaccination Advanced Service	www.PSNC.org.uk
Immform Survey User guide for GP practices, local NHS England teams, and NHS Trusts Flu vaccine uptake figures	www.gov.uk/government/collections/vaccine-uptake
Flu immunisation PGD templates (Note: These templates require authorisation before use)	www.gov.uk/government/collections/immunisation-patient-group-direction-pgd
ImmForm website for ordering child flu vaccines	www.immform.dh.gov.uk
National Q&As / training slide sets/ e-learning programme	www.gov.uk/government/collections/annual-flu-programme www.e-lfh.org.uk/programmes/flu-immunisation/
Seasonal flu/influenza GP practice vaccination programmes supporting documents	www.nhsemployers.org/vandi201819
Vaccine Update To **register** to receive the monthly newsletter by email please go to:	www.gov.uk/government/collections/vaccine-update https://public.govdelivery.com/accounts/UKHPA/subscribers/new?preferences=true
PHE Flu Immunisation Programme home page	www.gov.uk/government/collections/annual-flu-programme

Any **enquiries** regarding this publication should be sent to: immunisation@phe.gov.uk

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British Medical Association
Royal Pharmaceutical Society
Association of Pharmacy Technicians UK
Company Chemist's Association
National Pharmacy Association
Pharmaceutical Services Negotiating Committee
Local Government Association
Association of Directors of Adult Social Services
Council of Deans of Health
General Pharmaceutical Council

List of appendices

Detailed planning information is set out in the following appendices:

Appendix A: Groups included in the national flu immunisation programme

1. Groups eligible for flu vaccination are based on the advice of the Joint Committee on Vaccination and Immunisation (JCVI). The programme aims to provide direct protection to those who are at higher risk of flu associated morbidity and mortality. This includes older people, pregnant women, and those with certain underlying medical conditions.

2. In 2012 JCVI recommended extending flu vaccination to children to provide both individual protection to the children themselves and reduce transmission across all age groups.

3. In 2018/19, flu vaccinations will be offered under the NHS flu vaccination programme to the following groups:

    - all those aged two and three (but not four years or older) on 31 August 2018 (date of birth on or after 1 September 2014 and on or before 31 August 2016)
    - all children in reception class and school years 1, 2, 3, 4 and 5 (date of birth on or after 1 September 2008 and on or before 31 August 2014)
    - all primary school-aged children in former primary school pilot areas
    - people aged from six months to less than 65 years of age with a serious medical condition such as:
        - chronic (long-term) respiratory disease, such as severe asthma, chronic obstructive pulmonary disease (COPD) or bronchitis
        - chronic heart disease, such as heart failure
        - chronic kidney disease at stage three, four or five
        - chronic liver disease
        - chronic neurological disease, such as Parkinson’s disease or motor neurone disease, or learning disability
        - diabetes
        - splenic dysfunction or asplenia
        - a weakened immune system due to disease (such as HIV/AIDS) or treatment (such as cancer treatment)
        - morbidly obese (defined as BMI of 40 and above)
    - all pregnant women (including those women who become pregnant during the flu season)
    - people aged 65 years or over (including those becoming age 65 years by 31 March 2019)
    - people living in long-stay residential care homes or other long-stay care facilities where rapid spread is likely to follow introduction of infection and cause high morbidity and mortality. This does not include, for instance, prisons, young offender institutions, or university halls of residence

- those who are in receipt of a carer's allowance, or who are the main carer of an older or disabled person whose welfare may be at risk if the carer falls ill
- consideration should also be given to the vaccination of household contacts of immunocompromised individuals, specifically individuals who expect to share living accommodation on most days over the winter and, therefore, for whom continuing close contact is unavoidable

4. The list above is not exhaustive, and the healthcare professional should apply clinical judgement to take into account the risk of flu exacerbating any underlying disease that a patient may have, as well as the risk of serious illness from flu itself. Flu vaccine should be offered in such cases even if the individual is not in the clinical risk groups specified above.

Healthcare practitioners should refer to the Green Book influenza chapter for further detail about clinical risk groups advised to receive flu immunisation.
This is regularly updated, sometimes during the flu season, and can be found at:
www.gov.uk/government/collections/immunisation-against-infectious-disease-the-green-book

Appendix B: GP practice checklist

Practices are encouraged to implement the guidelines below which are based on evidence about factors associated with higher flu vaccine uptake[1].

Named lead

- Identify a named lead individual within the practice who is responsible for the flu vaccination programme and liaises regularly with all staff involved in the programme.

Registers and information

- Hold a register that can identify all pregnant women and patients in the under 65 years at risk groups, those aged 65 years and over, and those aged two to three years.
- Update the patient register throughout the flu season paying particular attention to the inclusion of women who become pregnant and patients who enter at risk groups during the flu season.
- Submit accurate data on number of patients eligible to receive flu vaccine and flu vaccinations given to its patients on ImmForm (www.immform.dh.gov.uk), ideally using the automated function. Submit data on uptake amongst healthcare workers in primary care using the ImmForm data collection tool.

Meeting any public health ambitions in respect of such immunisations

- Order sufficient flu vaccine taking into account past and planned improved performance, expected demographic increase, and to ensure that everyone at risk is offered the flu vaccine. For children guidance to be followed on ordering the vaccine from PHE central supplies through the ImmForm website.

Robust call and recall arrangements

- Invite patients recommended to receive the flu vaccine to a flu vaccination clinic or to make an appointment (eg by letter, email, phone call, text). This is a requirement of the enhanced service specification.
- Follow-up patients, especially those in at risk groups, who do not respond or fail to attend scheduled clinics or appointments and have not been offered the vaccine elsewhere.

Maximising uptake in the interests of at-risk patients

- Start flu vaccination as soon as practicable after receipt of the vaccine, with initial priority for aTIV being for those aged 75 years and over. Aim to complete immunisation of all eligible patients before flu starts to circulate and ideally by end of November.

- Collaborate with maternity services to offer and provide flu vaccination to pregnant women and to identify, offer and provide to newly pregnant women as the flu season progresses.
- Offer flu vaccination in bespoke clinics and opportunistically during routine primary care encounters.
- Where the patient has indicated they wish to receive the vaccination but is physically unable to attend the practice (for example is housebound) the practice must make all reasonable effort to ensure the patient is vaccinated. The GP practice and/or CCG will collaborate with other providers such as community pharmacies and community or health and social care trusts to identify and offer flu vaccination to residents in care homes, nursing homes and house-bound patients, and to ensure that mechanisms are in place to update the patient record when flu vaccinations are given by other providers.

For guidance on improving uptake among children in general practice see 'Increasing influenza immunisation uptake among children': www.gov.uk/government/collections/annual-flu-programme

1 Dexter L et al. (2012) Strategies to increase influenza vaccination rates: outcomes of a nationwide cross-sectional survey of UK general practice. bmjopen.bmj.com/content/2/3/e000851.full

Appendix C: National extension of flu programme to children

Rationale of programme

1. In 2012 the Joint Committee on Vaccination and Immunisation (JCVI), the independent expert group that advises Government on vaccination policy, recommended extending flu immunisation to children. The aim is to provide individual protection to the vaccinated children themselves and reduce transmission of flu across all ages. JCVI recommended that all eligible children are offered a live attenuated influenza vaccine (LAIV), administered as a nasal spray[2]. This is a quadrivalent vaccine.

2. Implementation of the programme began the following year with pre-school children offered vaccination through GP practices and a number of pilots for school aged children. In 2015/16 the programme began nationally in primary schools in a phased roll-out starting with the youngest school-aged children first. In 2018/9 the programme will include all children aged two and three years old and those in reception class and school years 1 to 5.

3. Vaccinating children each year means that not only does it help protect the children themselves but there will be reduced transmission across all age groups, lessening levels of flu overall and reducing the burden of flu across the population. Research into the first two years of the programme compared the differences between pilot areas, where the entire primary school age cohort was offered vaccination, to non-pilot areas. The results have shown a positive impact on flu transmission across a range of surveillance indicators from vaccinating children of primary school age. These include reductions in: GP consultations for influenza-like illness, swab positivity in primary care, laboratory confirmed hospitalisations and percentage of respiratory emergency department attendances[3,4].[5,6].

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2 JCVI (2012). 25 July 2012. Joint committee on Vaccination and Immunisation statement on the annual influenza vaccination programme – extension of the programme to children. www.gov.uk/government/uploads/system/uploads/attachment_data/file/224775/JCVI-statement-on-the-annual-influenza-vaccination-programme-25-July-2012.pdf

3 Pebody, R et al. 5 June 2014. Uptake and impact of a new live attenuated influenza vaccine programme in England: early results of a pilot in primary school age children, 2013/14 influenza season. Eurosurveillance, 19, Issue 22. www.eurosurveillance.org/ViewArticle.aspx?ArticleId=20823

4 Pebody, R et al. October 2015. Uptake and impact of vaccinating school age children against influenza during a season with circulation of drifted influenza A and B strains, England, 2014/15. Eurosurveillance, 20 (39). www.eurosurveillance.org/images/dynamic/EE/V20N39/art21256.pdf

5 Pebody, R et al. 5 June 2014. Uptake and impact of a new live attenuated influenza vaccine programme in England: early results of a pilot in primary school age children, 2013/14 influenza season. Eurosurveillance, 19, Issue 22. www.eurosurveillance.org/ViewArticle.aspx?ArticleId=20823

6 Pebody, R et al. October 2015. Uptake and impact of vaccinating school age children against influenza during a season with circulation of drifted influenza A and B strains, England, 2014/15. Eurosurveillance, 20 (39). www.eurosurveillance.org/images/dynamic/EE/V20N39/art21256.pdf

4. Since the introduction of the LAIV programme for children in the UK the vaccine effectiveness for laboratory confirmed infection has been good. In 2016/17 the 65.8% vaccine effectiveness found in the UK was within the normal range for this vaccine[7]. JCVI have advised that greater priority should be given to improving vaccine uptake in children because of the indirect protection this offers to the rest of the population. Priority should be given to the preschool children where uptake has been lower and because children under the age of five have the highest hospital admission rate for flu of any age group[8].

Children eligible for flu vaccination in 2018/19

5. All two- and three-year olds continue to be offered flu vaccination through GP practices. In 2018/19 the programme is being extended to school year 5 so that all children in reception year and school years 1 - 5 will be offered flu vaccination. It is anticipated that this will be in schools (apart from the Isles of Scilly where it is offered through general practice). See Appendix D for eligibility criteria for children.

6. In former school pilot areas all primary school aged children from reception class through to year 6 will be offered the vaccine.

7. At risk children who are eligible for flu vaccination via the school-based programme because of their age will be offered immunisation at school. However, these children are also eligible to receive vaccination in general practice if the school session is late in the season, parents prefer it, or they missed the session at school.

8. Arrangements should be made to ensure that children who missed out on vaccination during the routine school session are offered a second opportunity, if requested. Precise arrangements for achieving this are for local determination. Children who are home educated should also be offered vaccination. Children will be invited by the provider to a mutually acceptable appointment venue. Local NHS England teams should be consulted for details about local arrangements. Contact details can be found at: www.england.nhs.uk/about/regional-area-teams/

9. Where a child is vaccinated but not by their GP, it is important that the vaccination information is provided to the practice for the timely update of clinical records and that the data is entered on the system.

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7 Pebody, R et al. 2 Nov 2017. End-of-season influenza vaccine effectiveness in adults and children, United Kingdom, 2016/17. Eurosurveillance, 22, issue 44. www.eurosurveillance.org/content/10.2807/1560-7917.ES.2017.22.44.17-00306

8 Cromer D, Jan Van Hoek A, Jit M, Edmunds W J, Fleming D, Miller E. (2014) “The burden of influenza in England by age and clinical risk group: a statistical analysis to inform vaccine policy”. Journal Infect, 68 (4) (2014) pp 363-371.

Use of live attenuated influenza vaccine (LAIV)

10. JCVI recommended LAIV as the vaccine of choice for children. The vaccine is licensed for those aged from 24 months to less than 18 years of age. JCVI recommended LAIV as it has:

    - good efficacy in children, particularly after only a single dose
    - the potential to provide protection against circulating strains that have drifted from those contained in the vaccine
    - higher acceptability with children, their parents and carers due to intranasal administration
    - it may offer important longer-term immunological advantages to children by replicating natural exposure/infection to induce better immune memory to influenza that may not arise from use of inactivated flu vaccines

11. LAIV is unsuitable for children with contraindications such as severe immunodeficiency, severe asthma or active wheeze. Those with clinical risk factors that contraindicated LAIV should be offered an inactivated influenza vaccine.

12. Following more evidence on the safety of LAIV in egg allergic children, JCVI amended its advice in 2015 that, except for those with severe anaphylaxis to egg which has previously required intensive care, children with an egg allergy can be safely vaccinated with LAIV in any setting (including primary care and schools); those with clinical risk factors that contraindicate LAIV should be offered an inactivated influenza vaccine with a very low ovalbumin content (less than 0.12 µg/ml).

13. Children with a history of severe anaphylaxis to egg which has previously required intensive care, should be referred to specialists for immunisation in hospital. LAIV is not otherwise contraindicated in children with egg allergy. Egg-allergic children with asthma can receive LAIV if their asthma is well-controlled.

14. LAIV should be offered to all eligible children when not medically contra-indicated. This includes children in clinical risk groups. Children who are in clinical risk groups should be offered a suitable inactivated alternative vaccine if medically contraindicated to LAIV.

15. LAIV contains a highly processed form of gelatine (derived from pigs). Some faith groups do not accept the use of porcine gelatine in medical products. **Only** those who are in clinical risk groups are able to receive an inactivated injectable vaccine as an alternative.

16. Children who are not in clinical risk groups should only be offered LAIV. A child who is unable to have LAIV, for reasons other than being medically contraindicated, will continue to derive benefit from the programme by virtue of the reduction of transmission among their peers. They will not be eligible for an inactivated vaccine.

17. For the full list of contraindications please see the Green Book. GPs should ensure that they have ordered sufficient supplies of suitable alternative inactivated injectable vaccines through Immform for at-risk children who cannot receive LAIV for medical reasons.

18. The patient information leaflet provided with LAIV states that children should be given two doses of this vaccine if they have not had flu vaccine before. However, JCVI considers that a second dose of the vaccine provides only modest additional protection. On this basis, JCVI has advised that most children should be offered **a single dose** of LAIV. However, children in clinical risk groups aged two to less than nine years who have not received flu vaccine before should be offered two doses of LAIV (given at least four weeks apart).

Healthcare practitioners should refer to the Green Book influenza chapter for full details on contraindications and precautions for flu vaccines. This chapter can be found at: www.gov.uk/government/collections/immunisation-against-infectious-disease-the-green-book.

Appendix D: Child eligibility for flu vaccine and type to offer

Age on 31 August 2018	Is child eligible for LAIV?	Setting
Under 2 years of age	**Universal programme:** No. Only at risk children offered vaccination. **At risk children:** LAIV is not licenced for children under 2 years of age. At risk children over six months of age to be offered suitable quadrivalent inactivated flu vaccine (QIV).	General practice
Aged 2 to 3 years old [Born between 1 September 2014 and 31 August 2016].	**Universal programme:** All 2 and 3 year olds offered LAIV. Children who turn two after 31 August 2018 are not eligible. Children who were three on 31 August 2018 and turn four afterwards, are still eligible. **At risk children:** Offer LAIV. If child is contraindicated (or it is otherwise unsuitable), then offer suitable quadrivalent inactivated flu vaccine (QIV).	General practice
Aged 4 to 9 years old: [Born between 1 September 2008 and 31 August 2014]	**Universal programme:** All primary school years from reception class to year 5* offered LAIV. **At risk children:** Offer LAIV. If child is contraindicated (or it is otherwise unsuitable), then offer suitable inactivated flu vaccine. At risk children may be offered vaccination in general practice if the school session is late in the season, parents prefer it, or they missed the school session. Also, some schools may not offer inactivated vaccines to at risk children in whom LAIV is contraindicated.	School
Aged 10 years old to less than 18 years	**Universal programme:** No. Only at risk children offered vaccination. **At risk children:** Offered LAIV. If contraindicated (or it is otherwise unsuitable), then offer suitable quadrivalent inactivated flu vaccine (QIV).	General practice

* Reception class (4 to 5 year olds); Year 1 (5 to 6 year olds); Year 2 (6 to 7 year olds); Year 3 (7 to 8 year olds); Year 4 (8 to 9 year olds); Year 5 (9 to 10 year olds).

All childhood vaccines can be ordered from central supplies through the Immform website: www.immform.dh.gov.uk

Appendix E: Pregnant women

Rationale and target groups

1. All pregnant women are recommended to receive the inactivated flu vaccine irrespective of their stage of pregnancy.

2. There is good evidence that pregnant women are at increased risk from complications if they contract flu.[9, 10] In addition, there is evidence that having flu during pregnancy may be associated with premature birth and smaller birth size and weight[11, 12] and that flu vaccination may reduce the likelihood of prematurity and smaller infant size at birth associated with an influenza infection during pregnancy.[13] Furthermore, a number of studies show that flu vaccination during pregnancy provides protection against flu in infants in the first few months of life.[14, 15,16,17,18]

3. A review of studies on the safety of flu vaccine in pregnancy concluded that inactivated flu vaccine can be safely and effectively administered during any trimester of pregnancy and that no study to date has demonstrated an increased risk of either maternal complications or adverse fetal outcomes associated with inactivated influenza vaccine.[19]

9 Neuzil KM, Reed GW, Mitchel EF et al. (1998) Impact of influenza on acute cardiopulmonary hospitalizations in pregnant women. Am J Epidemiol. 148:1094-102
10 Pebody R et al. (2010) Pandemic influenza A (H1N1) 2009 and mortality in the United Kingdom: risk factors for death, April 2009 to March 2010. Eurosurveillance 15(20): 19571.
11 Pierce M, Kurinczuk JJ, Spark P et al. (2011) Perinatal outcomes after maternal 2009/H1N1 infection: national cohort study. BMJ. 342:d3214.
12 McNeil SA, Dodds LA, Fell DB et al. (2011) Effect of respiratory hospitalization during pregnancy on infant outcomes. Am J Obstet Gynecol. 204: (6 Suppl 1) S54-7.
13 Omer SB, Goodman D, Steinhoff MC et al. (2011) Maternal influenza immunization and reduced likelihood of prematurity and small for gestational age births: a retrospective cohort study. PLoS Med. 8: (5) e1000441.
14 Benowitz I, Esposito DB, Gracey KD et al. (2010) Influenza vaccine given to pregnant women reduces hospitalization due to influenza in their infants. Clin Infect Dis. 51: 1355-61.
15 Eick AA, Uyeki TM, Klimov A et al. (2010) Maternal influenza vaccination and effect on influenza virus infection in young infants. Arch Pediatr Adolesc Med. 165: 104-11.
16 Zaman K, Roy E, Arifeen SE et al. (2008) Effectiveness of maternal influenza immunisation in mothers and infants. N Engl J Med. 359: 1555-64.
17 Poehling KA, Szilagyi PG, Staat MA et al.(2011) Impact of maternal immunization on influenza hospitalizations in infants. Am J Obstet Gynecol. 204:(6 Suppl 1) S141-8.
18 Dabrera G, Zhao H, Andrews N et al. (2014) Effectiveness of seasonal influenza vaccination during pregnancy in preventing influenza infection in infants, England, 2013/14. Eurosurveillance. Nov 13;19. www.eurosurveillance.org/ViewArticle.aspx?ArticleId=20959
19 Tamma PD, Ault KA, del Rio C et al. (2009) Safety of influenza vaccination during pregnancy. Am. J. Obstet. Gynecol. 201(6): 547-52.

When to offer the vaccine to pregnant women

4. The ideal time for flu vaccination is before flu starts circulating. However, even after flu is in circulation vaccination should continue to be offered to those at risk and newly pregnant women. Clincians should apply clinical judgement to assess the needs of an individual patient, taking into account the level of flu-like illness in their community and the fact that the immune response following flu vaccination takes about two weeks to develop fully.

Data review and data recording

5. Uptake of vaccine by pregnant women, along with other groups, will be monitored. GPs will need to check their patient database throughout the duration of the flu vaccination programme in order to identify women who become pregnant during the season. GPs should also review their records of pregnant women before the start of the immunisation programme to ensure that women who are no longer pregnant are not called for vaccination (unless they are in other clinical risk groups) and so that they can measure the uptake of flu vaccine by pregnant women accurately.

Maternity services

6. All pregnant women are able to access flu immunisation from their GP practice or a community pharmacy. In addition local NHS England teams have commissioned maternity providers to provide flu immunisation covering around 70% of maternity services in 2017/18.

7. Midwives need to be able to explain the benefits of flu vaccination to pregnant women and offer them the vaccine, or signpost women back to their GP or community pharmacy if they are unable to offer the vaccine.

8. Where maternity providers or pharmacies provide the flu vaccine, it is important that the patient's GP practice is informed in a timely manner (within 48 hours) so their records can be updated accordingly, and included in vaccine uptake data collections. Maternity providers should ensure they inform GPs when a woman is pregnant or no longer pregnant.

Appendix F: Vaccine supply and ordering

Vaccine composition for 2018/19

1. Flu viruses change continuously and the WHO monitors the epidemiology of flu viruses throughout the world making recommendations about the strains to be included in vaccines for the forthcoming winter. It is recommended that quadrivalent vaccines for use in the 2018/19 northern hemisphere influenza season contain the following:

    - an A/Michigan/45/2015 (H1N1)pdm09-like virus;
    - an A/Singapore/INFIMH-16-0019/2016 (H3N2)-like virus;
    - a B/Colorado/06/2017-like virus (B/Victoria/2/87 lineage); and
    - a B/Phuket/3073/2013-like virus (B/Yamagata/16/88 lineage).

    It is recommended that the influenza B virus component of trivalent vaccines for use in the 2018/19 northern hemisphere influenza season be a B/Colorado/06/2017-like virus of the B/Victoria/2/87-lineage[20].

Vaccine supply for children's programme

2. Flu vaccines for the national offer to all children aged two to three years, children in reception class and school years 1 to 5, and for children in risk groups aged six months to less than 18 years, are supplied centrally by PHE. This includes both LAIV and quadrivalent inactivated flu vaccine.

3. For children in clinical risk groups under 18 years of age where LAIV is contraindicated, a suitable quadrivalent inactivated influenza vaccine will be supplied by PHE and should be offered. Fluenz Tetra and the quadrivalent inactivated influenza vaccine (injectable) can be ordered through the ImmForm website: www.immform.dh.gov.uk

4. Ordering controls using allocations based on previous years' uptake were first introduced two years ago on centrally supplied flu vaccines. These were put in place to reduce the amount of excess vaccine, in particular LAIV, ordered by NHS providers but not administered to children. The latest information on ordering controls and other ordering advice for LAIV will be available in Vaccine Update and on the ImmForm news item both prior to, and during, the flu vaccination period. It is strongly advised that all parties involved in the provision of flu vaccines to children ensure they remain up to date with this information.

20 www.who.int/influenza/vaccines/virus/recommendations/2018_19_north/en/

Choice of flu vaccine for adults

5. For all other eligible populations apart from children providers remain responsible for ordering vaccines directly from manufacturers.

6. On 5 February NHS England wrote to GPs and community pharmacies, and Clinical Commissioning Groups to confirm that the most effective flu vaccines for the population should be ordered[21].

7. The **adjuvanted trivalent inactivated flu vaccine (aTIV),** (Fluad®: Seqirus) was licensed late in 2017 and is available for use in the 2018/19 season. JCVI concluded at its October 2017 meeting that adjuvanted trivalent flu vaccine is more effective and highly cost effective in those aged over 65 years and above compared with the non-adjuvanted or 'normal' influenza vaccines currently used in the UK for this age-group. JCVI agreed that aTIV would be considered the optimal clinical choice for all patients aged 65 years and over. The JCVI specifically considered that the use of the adjuvanted trivalent flu vaccine should be a priority for those aged 75 years and over**,** given that the non-adjuvanted inactivated vaccine has showed no significant effectiveness in this group over recent seasons[22].

8. JCVI have also reconsidered the use of **quadrivalent influenza vaccines (QIV),** which offer protection against two strains of influenza B rather than one. As influenza B is relatively more common in children than older age groups, the main clinical advantage of these vaccines is in childhood. Because of this, those vaccines centrally supplied for the childhood programme in recent years have been quadrivalent preparations. Further modelling work by PHE suggests that, the health benefits to be gained by the use of quadrivalent vaccines compared to trivalent vaccines, **is more substantial in at risk adults under 65 years of age, including pregnant women**. On average use of quadrivalent over trivalent is likely to lead to reduced activity in terms of GP consultations and hospitalisations, and PHE's work suggests that the overall public health benefit would justify the additional cost of the vaccines compared to trivalent vaccines.

9. NHS England therefore advised that **65 year olds and over receive aTIV, and under 65s in at risk groups, including pregnant women, receive QIV** for the

21 www.england.nhs.uk/publication/vaccine-ordering-for-2018-19-influenza-season-letters/
22 Although aTIV is not licensed in those less than 65 years of age "off label" use is an option. Public Health England in consultation with NHS England are of the opinion that it is clinically appropriate to offer this vaccine "off label" to those becoming 65 before 31st March 2019. The Public Health England (PHE) Patient Group Direction (PGD) for inactivated influenza vaccine for 2018/19 is likely to incorporate this off label indication. This will be confirmed later when the PGD has completed the authorisation process.

2018-19 flu season. QIV should also be offered to healthcare workers aged under 65 years. Those healthcare workers aged 65 years and over should be offered aTIV.

Vaccines available in 2018/19

10. The vaccines that will be available for the 2018/19 flu immunisation programme are set out in the table below.

Supplier	Name of product	Vaccine type	Age indications	Contact details
AstraZeneca UK Ltd	Fluenz Tetra ▼	Live attenuated, nasal (quadrivalent)	From 24 months to less than 18 years of age	0845 139 0000
GSK	Fluarix Tetra ▼	Split virion inactivated virus (quadrivalent)	From six months	0800 221 441
MASTA	Quadrivalent Influenza Vaccine (split virion, inactivated) ▼	Split virion, inactivated virus	From six months	0113 238 7552
Mylan (BGP Products)	Quadrivalent Influenza vaccine Tetra MYL	Influenza virus surface antigen (inactivated)	From 18 years	0800 358 7468
	Quadrivalent Influvac sub-unit Tetra	Influenza virus surface antigen (inactivated)	From 18 years	
Sanofi Pasteur vaccines	Quadrivalent Influenza Vaccine (split virion, inactivated) ▼	Split virion, inactivated virus	From six months	0800 854 430
Seqirus UK Ltd	Agrippal®	Surface antigen, inactivated virus (trivalent)*	From six months	08457 451 500
	Fluad®	Surface antigen, inactivated, Adjuvanted with MF59C.1	65 years of age and over	

* This is a non adjuvanted trivalent vaccine and not one of the recommended vaccines for 2018/19.

11. None of the influenza vaccines for the 2018/19 season contain thiomersal as an added preservative.

12. Some flu vaccines are restricted for use in particular age groups. The Summary of Product Characteristics (SPC) for individual products **should always** be referred to when ordering vaccines for particular patients.

13. More detailed information on the characteristics of the available vaccines, including ovalbumin (egg) content will be published on the PHE Immunisation web pages.

14. Flu vaccines generally start to be distributed from late September each year. However, vaccine manufacture involves complex biological processes, and there is always the possibility that initial batches of vaccine may be subject to delay, or that fewer doses than planned may be available initially. Immunisers should therefore be flexible when scheduling early season vaccination sessions, and be prepared to reschedule if necessary.

15. aTIV may be delivered in stages throughout the coming flu season. If this is the case, then initial priority for aTIV should be those aged 75 years and above as this age group are likely to derive little clinical benefit from the standard non-adjuvanted influenza vaccine and are at highest risk of serious outcome. Once this group has been covered, 65-74 year olds should then be targeted as further deliveries of vaccine are made. Delivery timings will be confirmed by the supplier in the early summer. Providers will need to plan their clinics based on this advice on prioritisation.

16. As in previous years, PHE advise that school sessions are not planned before the second week in October, to reduce the risk of having to reschedule, due to vaccine availability.

Appendix G: Data collection

Introduction

1. As in previous years, flu vaccine uptake data collections will be managed using the ImmForm website (www.immform.dh.gov.uk). PHE coordinates the data collection and will issue details of the collection requirements by the end of July 2018 and guidance on the data collection process by early September 2018. This guidance will be available at: www.gov.uk/government/collections/vaccine-uptake which is where flu vaccine uptake data is also published.

2. Queries concerning data collection content or process should be emailed to influenza@phe.gov.uk. Queries concerning ImmForm login details and passwords should be emailed to helpdesk@immform.org.uk.

Reducing the burden from data collections

3. Considerable efforts have been made to reduce the burden of data collections on GPs by increasing the number of automated returns that are extracted directly from GP IT systems. Over 90% of GP practices benefited from using automated IT data returns for flu vaccine uptake for the final 2017/18 survey. GP practices that are not able to submit automated returns should discuss their arrangements with their GP IT supplier. If automated returns fail for the monthly data GPs will be required to submit data manually on to ImmForm to meet contractual obligations.

Data collections for 2018/19

4. Monthly data collections will take place over four months during the 2018/19 flu immunisation programme. Subject to the Burden Advice and Assessment (BAAS) approval, the first data collection will be for vaccines administered by the end of October 2018 (data collected in November 2018), with the subsequent collections monthly thereafter, and with the final data collection for all vaccines administered by the end of January 2019 (final data collected in February 2019). Uptake data for healthcare workers will collect information on immunisations given up to the end of February 2019 (final data collected in March 2019).

5. Data will be collected and published monthly at national level and by local NHS England team level. Additionally, data at local authority level will be collected once at the end of the campaign.

6. During the data collection period, those working in the NHS with relevant access rights are able, through the ImmForm website, to:
   - see their uptake by eligible groups
   - compare themselves with other anonymous general practices or areas
   - validate the data on point of entry and correct any errors before data submission
   - view data and export data into Excel, for further analysis
   - make use of automated data upload methods (depending on the IT systems used at practices)
   - access previous years' data to compare with the current performance

These tools can be used to facilitate the local and regional management of the flu vaccination programme.

Monitoring on a weekly basis

7. Weekly uptake data will be collected from a group of GP practices that have fully automated extract and upload facilities provided by their IT suppliers. These data will be published in the PHE weekly flu report available throughout the flu season at: www.gov.uk/government/statistics/weekly-national-flu-reports.

8. During the data collection period, those working in the NHS with relevant access rights are able, through the ImmForm website to view this data as per the monthly collections.

Vaccine uptake data collection of school aged children

9. PHE will be responsible for monthly collections of flu vaccine uptake for children in reception class and in school years 1 - 5 over four months during the 2018/19 flu season. Collection will be undertaken through the ImmForm data entry tool. NHS England teams will agree responsibility for completion of this monthly data entry to ImmForm with their providers.

Appendix H: Contractual arrangements

General practice

1. The Directed Enhanced Service (DES) specification for seasonal influenza and pneumococcal immunisation outlines the responsibilities of GP practices and details the service they will provide in respect of the flu vaccination programme. The DES specification has been agreed between NHS Employers (on behalf of NHS England) and the General Practitioners Committee (GPC) of the British Medical Association (BMA).

2. The people eligible for flu vaccination under the enhanced service are those patients aged 65 and over on 31 March 2019, pregnant women, those aged six months to 64 years (excluding patients aged two and three as of 31 August 2018) defined as at-risk in the Green Book.

3. There is a separate enhanced service specification for the childhood seasonal influenza vaccination programme, covering the vaccination of children aged two and three years as of 31 August 2018.

4. Children in clinical risk groups in reception year and school years 1 to 5 may be offered LAIV alongside their peers as part of school based delivery. If a child in an at-risk group does not receive flu vaccination through this route, then they should be offered it in general practice. For instance, a child may miss out because of being absent from school on the day the vaccination was offered or because the child is contraindicated to LAIV and the local service provider does not offer inactivated flu vaccines. Some parents may choose to continue to have children in clinical risk groups immunised by their GP, rather than at school.

5. It should be noted that no payment will be made for children not in clinical risk groups who are vaccinated in general practice, unless they are in the eligible two to three year old age cohort.

6. General practices are reminded that the enhanced service requires that a proactive call and recall system is developed to contact all at-risk patients through mechanisms such as by letter, e-mail, phone call, or text. Template letters for practices to use will be available at www.gov.uk/government/collections/annual-flu-programme nearer the time.

7. Every effort should be made to ensure all at-risk children who are not in one of the age groups eligible for flu vaccination at school are immunised in general practice.

8. NHS England will monitor the DES and enhanced service that GP practices provide for flu vaccination to ensure that services comply with the specifications. NHS

England teams will need assurance that providers have robust implementation plans in place to meet or exceed the vaccine uptake aspirations for 2018/19 and that they have the ability to identify eligible ‘at-risk’ patients as well as two- and three-year-olds.

Community Pharmacy Seasonal Influenza Vaccination Advanced Service

9. Since 2015 all community pharmacies can register to provide flu vaccination to eligible adult patients (that is those aged 18 years and over). The service can be provided by any community pharmacy on the NHS England Pharmaceutical List that has a consultation room, can procure the vaccine, meet the data recording requirements, and has appropriately trained staff.

10. Vaccination for children will not be offered through the Community Pharmacy Seasonal Influenza Vaccination Advanced Service.

11. Contractors will be required to offer the service in accordance with the service specification for 2018/19 which will be published on www.PSNC.org.uk. This service specification will include details such as:

    - payment and reimbursement details
    - details of eligible patients
    - accreditation requirements
    - data recording requirements
    - claiming for payments
    - post payment verification arrangements

12. Pharmacists are encouraged to use every opportunity to offer flu vaccination to eligible groups, such as identifying patients from their prescription history and during medical reviews.

13. Data on flu vaccinations administered outside general practice must be passed back to the patients’ GP practice (i.e. by close of business on the working day following the immunisation) for timely entry on the electronic patient record and submission to ImmForm for the national data survey. This is important for clinical reasons (such as any adverse events) and also to ensure that these vaccinations are included in the weekly and monthly vaccine uptake figures.

School-based provision

14. NHS England will make local provision for delivery of flu vaccination to school aged children. It is anticipated that this will be in primary school settings apart from the Isles of Scilly (where provision will be through general practice).

Supply and administration of vaccines

15. A range of mechanisms can be used for the supply and administration of vaccines, including patient group directions (PGDs), patient specific directions (PSDs) or prescribing for individual patients. Where PGDs are developed, they must comply with the legal requirements specified in the Human Medicines Regulations 2012, and should reflect NICE good practice guidance on PGDs: www.nice.org.uk/guidance/mpg2.

16. PHE PGD templates, and a PGD to support the pharmacy advanced service, will be available to support the national flu immunisation programme 2018/19. Please note, these PGD templates must not be altered or amended in any way and must be suitably authorised locally before use. These will be available prior to commencement of the programme from: www.gov.uk/government/collections/immunisation-patient-group-direction-pgd

The enhanced service specifications for GP practices on seasonal flu and the childhood flu vaccination programmes can be found at: www.england.nhs.uk/commissioning/gp-contract/

Appendix I: Communications

1. An integrated communications strategy will be produced for the national flu immunisation programme 2018/19. The strategy will be led by PHE and will provide communications colleagues in partner organisations with information and resources to assist the delivery of the programme. Partners include DHSC, NHS England, the Department for Education and the Local Government Association.

Publicity and information materials

2. Ahead of the flu season, NHS-branded patient information leaflets for different eligible groups will be reviewed including:

    - The flu vaccination: who should have it and why
    - Protecting your child against flu
    - All about flu and how to stop getting it: Easy read version for people with learning disabilities
    - All about flu and how to stop getting it: Easy read version for children with learning disabilities
    - Pregnancy: How to help protect you and your baby

3. The following template letters will also be available to GP practices:

    - to invite at-risk patients and those aged 65 and over for flu vaccination
    - to invite two-, and three-year-olds
    - an easy-read invitation letter template for people with learning difficulties

4. The following materials for the delivery of flu vaccination through schools will be available:

    - briefing for head teachers and other staff
    - a national consent form
    - template letters to invite eligible school age children for flu vaccination
    - the ‘Protecting your child against flu’ leaflet

5. Updated training and information materials for healthcare practitioners will also be available. These will include:

- National flu programme training slide set
- Childhood flu programme training slide set
- Inactivated influenza vaccine: information for healthcare practitioners
- Childhood flu immunisation programme: information for healthcare practitioners
- Flu immunisation e-learning programme

National marketing campaign

6. The 2017/18 marketing campaign ('Stay well this winter') is being evaluated and the lessons learned will inform any campaign plans for 2018/19. Further information will be issued in due course and resources can be downloaded from https://campaignresources.phe.gov.uk/resources/

All materials will be made available on the GOV.UK website at: www.gov.uk/government/collections/annual-flu-programme. Materials used in previous years can also be found here.

Free copies of the leaflets will be available to order through the DH health and social care order line: www.orderline.dh.gov.uk/ecom_dh/public/home.jsf

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Berkshire Seasonal Influenza Campaign 2017-18; flu activity summary, final vaccine uptake figures and feedback from local partners

Executive Summary

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

   Key aims of the immunisation programme in 2017-18 were to;

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

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

3. **Local uptake** - In 2017-18 uptake of vaccine among GP-registered patients in Berkshire was generally similar to or higher than in 2016-17. After observing an increase in uptake in 2016-17, uptake in Slough was slightly reduced in the 2017-18 flu season, with the exception of over 65's where uptake was slightly higher.
   - **Patients in clinical risk groups** – uptake was reduced by between 0.9% and 3.1% in this group, with the exception of RBWM and West Berkshire where uptake was similar to the previous season. Nationally uptake was very similar to the previous season.
   - **Over 65s** – Increased uptake of flu vaccine was observed in all Local Authorities within Berkshire. Uptake in West Berkshire reached 77.6%, exceeding the national 75% uptake ambition
   - **Pregnant Women** – In line with the national picture, uptake in this group was increased compared to 2016-17 with the exception of Slough where a reduction in uptake of 4.9% was observed. Bracknell Forest exceeded the national ambition of 55%, achieving 57% uptake.
   - **Children aged 2 and 3** – Uptake in two year olds increased in Reading, West Berkshire Wokingham and RBWM, but decreased slightly in Slough. A reduction was also observed in Bracknell Forest compared to the previous season. The uptake ambition was not reached in any local authority in Berkshire or nationally (3.9% increase resulting in 42.9% uptake). Among three year olds modest increases in uptake were observed in Bracknell Forest, West Berkshire and Wokingham, with small decreases observed in Reading and RBWM. Slough experienced a larger decrease in uptake. All areas with the exception of Reading and Slough achieved a higher uptake than the national figure of 44.2%
   - **Children in school years 0- 4** – this programme was again highly successful in Berkshire, the uptake ambition of 40% was exceeded in all local authorities reaching as high as 80% in at least one area.
   - **Healthcare workers** – Uptake among NHS staff increased compared to the 2016-17 season in all local Trusts with the exception of Berkshire Healthcare Foundation Trust, where uptake was slightly recued on the previous season despite more vaccines being given. Uptake in local NHS Trusts ranged from 62.6%-72.1%

Summary - Local Authority public health teams actively promoted flu vaccination to eligible groups using a range of channels and worked with commissioners and providers during the season to identify issues. Whilst uptake among school children was good, uptake in other risk groups remains below the desired level; this is in line with other areas of the country. There remains considerable variation in uptake between GP practices, both within and between CCGs. There is scope to improve communicating uptake to practices throughout the flu season and to improve the way patients are invited for vaccination. Myths and misconceptions regarding vaccines remain an important barrier to uptake. Other barriers may include variation in access to GP flu clinics, lack of health literacy and inclusion of porcine element in the children's vaccine making it inappropriate for some groups. Uptake among front line local authority social care workers remains difficult to measure; there is scope to improve data collection in this area.

Despite introduction of an NHS funded flu vaccine offer for frontline social care staff in nursing and residential care, local intelligence suggest uptake in this group remains low. Without more robust data from the National programme it is not possible to evaluate the success of this approach. Without changes to the flu programme, provision of flu vaccine to this group remains an occupational health responsibility and is likely to remain challenging for Local Authorities and CCGs to influence.

Locally, CCGs and their commissioned providers responded well to flu outbreaks in care homes and closed settings following development and implementation of flu outbreak plans. Close partnership working proved key to the success of this approach and closer working at the planning stage is warranted for future success.

4. Recommendations

Systems leadership

- Those in leadership roles should ensure Flu planning and in-season flu monitoring within Berkshire brings together both immunisation and outbreak response planning
- NHS England, Local authorities and CCGs should work together to ensure public messaging and communication to partners around flu is aligned

Communication and engagement

- Local authorities and CCGs should seek to upskill key community and voluntary sector champions and organisations to enable them to disseminate key messages.
- Local partners should consider holding local winter-themed workshop(s) specifically for community and voluntary groups to help embed flu vaccination and other health protection information into community group/s 'communication' plans/local forums and support them to directly access resources to support the groups they work with
- Local partners should develop an effective social media promotional plan via different media targeting priority groups locally
- Public communication and engagement should continue to focus on "myth busting" approach to the flu vaccinations, taking action to understand and act on key local barriers and enablers
- Organisational Senior managers and leaders should support staff flu vaccination by demonstrating their commitment and emphasising the importance of vaccination, where these do not already exist, supporting the development of internal Flu Teams has the potential to drive the campaign forward

Commissioning

- Commissioners should consider taking steps to improve access to flu vaccination for people in eligible groups who receive care for their conditions in hospital
- Residential, nursing care and domiciliary care commissioners should seek to include provision of staff flu vaccine within quality metrics

Vaccine delivery

- Practice staff should ensure all eligible groups are actively invited to take up their flu vaccine, using reminders is shown to be effective in increasing uptake
- All local partners should seek to improve links between medical specialties providing care for people in clinical risk groups to provide advocacy and improve signposting to primacy care
- Local partners should work in partnership to support effective response to flu outbreaks in closed settings such as care homes, nursing homes
- Local partners should work in partnership to enable residents of care / nursing homes and those receiving domiciliary care to take up their offer of a flu vaccine
- Local Authority flu leads should work with internal partners to more effectively estimate offer and uptake of staff vaccination within different staff groups

Flu outbreak response (key recommendations from the Thames Valley workshop)

- Communication between organisations should be effective: directed at the appropriate person, timely and clear
- Local partners should continue to have meetings which build on the learning from this meeting to plan and manage future flu seasons
- Flu leads to consider if plans, models and learning could effectively be shared across organisation
- Commissioning organisations should have robust and resilient plans in place for an effective response to flu outbreaks in all settings including closed communities both in and out of season
- All organisations should review and consider the suggested actions for prevention, response and recovery of flu outbreaks taking forward as appropriate for their organisation
- All organisations should work in partnership to improve flu vaccination uptake for all and particularly increase flu vaccination rates for care home / nursing home / domiciliary care home staff
- Local partners should provide support to care homes in preparing for, managing and recovering from flu outbreaks
- Commissioning organisations should have assurances from their commissioned services that they have systems in place for managing future flu seasons

1. Seasonal influenza

Seasonal influenza (Flu) is a key factor in NHS winter pressures. It impacts on those who become ill, the NHS services that provide direct care, and on the wider health and social care system that supports people in at-risk groups. Flu occurs every winter in the UK. The National Flu Plan aims to reduce the impact of flu in the population through a series of complementary measures. These measures help to reduce illness in the community and unplanned hospital admissions, and therefore pressure on health services generally and A&E in particular. The plan is therefore a critical element of the system-wide approach for delivering robust and resilient health and care services throughout the year. Successful local implementation of the flu plan depends on partnership working between stakeholders at National and local levels. Key stakeholders include Department of Health, NHS England, Clinical Commissioning Groups (CCGs), GP practices, Community Pharmacy, Public health England (PHE), Local Authorities and community groups.

2. Role of the local health and social care system

The National Flu Plan[1] states that;

Local authorities, through their DsPH, have responsibility for:

- providing appropriate advocacy with key stakeholders and challenge to local arrangements to ensure access to flu vaccination and to improve its uptake by eligible populations
- providing leadership, together with local resilience partners to respond appropriately to local incidents and outbreaks of flu infection

Local authorities can also assist by:

- promoting uptake of flu vaccination among eligible groups, for example older people in residential or nursing care, either directly or through local providers
- promoting uptake of flu vaccination among those staff providing care for people in residential or nursing care, either directly or through local providers

CCGs are responsible for

- quality assurance and improvement which extends to primary medical care services delivered by GP practices including flu vaccination and antiviral medicines

Additionally a letter to CCGs from the NHS England Head of Primary Care Commissioning on 12th June 2017 stated that 'CCGs will commission appropriate primary care clinicians to respond to flu outbreaks, by assessing exposed persons for the antiviral treatment or prophylaxis and completing a patient specific direction for this purpose'.

GP practices and community pharmacists are responsible for;

- educating patients, particularly those in at-risk groups, about the appropriate response to the occurrence of flu-like illness and other illness that might be precipitated by flu
- ordering the correct amount and type of vaccine for their eligible patients, taking into account new groups identified for vaccination and the ambition for uptake
- storing vaccines in accordance with national guidance
- ensuring vaccination is delivered by suitably trained, competent healthcare professionals who participate in recognised on-going training and development in line with national standards
- maintaining regular and accurate data collection using appropriate returns

[1] National Flu Plan - Winter 2017-18, PHE

- encouraging and facilitating flu vaccination of their own staff

- In addition, GP practices are responsible for:
    - ordering vaccine for children from PHE central supplies through the ImmForm website and ensuring that vaccine wastage is minimised
    - ensuring that all those eligible for the flu vaccine are invited personally to receive their vaccine

Locally, Berkshire Healthcare Foundation Trust Schools Immunisation Team is commissioned to deliver the flu immunisation programme to children in school years Reception to year 4 through a schools-based delivery model.

3. 2016-17 Flu activity

The PHE report, 'Surveillance of influenza and other respiratory viruses in the UK: Winter 2017 to 2018 released on 24 May 2018, indicated that;

- In the 2017 to 2018 season, moderate to high levels of influenza activity were observed in the UK with co-circulation of influenza B and influenza A(H3), which is different to 2016-17 where H3N2 predominated.

- Indicators for GP consultation for flu-like illness in and out of hours and for NHS 111 calls were at higher levels than in 2016-17, patterns of activity were similar peaking in week 52.

- Peak admissions rates of influenza to hospital and intensive care were higher than seen in the previous 6 seasons.

- The majority of circulating A(H3N2) strains in the UK were genetically and antigenically similar to the Northern Hemisphere 2016/17 (H3N2)vaccine strain, this is in line with many Northern Hemisphere countries.

- The impact of this co-circulation was predominantly seen in older adults, with a consistent pattern of outbreaks in care homes noted. Reported outbreaks peaked in week 52 of 2017

- Levels of excess all-cause mortality were elevated particularly in the elderly, similar to the 2016 to 2017 season but were lower than in the 2014 to 2015 season in which influenza A(H3N2) also dominated.

Figure 1: Reported Outbreaks (National)

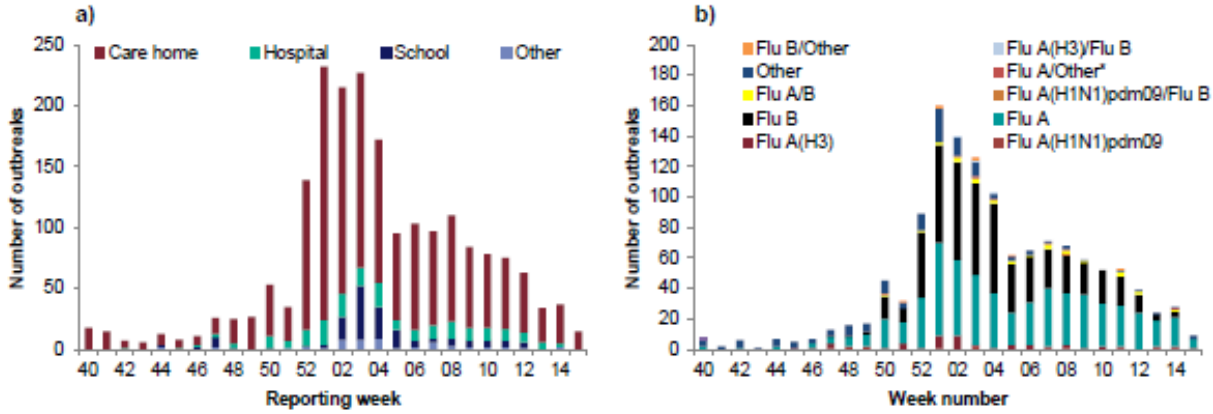

Figure taken from [Surveillance of influenza and other respiratory viruses in the UK: Winter 2017 to 2018] (PHE, 2017)

In England a total number of 1,832 outbreaks of acute respiratory infection were reported to Public Health England between week 40 2017 and week 15 2018 compared to 1,009 in the 2016 to 2017 season. The majority of outbreaks were from care homes settings (79.7%) similar to the previous season. Hospital outbreaks accounted for 9.1% of outbreaks; this is slightly lower than in the 2016 to 2017 season (13.5%). School outbreaks accounted for 8.4% of all outbreaks compared to 5.9% in the 2016 to 2017.

4. Local outbreaks

There were 51 outbreaks of influenza-like illness (ILI) reported in the Thames Valley between 1st September 2017 and 31st March 2018, of these 43 were in care, residential and nursing home settings. Three were in schools, three in hospitals and two in custodial institutions. 35 of the ILI outbreaks reported during this time period received laboratory confirmation for swabs taken. The results returned were for a mix of influenza A (9 outbreaks) and B (15 outbreaks), including a number of outbreaks where both flu A and flu B were co-circulating (9 outbreaks). There were two outbreaks in which laboratory confirmation was received but the typing is unknown. Flu B strains were associated with a higher proportion of care home flu outbreaks than observed in previous years, although Flu A H3N2 and Flu A H1N1 strains were also detected.

There were 9 outbreaks in which deaths were recorded with influenza-like-illness listed as a possible contributing factor (based on self-report from the care home and not death certificates). Hospitalisation of residents was required in 33 outbreaks.

Following the national direction from NHSE for CCGs to develop plans for responding to outbreaks of flu in closed settings both in and out of season, much closer working between CCGs, PHE and LAs developed over the 2017-18 flu season. A workshop was held in March 2018 to review this work across Thames Valley, a report is available from PHE South East (Thames Valley) Health Protection Team, (see embedded document at the end of this report).

5. Flu vaccine efficacy

At time of publication, final influenza vaccine efficacy estimates for 2017-18 had not been released.

Interim results from five European studies indicate that, in all age groups, 2017/18 influenza vaccine effectiveness in the early part of the 2017-18 flu season was 25 to 52% against any influenza, 36 to 54% against influenza B, 55 to 68% against influenza A(H1N1)pdm09 but only −42 to 7% against influenza A(H3N2) .[2] In the UK for the period 1 Oct 2017 to 14 Jan 2018, interim vaccine efficacy against any medically attended influenza among all ages was estimated to be 25% (95% CI: −10 to 48) in the UK. Interim vaccine effectiveness of the quadrivalent children's nasal vaccine was reported to be 53% (95% CI: −56 to 86) and interim efficacy of the injected vaccine, 18% (95% CI: −23 to 45) in adults.

The higher burden of H3N2 among elderly people together with the lower VE of vaccines against this sub-type support the need for more effective interventions[3] and the UK Joint Committee on Vaccination and Immunisation has advised that use of adjuvanted trivalent inactivated vaccines (TIV) in those aged 65 years and older would be both more effective and cost-effective than the non-adjuvanted trivalent or quadrivalent vaccines currently in use[4].

In February 2018, NHS England wrote to GP Practice and Community Pharmacies advising that they should offer the adjuvanted trivalent vaccine (aTIV) for all 65s and over and the quadrivalent vaccine (QIV) for those age 18 to 64 at risk[5].

6. Groups eligible for vaccination

Flu vaccination remains the best way to protect people from flu. People in certain groups are at increased risk of severe symptoms and deaths if they contract flu, these groups were eligible for free flu vaccine in 2017-18.

- Adults aged 65 or above
- Children aged 2 to 4 years or in school years 1, 2 and 3
- Pregnant women
- Paid and unpaid carers
- Frontline health and social-care workers
- People living in long-stay residential care homes,
- Adults and children (6 months to 64 years) with one or more of the following conditions;
    - a heart problem
    - a chest complaint or breathing difficulties, including bronchitis, emphysema or severe asthma
    - kidney disease
    - lowered immunity due to disease or treatment (such as steroid medication or cancer treatment)
    - liver disease
    - stroke or a transient ischaemic attack (TIA)

[2] http://www.eurosurveillance.org/content/10.2807/1560-7917.ES.2018.23.9.18-00086#html_fulltext
[3] https://assets.publishing.service.gov.uk/government/uploads/system/uploads/attachment_data/file/641162/Influenza_vaccine_effectiveness_in_primary_care_1617_final.pdf
[4] https://www.gov.uk/government/publications/flu-vaccination-supporting-data-for-adult-vaccines/summary-of-data-to-support-the-choice-of-influenza-vaccination-for-adults-in-primary-care
[5] NHS England gateway reference: 07648

- diabetes
- a neurological condition, e.g. multiple sclerosis (MS), cerebral palsy or learning disability
- Morbidly obese individuals (BMI>40)

The only change to the programme in 2017-18 compared to 2016-17 was the extension of the offer of live attenuated influenza vaccine (LAIV) to children of appropriate age for reception class (R) and school year 4, in addition to those children in school years 1, 2 and 3 and the corresponding removal of children aged 4 from the GP immunisation programme. This is in line with the principle for future extension of the programme to extend upwards through the age cohorts.

In Berkshire, children of appropriate age for school years R to 4 were offered flu vaccine in school, with arrangements in place to ensure home-schooled children are also offered a vaccine.

Although The Green Book had recommended that people with a BMI over more than 40 should have a flu vaccine[6], 2017-18 was the first flu season where this group was included in the payment scheme for General Practice.

In October 2017, NHS England announced that £10M had been made available nationally to fund flu vaccination for residential, nursing and domiciliary care staff employed by a registered residential care/nursing home or registered domiciliary care provider, and who are directly involved in the care of vulnerable patients/clients at increased risk from exposure to influenza [7] (i.e., those patients or clients in a clinical risk group or aged 65 or over). This offer was available through community pharmacies and most GP Practices.

7. Aims of the flu immunisation programme

The aims of the immunisation programme in 2017-18 were to;

- Actively offer flu vaccine to **100%** of people in eligible groups.
- Immunise 60% of children, with a minimum **40%** uptake in each school
- Maintain and improve uptake in over 65s and 6 months to 64 years in clinical risk groups with at least **75%** uptake for those aged 65 years and over and **75%** uptake for health and social care workers
- Improve uptake over and above last season among those in clinical risk groups and prioritise those with the highest risk of mortality from flu but who have the lowest rates of vaccine uptake (i.e. immunosuppression, chronic liver and neurological disease, including people with learning disabilities); achieving at least 55% uptake in all clinical risk groups and maintain higher rates where they have previously been achieved.

8. Communications and resources

In 2017-18, flu vaccine was for the third year running included as a component of the jointly coordinated PHE and NHS England “Stay well this winter” campaign.

[6] https://www.gov.uk/government/publications/influenza-the-green-book-chapter-19
[7] http://www.nhsemployers.org/news/2017/11/how-care-staff-can-get-free-flu-vaccine

Resources were available from the online PHE Campaign Resources Centre.

Local authorities and CCGs across Berkshire used their social media accounts to enforce national messages on flu vaccine as well as other winter health messages. A Berkshire press release template was prepared for local modification by local authority public health teams. Leaflets and posters from the national resource centre were distributed to local venues including Children's centres, childcare settings and local shops by local authority public health teams. Easy-read versions of the leaflet were shared with LA Learning Disabilities colleagues for use with their clients. Flu vaccine was promoted to carers during national Carer's Rights Day (20/11/2017) and to those with long term conditions as part of National Self-Care Week (16-22/11/2017).

Following the announcement of the NHS-funded offer of flu vaccination for residential, nursing and domiciliary care staff, local authorities and CCGs communicated directly with local care providers to raise awareness of the offer and encourage staff to get vaccinated against flu.

9. Local delivery of flu vaccination programme

Across Berkshire, residents were able to access flu vaccine in a number of ways (Table 1).

Table 1: **Access to flu vaccine for eligible groups**

Group	Provider
Children aged 2 to 4	Primary Care
Children in School years 1, 2 and 3	School based programme delivered by Berkshire Healthcare Trust
Special Schools	School based programme delivered by Berkshire Healthcare Foundation Trust
Adults aged 65 or above	Primary Care or Community Pharmacy
Adults in clinical risk groups	Primary Care or Community Pharmacy
Children in clinical risk groups	Primary Care (or through special school programme)
Paid and unpaid carers	Primary Care or Community Pharmacy
Pregnant Women	Maternity Unit at Royal Berkshire Hospital, Wexham Park Hospital or Primary Care
Health and social care workers	Via occupational health arrangements and for nursing, residential and domiciliary care workers via GP and Pharmacy following the National announcement

A stakeholder workshop was held in June 2017 this was jointly delivered by Jo Greengrass (East Berks CCGs), Dr Chris Cook and Harpal Aujla, Screening and Immunisation Team NHS England South - South Central and Berkshire local authority public health teams from Bracknell Forest, Reading, Slough, Windsor and Maidenhead, West Berkshire and Wokingham. Participants from a range of stakeholder organisation attended, including representatives from East Berkshire and Berkshire West CCGs, GP practices, NHS provider organisations, Public Health England, Residential and Nursing Care providers and public health teams across Berkshire.

The aims of the workshop were to;

- review and reflect on 2016-17 flu season
- understand commissioning intentions for 2017-18

- draw on learning to put in place actions to improve uptake and reduce practice variation between practices
- listen to what enables and blocks residential care providers to offer vaccine to staff

10. Local Communications and Engagement Activities

Recommendations for 2017-18 from the 2016-17 flu seasons are shown in Table 2 together with actions taken in response to these.

Table 2: Recommendations and responses

Recommendation	Action(s)
Establish a joint flu communications plan with CCG comms colleagues ahead of the flu campaign launch and ensure LAs provide regular updates on planned timing and nature of LA flu comms to the CCGs to improve the uptake of opportunities to share communications. Communications should take account of uptake in each eligible group and target appropriately.	Workshop held in June 2017 to establish partnership working. East and West Berkshire Flu Action groups met monthly from September to monitor uptake and tailor internal and external flu communication and engagement activities.
Ensure communication between all LAs in the summer period to establish model for staff flu vaccine offer in order to secure most cost-effective and accessible.	Although a single approach was not developed, LAs shared plans and approaches over the summer period.
Deliver a separate event/ specific publicity for training/planning for Care Agencies/ residential homes to advocate for provision of staff vaccines and support employers.	Working with CCG colleagues a revised newsletter for Nursing and Residential care providers was developed and circulated together with the annual PHE guidance on managing outbreaks of influenza-like-illness Following the announcement of the national offer for care workers, LA and CCG partners engaged with providers to raise awareness of the campaign. In December a briefing for Directors of Adult Social Care, LA Consultants in Public Health, Lead Members, Health & Wellbeing Board Chairs was developed to raise awareness and seek support in promoting flu vaccine to eligible care workers.
Work with commissioners of residential, nursing and domiciliary care to include KPIs around staff flu vaccine and record keeping.	This is an important recommendation which was not taken forward in 2017-18, largely due to the short time frame following the workshop and the start of the flu season.
Liaise more closely with PHE colleagues to measure and communicate the impact of	Following the national direction from NHSE for CCGs to develop plans for responding to

Recommendation	Action(s)
suspected and confirmed flu outbreaks in care home and childcare settings.	outbreaks of flu in closed settings both in and out of season, much closer working between CCGs, PHE and LAs developed over the 2017-18 flu season. A workshop was held in March 2018 to review this work across Thames Valley , a report is available from PHE South East (Thames Valley) Health Protection Team.
Continue to engage with hospital specialists and local patient advocates to help promote flu vaccine to patients with clinical risk conditions.	Building on the work achieved in 2016-17 has been challenging to sustain in 2017-18 and there is still opportunity to improve the way in which some patient groups are supported to access flu vaccine. The Team in the East of Berkshire have included flu vaccine reminders for patients with chronic respiratory disease and asthma on clinic letters.
Continue to support the school immunisation team to communicate with schools and head-teachers on the flu programme ahead of the autumn term and throughout flu season.	LA Public health flu leads have continued to support the Schools Immunisation Team to engage with schools and have facilitated discussions regarding information sharing and the need for nurses to have access to mobile devices in the school. LA teams have promoted mop-up clinic dates to local communities. It remains challenging for the School Immunisation Team to receive denominator data on eligible children prior to the school visit.

In addition to the fortnightly Thames-Valley teleconferences led by NHS England, fortnightly teleconferences or meetings were held in East and West Berkshire to monitor flu levels, vaccine uptake and progress with local actions. Outputs from the workshop enabled stakeholders in each locality to identify key actions for inclusion in their local ‘Flu Action Plan’, building on work done in the previous flu season. Communications and engagement activities undertaken by local authority and CCG teams are summarised in Table 3.

Table 3: Local communications and engagement activities

Organisation	Actions
LA Public Health Teams	• promoting flu vaccine though joint communications initiatives CCG, increased use of targeted social media to promote vaccination to specific groups – see Section 13 for more detail. • use of corporate and public health social media channels to communicate with residents • targeted social media campaign to parents with young children through Children's Centres and local nurseries • internal comms to LA staff, including LA newsletters, intranet articles and internal screen-savers • attending local events and workshops, such as National Carers Rights Day • distributing national campaign materials to other local organisations, such as children's centres, child minders and organisations supporting older people and people with learning disabilities • promoting through LA newsletters and websites • providing leaflets to older people at lunch clubs and when collecting a free bus-pass • placing promotional materials in community settings used by older people and young families • working with care staff to advocate to those with stable neurological conditions living in the community • a letter was sent to Healthwatch asking for their support in making people aware of their eligibility and right to receive a free flu vaccine • series of communication to care home providers including a letter for HWB to go to residential care homes encouraging uptake of NHS-funded vaccine for care workers caring for vulnerable residents • resources for people with Learning Disabilities circulated to key organisations • using links into parish councils to communicate in other community settings and village events • participation in East of Berkshire Flu Action Group and TV Flu Teleconference and South East Flu Communications Teleconferences • working closely with BHFT School Immunisation Team to support delivery of programme, advertising school and mop up clinics through LA websites and directly with schools for onward promotion to parents
East Berkshire CCG	• numerous press releases have been issued locally featuring different target groups and shared with media, partners, stakeholders, on our websites and via social media • media interviews on BBC Radio Berkshire and on Asian Star radio station in Slough • three short flu videos starring local GP Dr Jim O'Donnell have been shared via social media, partners • two week radio campaign on Asian Star which contained key messages targeting parents of children aged 2-8 in both English and Hindi • an advert was placed in the Primary Times magazine which is delivered to parents of young children

	across Berkshire. This was financed by BCF. • working with Language Line, the national children's flu poster was translated into Urdu, Punjabi, Hindi and Polish and shared with all local partners • the team has worked closely with the schools immunisation programme lead to advertise the extra flu clinics • flu updates for GP Practices across East Berkshire have been included in the weekly bulletins • the team has helped arrange and co-ordinate publicity for staff flu clinics which have been well attended this year • taking part in the NHSE flu comms call updating on local progress and sharing ideas • Included a piece on the importance being vaccinated in the new East Berkshire CCG quarterly stakeholder newsletter issued this month (Jan) • training sessions for practices on improving flu uptake and support offered particularly in WAM through BCF money - expert help to increase flu uptake
Berkshire West CCG	• NHS partners across the Berkshire West locality including West Berkshire CCGs, Royal Berkshire FT and Berkshire Healthcare FT developed a joint winter planning communications strategy that uses NHS England messaging throughout the period of September 2017 – the end of March 2018. • the Strategy was shared with and approved by the local A&E Delivery Board. • Berkshire CCGs clinical leads and GPs have taken part in interviews with local broadcast channels, BBC Radio Berkshire and South TV during the campaign period
Community Pharmacy	• Pharmacy Thames Valley funded undertook a number of communications over the flu season including; • a local radio campaign for two weeks at the start of the season; • committee member was interviewed on local radio • flu stickers and badges were supplied for use by pharmacy teams to raise awareness of the service

11. National Vaccine Uptake 2017-18

Uptake of vaccine in primary care, community pharmacy and among healthcare workers is monitored by Public Health England. During Flu season, NHS England commissioners of the vaccine programmes extracted and collated uptake data from GP practices on a weekly basis and nationally on a monthly basis. Data on numbers of vaccines provided to adults through community pharmacy and to pregnant women by NHS midwives was monitored by NHSE and shared with stakeholders.

Influenza vaccine uptake in 2017 to 2018 in England was higher than the 2016 to 2017 season across all of the target groups in particular in the 65+ year olds (72.6%) and in (NHS) healthcare workers (68.7%). Uptake of the nasal flu vaccination among children increased form the previous year in England from 38.9% to 42.8% for two year olds and from 41.5% to 44.2% in three year olds. Overall uptake for children in school years reception, 1, 2, 3 and 4 age by LA ranged from 26.0% to 79.3%.

11.1. GP registered patients by CCG

In keeping with the national and regional picture, uptake of vaccine among GP-registered patients in Berkshire was generally higher in 2016-17 than in 2017-18. The increased uptake observed in Slough CCG during 2016-17 was not sustained in 2017-18 with reduced uptake across all risk groups with the exception of over 65s, see Table 4.

Newbury & District and North and West Reading CCGs achieved the 75% target for patients aged 65 and above, something which was not achieved nationally.

The increased uptake among patients in clinical risk groups observed in 2016-17 was not sustained in 2017-18. Uptake decreased in the majority of CCGs with only South Reading and Windsor, Ascot & Maidenhead improving uptake on the previous year.

Uptake among pregnant women was increased in all CCGs with the exception of Slough where there was a decrease of 4.9%. Nationally, and across Thames Valley, uptake in this group remained similar to the previous season.

Uptake among 2 year olds increased in all Berkshire CCGs with the exception of Slough and Bracknell & Ascot, uptake among 3 year olds increased or was maintained in all CCG areas. For four years olds, uptake increased in all CCGs except Slough.

Table 4: Flu vaccine uptake among GP registered patient by CCG - Sept 1 2017 to Jan 31 2018 in comparison to 2016-17 time-point.*

	Risk Group				
	65 and over	Under 65 (at-risk)	All Pregnant Women	2 Years old	3 Years old
NHS BRACKNELL AND ASCOT 2017-18	73.5	53.8	55.8	47.0	51.9
2016-17	70.9	54.0	51.1	49.5	50.5
2016-17 Variation	2.6	-0.2	4.7	-2.5	1.4
NHS NEWBURY AND DISTRICT 2017-18	77.5	55.5	52.1	58.3	55.6
2016-17	74.4	55.7	45.1	53.6	53.9
2016-17 Variation	3.1	-0.2	7	4.7	1.7
NHS N & W READING 2017-18	75.0	50.4	48.1	47.8	49.4
2016-17	74.0	54.1	46.3	42.4	49.1
2016-17 Variation	1	-3.7	1.8	5.4	0.3
NHS SLOUGH 2017-18	69.9	47.5	35.9	26.3	28.1
2016-17	68.2	50.6	40.8	26.7	33.2
2016-17 Variation	1.7	-3.1	-4.9	-0.4	-5.1
NHS SOUTH READING 2017-18	70.4	47.8	43.9	37.1	40.5
2016-17	68.9	46.4	39.3	35.7	39.6
2016-17 Variation	1.5	1.4	4.6	1.4	0.9
NHS WINDSOR, ASCOT & M'HEAD 2017-18	70.8	47.5	49.4	44.1	44.5
2016-17	68.4	47.0	44.5	37.0	44.2
2016-17 Variation	2.4	0.5	4.9	7.1	0.3
NHS WOKINGHAM 2017-18	73.8	48.6	52.6	55.4	54.2
2016-17	72.7	50.7	50.4	48.1	53.5
2016-17 Variation	1.1	-2.1	2.2	7.3	0.7
Thames Valley Total 2017-18	**74.0**	**50.0**	**50.4**	**46.8**	**48.8**
2016-17	72.1	50.7	47.2	43.3	47.0
2016-17 Variation	1.9	-0.7	3.2	3.5	1.8
England Total 2017-18	**72.6**	**48.9**	**47.2**	**42.8**	**44.2**
2016-17	**70.4**	**48.7**	**44.8**	**38.9**	**41.5**
2016-17 Variation	**2.2**	**0.2**	**2.4**	**3.9**	**2.7**

Data source: **Seasonal influenza vaccine uptake amongst GP Patients in England. Provisional monthly data for Sept 31 2017 - Jan 2018**

* includes those GP-registered patients who were vaccinated through national community pharmacy scheme or by hospital midwives

Table 5: Flu vaccine uptake among GP registered patient by LA - Sept 1 2017to Jan 31 2018 in comparison to 2016/17time-point

	Risk Group				
	65 and over	Under 65 (at-risk)	All Pregnant Women	2 Years old	3 Years old
Bracknell Forest 2017-18	73.5	53.9	57.0	46.3	51.7
2016-17	71.7	54.9	52.5	50.4	50.6
2016-17 Variation	1.8	-1	4.5	-4.1	1.1
Reading 2017-18	72.3	47.0	45.2	38.8	40.9
2016-17	71	48.5	41	35.8	41.6
2016-17 Variation	1.3	-1.5	4.2	3	-0.7
Slough 2017-18	69.9	47.5	35.9	26.3	28.1
2016-17	68.2	50.6	40.8	26.7	33.2
2016-17 Variation	1.7	-3.1	-4.9	-0.4	-5.1
West Berkshire 2017-18	77.6	55.3	52.1	58.1	56.6
2016-17	74.9	56.2	46.9	54.1	54.8
2016-17 Variation	2.7	-0.9	5.2	4	1.8
Windsor and Maidenhead 2017-18	71.6	48.6	49.7	44.4	45.1
2016-17	68.7	47.6	44.7	38	45.8
2016-17 Variation	2.9	1	5	6.4	-0.7
Wokingham 2017-18	73.3	48.6	52.4	58.5	57.7
2016-17	72.3	50.5	50.0	49.8	55
2016-17 Variation	1	-1.9	2.4	8.7	2.7
England Total 2017-18	**72.6**	**48.9**	**47.2**	**42.8**	**44.2**
2016-17	**70.5**	**48.6**	**44.9**	**38.9**	**41.5**
2016-17 Variation	**2.1**	**0.3**	**2.3**	**3.9**	**2.7**

Data source: Seasonal influenza vaccine uptake amongst GP Patients in England. Provisional monthly data for Sept-31 2017 - Jan 2018

11.2. Schools Campaign

In Berkshire, the children's quadrivalent live attenuated intra-nasal vaccine (LAIV) was delivered in primary schools by a team of school immunisation nurses from Berkshire Health Foundation Trust. The team arranged and carried out visits at around 300 schools across Berkshire, including special schools where all year groups were offered vaccine The BHFT school immunisation team delivered over 40,000 doses of vaccine and succeeded in reaching and exceeding the 40% overall uptake target in every Berkshire LA, see Table 6.

Table 6: Uptake for school year R,1, 2 , 3 and 4 children[8], by local authority 2017-18

		Bracknell Forest	Reading	Slough	West Berks	RBWM	Wokingham	South Central	England
Reception (age 4-5)	Estimated no. eligible children	1,402	1,906	2,164	1,981	1,665	1,974	42,971	656,251
	Estimated no. of children vaccinated	1,110	1,330	1,157	1,575	1,370	1,820	30,923	410,565
	% influenza vaccine uptake	79.2	69.8	53.5	79.5	82.3	92.2	72.0	62.6
Year 1 (age 5-6)	Estimated no. eligible children	1,610	2,094	2,504	2,026	1,944	2,400	45,617	680,602
	Estimated no. of children vaccinated	1,179	1,297	1,132	1,620	1,325	1,799	31,064	414,317
	% influenza vaccine uptake	73.2	62.2	45.2	80.0	68.2	75.0	68.1	60.9
Year 2 (age 6-7)	Estimated no. eligible children	1,557	2,081	2,515	2,098	1,963	2,282	46,019	682,256
	Estimated no. of children vaccinated	1,159	1,314	1,177	1,627	1,309	1,756	31,339	411,375
	% influenza vaccine uptake	74.4	63.1	46.8	77.6	66.7	77.0	68.1	60.3
Year 3 (age 7-8)	Estimated no. eligible children	1,598	2,036	2,495	2,051	1,989	2,373	45,564	674,105
	Estimated no. of children vaccinated	1,093	1,206	1,079	1,539	1,275	1,745	29,335	387,648
	% influenza vaccine uptake	68.4	59.2	43.2	75.0	64.1	73.5	64.4	57.5
Year 4 (age 8-9)	Estimated no. eligible children	1,624	1,995	2,452	2,010	1,975	2,262	44,119	668,153
	Estimated no. of children vaccinated	1,081	1,155	1,031	1,492	1,222	1,606	27,662	371,927
	% influenza vaccine uptake	66.6	57.9	42.0	74.2	61.9	71.0	62.7	55.7

Data source: Seasonal influenza vaccine uptake for children of primary school age, Provisional monthly data for 1 September 2017 to 31 January 2018 by Local Authority

[8] Data is provisional and represents 100% of all Local Authorities (LAs) in England responding to the January 2017 survey. Where a total for England is quoted (e.g. sum of number of patients registered and number vaccinated) this is taken from the 100% of all LAs and is therefore NOT an extrapolated figure for all of England.

11.3. Pharmacy Campaign for adults

As in 2015-16, in 2016-17 pharmacies signed up to the National Advanced Service could offer flu vaccine to the following groups;

- People aged 65 and over.
- Pregnant women
- Adults in a clinical risk group

Similarly to 2016-17, national data from the Pharmoutcomes Sonar Informatics and Healthi systems indicates that the majority of those receiving a flu vaccine in community pharmacy were aged over 65, with over two thirds of the vaccines provided via this service being given to people over 65 years of age. Nationally, among pharmacies using Pharmoutcomes, 66.5% of doses were to people aged 65 or over, 3.6% to carers and 1.4% to pregnant women, with the remainder given to adults in clinical risk groups, people with diabetes accounted for7.3% of the total doses recorded in Pharmoutcomes, this is a very similar pattern to that observed in 2016-17. Further breakdown of the risk groups receiving their vaccine in community pharmacy is given in Table 7.

It should be noted that this data shows the eligibility groups of patients who have been recorded as receiving flu vaccination in community pharmacy (to 5th April 2018). Some Pharmacy contractors are not able to use or have decided not to use electronic systems to record administration of vaccines. Therefore this data does not cover all patients vaccinated in community pharmacy during the 2017/18 flu season.

National data from the Pharmaceutical Services Negotiating Committee [9] shows that at least 1,199,264 doses were delivered in pharmacies as part of the National Advanced Service. This figure is generated from the NHS BSA and so include all those vaccinations claimed for and not just those that use the electronic systems so is likely to be accurate.

Pharmacies in Berkshire provided 37,318 doses of vaccine (Table 8), an increase of 4597 (14%) compared to the number of doses recorded in the previous flu season, the majority of Berkshire pharmacies used the Pharmoutcomes system to record the number of vaccines given.

[9] Flu vaccination data from PharmOutcomes, Sonar Informatics and Healthi for 2017-18

Table 7: Flu vaccinations given in Community Pharmacy in England, by risk group

Vaccination eligibility group	PharmOutcomes	Sonar	Healthi
Aged over 65	66.5%	57.4%	81%
Asplenia/splenic dysfunction	0.2%	0.2%	0.3%
Carer	3.6%	4.1%	1.9%
Chronic heart disease	2.8%	3.8%	3.1%
Chronic kidney disease	0.4%	0.4%	0.6%
Chronic liver disease	0.2%	0.2%	0%
Chronic neurological disease	1.3%	1.2%	1.2%
Chronic respiratory disease	12.8%	13%	5%
Diabetes	7.3%	13%	3.7%
Household contact of immunocompromised individual	0.6%	0.7%	0.6%
Immunosuppression	2.2%	3%	1.9%
Morbid obesity	0.2%	0.1%	0%
Person in long-stay residential or home	0.2%	0.3%	0%
Pregnant woman	1.4%	2.7%	0.6%
Social care workers	0.5%	0.1%	0%

Data source: Flu vaccination data from PharmOutcomes, Sonar Informatics and Healthi for 2017/18

Table 8: Berkshire Pharmacies and Flu vaccine doses 2017-18 compared with 2016-17

CCG	Vaccines claimed to March 2017	Vaccines claimed to March 2018
BRACKNELL AND ASCOT CCG	2,023	1,742
NEWBURY AND DISTRICT CCG	1,825	1,441
NORTH & WEST READING CCG	1,060	1,415
SLOUGH CCG	1,492	1,089
SOUTH READING CCG	1,439	2,028
WINDSOR, ASCOT AND MAIDENHEAD CCG	2,767	2,383
WOKINGHAM CCG	2,728	3,208
Berkshire CCGs	**13,334**	**13,306**
Thames Valley	**32,721**	**37,318**

Data source: PharmOutcomes data, Thames Valley LPC

11.4. Healthcare workers (NHS Flu Fighters)

Nationally uptake of flu vaccine among front line healthcare workers in NHS Trusts is reported by Trusts and uptake among healthcare workers in Primary Care and ISHCP.

Frontline HCWs involved in direct patient care in acute trusts, ambulance trusts, mental health trusts, foundation trusts, primary care, and independent sector health care providers are encouraged to receive seasonal influenza vaccination annually to protect themselves and their patients from influenza. In NHS South Central uptake in 2017-18 was 66.1%. This cannot be compared with previous figures for Thames Valley.

Nationally, uptake among healthcare workers with direct patient care (based on 98.9% of NHS Trusts) was 68.7%, an increase from the 2016-17 figure of 63.4% and 50.8%, 2015-16.

Uptake for frontline healthcare workers in Berkshire overall and by staff group is outlined in Table 9. Uptake in Royal Berkshire Foundation Trust, Frimley Health Foundation Trust and South Central Ambulance Trust improved compared to the previous flu season.. Although Berkshire Healthcare Trust did not increase their percentage uptake, they did maintain a consistent level and managed to vaccinate more healthcare staff this year than in previous years.

It should be noted that for the 2017-18 flu season NHS England published clarification around the requirements for the CQUIN data collection. This included removing leavers, addition of new starters and addition of students, bank, agency and third party organisation staff that have patient contact into the denominator data. This required the denominator data to be updated each month prior to submission to reflect the dynamic nature of the workforce being vaccinated. As a result to percentage uptake each month could go down as well as up as the campaign progressed.

Table 9: Vaccine uptake among front line healthcare workers

	2016-17				2017-18		
Organisation	**All HCWs in direct patient care**	**Seasonal flu doses given since 1 Sept 2016**	**Vaccine uptake (%)**		**All HCWs in direct patient care**	**Seasonal flu doses given since 1 Sept 2016**	**Vaccine uptake (%)**
Royal Berkshire NHS Foundation Trust	4,714	2,855	60.6	↑	4,860	3,043	62.6
Berkshire Healthcare Foundation Trust	2,971	2,264	76.2	↓	3,395	2,423	71.4
Frimley Health NHS Foundation Trust*	9,263	3,577	38.7	↑	6,947	5,006	72.1
South Central Ambulance Trust	2,484	1,358	54.7	↑	2,559	1,612	63.3
NHS South Central					**60,447**	**39,981**	**66.1**
England	**974,568**	**618,275**	**63.4**	↑	**1,025,547**	**704,242**	**68.7**

Source: Seasonal influenza vaccine uptake amongst frontline healthcare workers (HCWs) in England, February Survey 2017-18

*Data for Frimley Health includes staff at all hospital sites including Wexham Park and Heatherwood Hospitals in Berkshire and Frimley Hospital in Surrey. Frimley Health figures are not included in the Thames Valley total.

11.5. LA Health and Social Care staff and others

Local authorities are responsible for providing flu vaccine for frontline health and social care workers that are directly employed. Local authorities may also provide vaccine to staff members as part of business continuity arrangements.

The majority of residential care provision in Berkshire is through privately run care homes and nursing homes. Employers are responsible for providing flu vaccine to their employees under occupational health arrangements, in addition, NHS England funded flu vaccination for workers employed by a registered residential care/nursing home or registered domiciliary care provider, and be directly involved in the care of vulnerable patients/clients at increased risk from exposure to influenza from December 2018.

There is currently no data available regarding the uptake of this offer as no definitive denominator population data is available. Data on the numbers of doses provided to workers under this scheme in GP practices and pharmacies is expected to become available at a later date.

During the 2017-18 flu season, LAs provided flu vaccine to their directly employed social care workers and to some other groups of staff for business continuity reasons. An outline of how schemes were funded, and delivered together with uptake or doses give is show in Table 10.

Table 10: LA Business Continuity and Health and Social Care staff vaccine schemes

Local Authority	Vaccination scheme description
RBWM	No information provided.
Bracknell Forest	Free flu vaccinations are offered to all staff who fall under the categories of Business Critical, providing personal care or are front line, as well as all members of the departmental management team. A total of 146 vaccinations were given, 65 within Adult Social Care Health & Housing, 55 of which were given to front line staff and / or those providing personal care. Within the Children Young People and Learning directorate, 34 vaccines were given. Forty two doses were given to staff within the resources directorate. A number of those receiving vaccine were both front line and business critical staff.
Slough	Flu vaccine is directly promoted to care workers where they are in charge of vulnerable adults. Other staff are risk assessed based on need for the Flu vaccination. There is a direct link with HR and Internal comms A total of 60 vaccinations were given, this is a 233% increase on the previous year when only 18 staff received a flu vaccine.
Reading	Staff were able to receive a free flu vaccination by presenting a valid RBC Staff ID at participating local pharmacies. Free vaccinations were offered to all staff who worked in services considered essential for business or were frontline working with vulnerable adults/children. Eligible staff were once again identified via RBCs business continuity plan. This approach was supported by all DMT's across the Council. DMT's were provided with an opportunity to provide feedback on this approach, as well as content of planned communications. Once approved, these were sent to key contacts i.e. Heads of Services to disseminate to staff in the most appropriate way for their business. 57 staff received a vaccine, this is a 20% increase on the 2017/18 but still markedly lower number than in 2016/17 when vaccinations were delivered onsite at the Civic Centre using the occupational health suite.

West Berkshire	WBC offer a free seasonal flu vaccine to personnel not already eligible for an NHS-provided seasonal flu vaccine, with a view to increasing uptake year-on-year. Vaccine was offered to the following groups through a mixture of vouchers and clinics. Vaccines were offered to front-line staff including adult social care and children and family services staff, early years staff, and staff self-identifying as in need of a flu vaccine • business critical staff, eg civil contingency staff • staff in special schools (three out of four special schools' staff in West Berkshire take up the offer) • our partner Third Sector groups, eg Volunteer Centre, Soup Kitchen, Healthwatch, Homestart. • Unpaid carers that are brought to our attention by colleagues/partners who have not been eligible to an NHS flu vaccine, are considered. 309 flu vouchers were given out to staff. In addition, 166 people received a vaccine in a WBC clinic. 410 doses of vaccine were recorded on Pharmoutcomes, suggesting that not all vouchers were redeemed.
Wokingham	The campaign was supported by internal communications to all staff and social media messages. Staff were offered vaccinations at an on-site drop in clinic at various times over a number of days, this was delivered by a local pharmacist. A total of 254 WBC staff took up the offer of the vaccination an increase of 30% on the previous year. On-site staff clinics have been running in Wokingham for a number of years and have become 'part of the norm' with staff enquiring as early as September as to when the flu clinics will be running. Feedback from staff at Induction sessions identified free staff flu clinics as an employee benefit.

12. Summary of local flu campaign activities - feedback from LA, CCG and NHS provider partners

Did you do anything new to promote flu vaccination this year? If so what and how did you measure success?
Reading A new approach in Reading was the change to the RBC Staff Flu Vaccination Programme following feedback from 2016/17 – the aim was remove unnecessary barriers to improve uptake. The 2018/19 was designed so as to remove the need for staff to print vouchers. This was measured by the uptake of the staff offer. There was a 20% increase in uptake – 57 vaccination compared to 47 in 2016/17. As the numbers are so low it is difficult to say that the increase was as a direct result of these changes. **West Berkshire** Invested time in trying to persuade LA adult care settings (4), and LA adult care resource settings (3) and family hubs (3) to have on-sight flu clinics, 3 out of the 10 took up this offer. Providing the clinics was expensive through the service level agreement (though within budget) and would consider making an arrangement with pharmacies providing the clinics outside of the SLA next year. Flu lead had her photo taken having a flu vaccine and posted on social media and invited people to comment on their experience of flu jabs. Pharmacist video clip. Increased and persistent messages via social media on encouraging people to have a flu vaccine coupled with stay well this winter messages and encouraging people to look out for the welfare of vulnerable neighbours; trying to make the messages varied - eg addressing different vulnerable groups - and arresting and calling to action. In addition, weaving flu vaccine messages into cold winter weather alerts. End of flu season survey monkey with a view to harnessing greater insight into what persuades people to go ahead and get vaccinated. **Bracknell Forest** Engaged with different valuable groups through their leads, using the leads to access their social media forums, for example through the GRT (BF Gypsy, Roma Travellers) forum/Newsletter and Polish Facebook pages via PCSO (BF and Berkshire Wide). Measuring success from the feedbacks from the leads. **Slough** The PH team has entered into the digital world with the launch of twitter (@SloughPH) and a monthly e-newsletter. We have also established more formal communication channels with a range of local community groups, providers and businesses to help expand our reach. The flu vaccination promotion featured heavily in all our outward facing promo work from August through to February. This was then expanded on through the normal channels i.e. Council main twitter account and the various other internal departments which have social media.

A variety of paid and unpaid Facebook adverts promoting the vaccine uptake to key groups, as well as producing hard resources (Flyers and posters) with tailored letters to other audiences , some of which involved tailored presentations to their user groups and all of which were followed up on a monthly update with flu progress and vaccination updates

e.g.

- Young Carers
- Social care groups
- Care Homes and domiciliary care providers
- Children Centres
- Libraries
- All GP practices
- Children Services
- Healthwatch
- Home Start Slough
- Family Information services

Wokingham:

- The Staff Flu Vaccination Clinics which are generally popular were extended to include other satellite venues rather than just offering them at Shute End. Locations including Children's Centres and The Forge. However, these were subsequently cancelled due to low numbers. This will be reviewed for 2018/19.
- We promoted campaigns through numerous social media channels, e.g. corporate communications, Children's Centres, Community Warden and local community group channels to increase the reach and enable targeted messages to be sent to vulnerable groups.
- Our list of key contacts has grown which enabled us to send targeted messages out to key audiences and promote the flu campaign.

What worked well this year?

Reading

- Wellbeing Officers were contacted in advance of the national and local offer launching. This demonstrates that people are starting to recall the offer and there are individuals who are seeking to proactively protect themselves and those they work with against flu. This is likely linked to the consistency of messaging and the relationships/partnerships that have being built on since 2013 and this should continue.
- There was high interaction on social media information posted which specifically related to catching up on school immunisations – this was for both Facebook and Twitter. This indicated that people in the community are being motivated to interact with this form of messaging.
- A piece of work completed by Reading Learning Disability Partnership which was a collation of case studies from people with learning disabilities about having a flu vaccinations. This provided important insight in the experiences of people with learning disabilities and shared key learning points for people to consider about having vaccinations or supporting someone to decide and have a vaccination.

The Reading Learning Disability Partnership used this in local forums and permitted it to be shared with health and social care colleagues, as well as across other partners in Berkshire

West Berkshire
Paper or electronic flu and stay well this winter materials and messages were sent early in the flu season and at appropriate times throughout the flu season to stakeholders

- Chief Executive and local MP both photographed receiving their flu vaccines from the Leader of the Council, (who is also a pharmacist). Excellent coverage on the news feed of West Berkshire Council; tweeted and Facebooked.
- The clinics were organised early in the season.
- The vouchers were redeemable from opted-in pharmacies in West Berks and Reading and payment was made via Pharmoutcomes.
- Increased uptake flu vaccine figure for the LA offer (the local scheme as outlined in table 10 above), highest since scheme began in 2013-14

Bracknell Forest
Engagements with local partners, internally staff engagement with the Flu programme and colleagues from various directorates supported the engagement activities, for example, School admission team, Social Care, Commissioning and contract teams.

Slough
Gradually expanding on our reach into the community and increasing in our partner base and awareness. Working with Occupational Health to review staff uptake.

Wokingham
- Staff vaccination clinics are now becoming part of the norm and staff were enquiring as early as September as to when the flu vaccination clinics would be running. This year a total of 254 WBC were vaccinated, an increase of 30% on the previous year. Flu vaccination clinics are often cited as an employee benefit at staff induction sessions.
- We improved our social media reach and were able to tailor messages to key vulnerable groups.
- Flu and winter health are now an established seasonal agenda item within key local forums, including Carers, Safeguarding Adults, Provider forums and the local Learning Disability Partnership Board. This helps us deliver key messages to these target groups as well as providing us with information on how to improve future campaigns.

What was the biggest challenge?

Reading

- Limitations to resource will continue to be a challenge to understanding what the local barriers are for individuals/communities. Conflicting pressures within organisations also have an impact on flu promotion work.
- It was recognised that inclusion of KPIs for offering and recording staff and resident flu vaccinations could be a useful tool, but also that this approach has limitations.

West Berkshire

- ensuring that staff in clinics where eligible groups go, eg COPD, CKD, etc are giving persistent messages throughout the seasonal flu season to get a flu vaccine
- reaching underserved groups who are eligible and at risk, e.g. homeless people, gypsies and travellers
- making best use of 'Flu Champions'

Bracknell Forest

- Promoting Free Social Care staff immunisation, as the national agreement came in later during the flu season.

Slough

- Converting promotion and engagement with the local community to actual vaccinations! i.e. potentially related to behaviour change. Following on from feedback from various community groups there is still the belief that:
  - "We don't ACTUALLY need the vaccination"
  - "The vaccination doesn't actually work"
  - "Flu isn't a big deal"
  - "It's a live vaccination so I will catch the flu after the vaccination"
  - "I'm not part of the vulnerable groups, therefore can't get the vaccination"
  - "I can only get the vaccination at my GP"
  - By December – "It's too late now to get the vaccination"
- Being down on certain school vaccinations due to challenges from some Faith schools due to the content of the vaccination i.e. Pork content. Also down in 65+ bracket, which will form imminent review for 2018/2019

Wokingham

- Social care staff and providers remain a challenge, this needs to be addressed for 2818/19 as we had a number of outbreaks in local care homes.
- Myths surrounding flu vaccinations remain an issue

Plans for 2018-19 to address challenges
Reading • Shared learning and joining up of resources will continue to be a priority for Reading. We will continue to seek new and innovation ideas and solutions to disseminate key information and messages – particularly to those in clinical risk groups. • There will be a change to the RBC Staff Programme but local decisions are yet to be ratified with regards to if and how vaccinations will be made available. • Engaging with the Care Quality Commission around the offer, uptake and recording of flu vaccinations in residential care and nursing home settings at a Berkshire or Regional level during the planning phase. **West Berkshire** • Provide more flu clinics, if possible, at different locations where staff are based **Bracknell Forest** • Work with existing partners and new partners and plan for the new activities • Look for new opportunities internally and externally to further Flu promotional activities **Slough** • Survey work with top and bottom GP practices to review patients approach/views on vaccinations • Additional social media campaign work for this coming year – More on Facebook, potentially short videos detailing the importance, which can be used on twitter etc. • Internal 'flu steering group' to be established within the council to start in Summer 2018. Formed of key stakeholder departments within the council to see how we can better reach the local community with flu information and better provide for the council staff itself **Wokingham** • Review Staff Flu Vaccination clinics for non-Shute End Staff with a particular focus on social care staff. • Learn lessons from flu outbreaks in care homes. • Enhance and strengthen social media opportunities to promote the campaign and dispel myths.

13. Use of social media in flu campaigns

13.1. Reading Borough Council

Social media formed a large part of the 2017/18 campaign, as it is a quick and easy method to share simple key messages. NHS England produced social media messages which local authorities were asked to use on local forums. Officers are able to gather the analytics behind social media (Facebook and Twitter) however there are limitations to our ability to measure the direct impact this type of health promotion has on local uptake. Reading Borough Council has 20.1k followers on Twitter and 2,671 on Facebook. The social media activity posted by Reading Borough Council throughout the season showed:

Twitter

- 12 Tweets (including 2 NHS re-tweets) from the start of November to end of January.
- Average Tweet impressions[10] was just over 1,500 – total was over 18,000.
- Average number of engagements[11] was 10 per tweet – total was 139.

The key messages covered:

- November: Flu Jab for pregnant women, immunisations for children age 2 and 3, Long Term health conditions
- December: immunisations for children age 2 and 3, School immunisation catch up
- January: Long term /Chronic health conditions, School immunisation catch up, Catch it/Kill it / Bin it.

The most popular Tweet was by far the info on the school immunisation catch ups - this had 2,551 impressions and 16 engagements. This appeared in the top ten most popular tweets that month. Information on catch up clinics in January had the most engagement overall, with 21 and it was children related vaccination information that had the most retweets.

Most of the activity on Twitter is replicated on Facebook. Analytics behind Facebook include:

- 8 posts from the start of November to end of January.
- Average reach[12] was just over 700 – total was over 5737.
- The average reach is skewed by the post which related to children missed vaccinations – this recorded nearly 3,000 reaches which is more than half of all Facebook activity.
- Average number of interactions[13] was 5 per post – total was 40.
- The average reach and interactions are skewed by the post about missed school vaccinations catch up clinics – this post alone had more than 50% of all activity (reaches and interactions) on Facebook.

The key messages on Facebook were mostly the same as on Twitter and at the same time.

Facebook traffic mirrored that on Twitter – with information targeting parents about children's vaccination registering the most interactions.

[10] The total number of times that your content is displayed in the news feed of anyone.
[11] Total number of times a user interacted with a Tweet re-tweets, click on tweet, comments, likes etc
[12] Reach represents the number of unique people who saw the content posted.
[13] Total number of times a user interacted with the post through likes, comments or shares.

13.2. West Berkshire Council

24 items promoting flu vaccination were posted on the West Berkshire Public Health Facebook from 4-08-17 to 26-1-2018.

- The total reach was 7137, with an average reach per post of 297
- In total there were 193 clicks or actions, with an average number of 8 per post
- The post with the most reach was: “We recommend that you get your flu vaccine as soon as you can from your pharmacy or your GP! “ at a reach of 1200.
- The most clicks/actions were achieved for a post featuring a local MP getting his flu jab (90 clicks or actions following this post)

Twitter was also used by the West Berkshire Team, which is likely to have increased the reach.

13.3. Wokingham Borough Council

Wokingham Borough Council used Twitter to promote flu vaccination.

Children’s Centres account

- Flu vaccination - 561 people reached, 2 likes, 4 link clicks
- Catch it. Bin it. Kill it – 409 people reached

Corporate Comms account

- Ask your GP about flu jab – 1 retweet
- Is your child 2-3 – 5 retweets, 1 favourite
- Free nasal flu spray – 127 retweets, 45 favourite
- Flu clinic catch-up – no retweets
- Catch it. Bin it. Kill it – no retweets

13.4. Bracknell Forest Council

Bracknell Forest Public Health Facebook account ran four posts during flu season. These resulted in a total reach of 5,575;

- 1,737 reached (pregnancy)
- 977 reached (Children’s Flu)
- 1,552 reached (painless Flu BBC News)
- 1,309 reached (Children need the right vaccine)

Content was also shared with a closed FaceBook group used by the Polish community in Bracknell Forest and resulted in discussion.

13.5. Royal Borough of Windsor & Maidenhead

No data received.

13.6. Slough Borough Council

A flu article and local/national update featured in the SBC Public Health monthly e-newsletter in Aug/Sept/Oct/Nov/Dec. Readership is fairly small at present, around 400, but this is aimed at our key partners, organisations and local community groups as oppose to the general public; this achieved;

- 50 click throughs for “More info” from our e-newsletter for NHS choices
- 18 tweets from our PH twitter account with just over 13,000 impressions (720 average impressions per tweet)

Where other proactive twitter accounts were tagged they have been shared and retweeted well. Especially where we have started the tweet with “NEWSFLASH” or “URGENT”

13.7. Berkshire East CCG

Twitter – data taken from Slough account (all 3 accounts mirror each other so results are very similar):

- 52 posts between November 1st and January 31st
- Average Tweet impressions 371 total was 19,303
- Average number of engagements 3.17 per tweet total 165

Key messages covered:

- November: long term health conditions, children flu jab information, career flu jab and learning difficulty flu jab information.
- December: flu jab for school age children, Asian star advert regarding flu jabs (children)
- January: catch it bin it kill it

Most popular tweet included information on children of school age flu jabs; this had 1751 impressions with 26 engagements. Overall the communications regarding children’s vaccines got the most retweets with the most being 4.

Facebook – one account for all 3 CCG’s

- 48 posts from start of October to end of February
- Average reach was over 300 – total was over 14,428. The post with the most reach was in relation to pregnant women getting the flu jab; this has 4.6K reach with 70 clicks/actions.

The average number of interactions was over 7 per post – total was 356

14. Recommendations for 2018-19 flu season

Systems leadership

- Those in leadership roles should ensure Flu planning and in-season flu monitoring within Berkshire brings together both immunisation and outbreak response planning
- NHS England, Local authorities and CCGs should work together to ensure public messaging and communication to partners around flu is aligned

Communication and engagement

- Local authorities and CCGs should seek to upskill key community and voluntary sector champions and organisations to enable them to disseminate key messages.
- Local partners should consider holding local winter-themed workshop(s) specifically for community and voluntary groups to help embed flu vaccination and other health protection information into community group/s 'communication' plans/local forums and support them to directly access resources to support the groups they work with
- Local partners should develop an effective social media promotional plan via different media targeting priority groups locally
- Public communication and engagement should continue to focus on "myth busting" approach to the flu vaccinations, taking action to understand and act on key local barriers and enablers
- Organisational Senior managers and leaders should support staff flu vaccination by demonstrating their commitment and emphasising the importance of vaccination, where these do not already exist, supporting the development of internal Flu Teams has the potential to drive the campaign forward

Commissioning

- Commissioners should consider taking steps to improve access to flu vaccination for people in eligible groups who receive care for their conditions in hospital
- Residential, nursing care and domiciliary care commissioners should seek to include provision of staff flu vaccine within quality metrics

Vaccine delivery

- Practice staff should ensure all eligible groups are actively invited to take up their flu vaccine, using reminders is shown to be effective in increasing uptake
- All local partners should seek to improve links between medical specialties providing care for people in clinical risk groups to provide advocacy and improve signposting to primacy care
- Local partners should work in partnership to support effective response to flu outbreaks in closed settings such as care homes, nursing homes
- Local partners should work in partnership to enable residents of care / nursing homes and those receiving domiciliary care to take up their offer of a flu vaccine
- Local Authority flu leads should work with internal partners to more effectively estimate offer and uptake of staff vaccination within different staff groups

Flu outbreak response (key recommendations from the Thames Valley workshop)

- Communication between organisations should be effective: directed at the appropriate person, timely and clear
- Local partners should continue to have meetings which build on the learning from this meeting to plan and manage future flu seasons
- Flu leads to consider if plans, models and learning could effectively be shared across organisation
- Commissioning organisations should have robust and resilient plans in place for an effective response to flu outbreaks in all settings including closed communities both in and out of season

- All organisations should review and consider the suggested actions for prevention, response and recovery of flu outbreaks taking forward as appropriate for their organisation
- All organisations should work in partnership to improve flu vaccination uptake for all and particularly increase flu vaccination rates for care home staff
- Local partners should provide support to care homes in preparing for, managing and recovering from flu outbreaks
- Commissioning organisations should have assurances from their commissioned services that they have systems in place for managing future flu seasons

Jo Jefferies, Public Health Services for Berkshire
May 2018

Berkshire Flu Planning Workshop 2018

Open Learning Centre, Bracknell
8th June 2018

Introduction and aims

The workshop was organised by Berkshire Shared Public Health Team and attended by >40 stakeholders from a range of organisations; CCG, local authority (public health and social care), primary care, PHE, NHS Trusts, Berkshire Care Home Association and Involve (Voluntary Sector).

The aims of the workshop were to;

- Review flu activity and impact of flu in 17-18
- Hear commissioning intentions for 18-19 vaccination campaign
- Learn from each other about what works and where challenges remain
- Identify real actions that we can take forward over the summer and into flu season

A full attendee list is attached as Appendix 1
A full slide set from the event is attached as Appendix 2

Flu Activity and impact in Berkshire Winter 2017-18
Rachel Mearkle, CCDC, Thames Valley Health Protection Team, PHE South East

National

- Moderate to high levels of influenza activity were observed in the UK with co-circulation of influenza B and influenza A(H3), which is different to 2016-17 where H3N2 predominated. Indicators for GP consultation for flu-like illness in and out of hours and for NHS 111 calls were at higher levels than in 2016-17, patterns of activity were similar peaking in week 52. Peak admissions rates of influenza to hospital and intensive care were higher than seen in the previous 6 seasons.
- There were 51 outbreaks of influenza-like illness (ILI) reported in the Thames Valley between 1st September 2017 and 31st March 2018, of these 43 were in care, residential and nursing home settings. This a larger number than observed in last two seasons
- In Berkshire most outbreaks were in Berkshire West, Wokingham had the highest number of outbreaks reported (8), Berkshire East reported much lower numbers – this is consistent with recent years but it is unclear what underlying reasons for differences are.

Challenges for PHE Health Protection Team were;

- Rates of flu higher than last year
- Ensuring a resilient and timely response
- Identifying levels of vaccine uptake in staff and residents
- Communication - improved through the season with new relationships being developed with CCG and providers of outbreak response services
- Operational issues: pressures on commissioned services, access to antivirals and medical records
- Commissioning arrangements – at start of flu season these were not in place

Berkshire review & planning
Harpal Aujla, NHSE Screening and Immunisation team

2017/18 Performance
Nationally and locally there was an increase in vaccination uptake in most groups, however in Thames Valley a decrease in uptake among under 65's in clinical risk groups was observed.

In Slough CCG, uptake in all groups except those aged over 65s was lower than last year, this was despite increased communication and engagement with practices and the public throughout the season.

Uptake in WAM CCG improved in 2017/18 for all groups compared to the previous season, the ambition to immunise 75% of over 65s and 55% in other groups was not met.

In Bracknell & Ascot CCG, uptake in under 65s at risk fell slightly as did uptake in 2 year olds. Ambition was met in pregnant women, with 55.8% of women in this group vaccinated.

Newbury and District CCG, achieved the highest uptake among over 65s within Berkshire with 77.5% being vaccinated, uptake was also increased in all other groups with the exception of under 65s at risk. A similar pattern was observed in both Wokingham and Newbury & District CCGs.

In South Reading, uptake was higher than the previous year in all groups although ambition to vaccinate 75% of over 65s and 55% in risk groups was not met.

Uptake of vaccine delivered through the school-aged flu programme was up on last year with the target uptake of 40% overall exceeded in all local authority areas. Uptake tended to be lower in older children with uptake decreasing with each year group; this is in line with national data. More than 61,000 children received their vaccines through this programme delivered by the BHFT school immunisation team who engaged with 400 schools and also ran several mop-up clinics across Berkshire.

15,462 doses were delivered through community pharmacy and 200 doses to pregnant women in maternity services. Numbers of pregnant women vaccinated in Wexham Park Hospital were significantly reduced compared to 2016-17, when a different delivery model based on a single lead midwife was in operation. In 2017-18 the model was for more mid-wives to be able to vaccinate, however this loss of "ownership" within a busy service has resulted in less women being vaccinated. This is being reviewed for 2018-19.

It was noted that groups with the highest relative risk of mortality from flu have the lowest uptake (kidney, neuro, immunosuppressed, chronic liver disease). These should be the highest priority groups. It was discussed that may of these patients may receive most of their care in the hospital setting rather than at GP and that working with hospital specialties to increase staff awareness of the eligible patient groups and the ability / time / confidence of these staff in signposting and supporting patients to attend GP or pharmacy for their vaccine was an area of work that could be taken forward on a more systematic basis

It was also discussed that people with learning disabilities are eligible for flu vaccine as part of the neurological conditions risk group. See 'learning from local areas' for more discussion.

2018/19 Commissioning Intentions
The commissioning intentions are very similar to last year. Key changes are that school year 5 children are added to the school-aged programme, with an uptake ambition of 40 to 65%.

Community pharmacy will again be commissioned nationally to provide vaccine to all eligible adult groups. It is expected that the PGD will be published in August to support this.

In Oxfordshire and Buckinghamshire renal units have been commissioned to provide flu vaccine to eligible CKD patients attending for dialysis. Discussions regarding rolling this out in Berkshire are currently under way.

Flu vaccine recommendations and availability

The higher burden of H3N2 among elderly people together with the lower VE of vaccines against this sub-type support the need for more effective interventions[1] and the UK Joint Committee on Vaccination and Immunisation has advised that use of adjuvanted trivalent inactivated vaccines (TIV) in those aged 65 years and older would be both more effective and cost-effective than the non-adjuvanted trivalent or quadrivalent vaccines currently in use[2].

In February 2018, NHS England wrote to GP Practice and Community Pharmacies advising that they should offer;

- adjuvanted trivalent vaccine (aTIV) for all 65s and over
- quadrivalent vaccine (QIV) for those age 18 to 64 at risk

LAIV nasal vaccine should continue to be offered to healthy children aged 2 and above

It was raised that in previous years, community pharmacies have received their vaccine stocks before general practice which has led to dissatisfaction among practices that are then left with vaccines.

Q: *Would this happen again this year?*

A: *As there is a single supplier of the adjuvanted vaccine stocks will be made available to both practices and pharmacies in three phases 40%/20%/40% in Sept/Oct/Nov), therefore these issues are less likely to impact on practices in the same way this year.*

ACTION:
HA to escalate to National Flu team and feed back

This phased approach may mean that practices may need to change the way they deliver vaccine.

RECOMMENDATION:
Practices should consider adopting a mixed approach to clinics, rather than >65 clinics only. Clinics will need to be spread out through September, October and November in order to offer adjuvanted vaccine to over 65s.

NHS England next steps
July

- Renal Flu implementation in Berkshire
- NHS England South East (Thames Valley) Action plan and timelines

[1] https://assets.publishing.service.gov.uk/government/uploads/system/uploads/attachment_data/file/641162/Influenza_vaccine_effectiveness_in_primary_care_1617_final.pdf
[2] https://www.gov.uk/government/publications/flu-vaccination-supporting-data-for-adult-vaccines/summary-of-data-to-support-the-choice-of-influenza-vaccination-for-adults-in-primary-care

August
- Thames Valley Comms Plan developed
- GP briefing, LPC Meeting & final provider checks

September
- Start of Seasonal Flu Season
- Seasonal Flu training Workshops- OVG hosted
- First Fortnightly stakeholder teleconference

It was raised that it would be useful to have a timeline of when leaflets, PGDs, etc will be available to share with all stakeholders as part of the NHS England South East (Thames Valley) Action plan

ACTION:
Harpal to take this request back to the team in NHSE and let local flu leads know

Key learning from local areas, LA / CCG Flu leads

East of Berkshire CCG - Jo Greengrass
- Monthly meeting useful – to discuss how the flu season is going, review data to identify practices that might need support – particularly in Slough, encourage learning from one another
- Hoping to do a flu survey of patients in Slough to understand why they aren't having the vaccine
- Improvements in RBWM with better care fund money to work with the practices to give advice about how they can improve uptake
- RBH – increase in number vaccinated

Berkshire West CCG – Victoria Farley
- Lots of changes in landscape – emerging alliances can support each other increase in vaccine uptake in reading
- Plans now in place in the CCG

Bracknell Forest PH team – Annie Yau-Karim
- There have been internal issues with HR to identify the numbers working for them that require vaccine
- Working with community groups to promote vaccine including Polish, GRT, NCT – e.g. Polish group through a closed Facebook Group used by polish mums

- **RBWM PH team – Sian Smith**
- Workforce – social care outsourced so struggled to get staff – took time to identify number of staff they had
- They also had difficulty sourcing vaccinate – more costly to organise directly than to pay e.g. Lloyds to do
- Discussed the possibility of several groups working together to order vaccine in bulk which could reduce the individual cost

ACTION: JJ to coordinate a meeting of LA flu leads to enable discussion and agreement on this can take place ASAP

Slough PH team - Tim Howells
- Targeting Comms – work with local groups to get messages out challenges Polish

and Roma community
- Using the NCMP as inspiration they plan to use personalised letter for school to tell them how they can improve – so this year schools will get personalised letter with the number of pupils vaccinated – aim to dispel myths
- ACTION discuss that will try to roll out across all Berks these individual letters for schools
- Also discussed the possibility of approaching governors as well as heads
- Internal issues with not knowing frontline staff – there will be a working group set up to assess vaccine for council staff

Reading PH team - Suzie Watt
- Key issues are relationship, social media, community groups
- Working with LA colleagues year on year to embed the staff flu vaccination offer, although budget reductions may mean that this is at risk for 2018-19 **– see above action**

West Berks PH team - Maria White
- Social media using content of local system leaders CEO and local GP being vaccinated to underpin importance of vaccination - has proved engaging as shown by analytics
- Have encouraged key council staff to promote vaccine within directorates Flu champions have come forward as a result of survey last season
- Laminated winter readiness pack with summary has been helpful

Wokingham PH team - Carol-Anne Bidwell
- Staff vaccination clinics – went well, mentioned as staff benefit for new starters at the council
- Key areas such as community mental health, children centres were cancelled due to lack of demand – this requires further thinking about which sites and venues offer best accessibility for staff
- Care home staff are a top priority for next year

Berkshire Care Homes Association
- Care home staff vaccination letter came very late last year, discussed that the letter would be helpful earlier
- Would be helpful to have a coordinated communications approach about vaccination for care staff with emails spread out over time with gentle reminders rather than all at once.
- Also need to have clear message about where staff can access their vaccine – GP/Pharmacy and what evidence might be required

ACTIONS:

- **HA to seek further clarity from national team / NHSE regarding care workers vaccination offer**
- **HA to ensure that comms plan includes messages, channels and time frame that these will go out to this group**
- **JJ to liaise with local flu leads in LAs and CCGs to ensure care homes and domiciliary care do not get bombarded with information**

Berkshire Healthcare Foundation Trust
- Issues with staff for prophylaxis – difficulty if Occupational Health outsourced, consultants don't work full time etc. Clarified that provision of prophylaxis for exposed staff is an occupational health responsibility for community trust

ACTION:

DGi to share documentation on OH responsibility with BHFT

Royal Berkshire Foundation Trust

- Staff vaccination programme – offering clinics at different times to meet working patterns of staff
- Developing internal posters using images of staff members with the "I got a flu vaccine because…" content went down well
- Awarding wards / offices a basket of fruit for highest uptake was a low cost incentive

Involve Bracknell on behalf of Voluntary organisations

- Involve asked why voluntary workers providing support to vulnerable groups are not offered a flu vaccination and who would be responsible for providing / funding this. The work of these agencies helps to keep people out of hospital so is there a moral obligation to offer vaccine to volunteers in order to protect clients and ensure service can continue over winter when flu is circulating.

JJ agreed there is a need to think about how this can be discussed/addressed.

ACTION:
JJ to discuss scope of LA flu vaccine offer with LA and CCG flu leads

Specific discussion followed around how to better reach people in the clinical risk groups with higher relative risk such as neurological conditions, immunosuppression and kidney and liver disease and also specific actions that could be taken to ensure that people with LD receive information in a way that is appropriate and useful and enables them to make more informed choices on flu vaccine

Neurological/Liver/Renal Patients

- Consider also how inpatients/patients seen by HCWs e.g. neurology patients are also a vulnerable group
- In neuro/liver/renal patients prioritise message about protecting patients as well
- Text messaging patients in risk groups is useful particularly for those who are not regularly engaging with GPs/Pharmacy etc. – this seems to happen in lots of areas across the patch already but does not seem to result in the level of uptake we would like to see

People with Learning difficulties

- DGa – highlighted that people with learning difficulties are a priority group. SW said that TalkBack UK had co-produced a useful resource last year and that this had been shared across Berkshire
- Discussed that deaths in people with learning difficulties are now being reviewed formally
- DGi sais that OH at RBH have produced video for people with learning difficulties that could be circulated
- Discussed if something similar be done on video with other priority groups

ACTION:
SW to confirm with Talkback UK that resources can be shared to https://www.healthresourceberkshire.org/
DGi to share the link to the LD video

NHS staff
Increasing uptake

- Catherine Greaves reported sending individual email in December which prompted

stragglers to be vaccinated (about 100)

- Using lost days of work/school (+cost of this) can be powerful

Actions that will be taken as a result of the workshop – to be included and expanded upon within individual organisational flu action plans

Category	Action	Owner	Due date
Communication & Engagement	Share NHSE Thames Valley Flu Action Plan with dates, ensuring comms plan activities are included in the plan	**NHS England (Harpal / Oasis)**	Jul-18
Communication & Engagement	Arrange Berkshire LA Flu leads meeting to follow up on actions from this workshop	**JJ**	complete
Communication & Engagement	Arrange follow up meeting to agree on LA staff vaccination plans	**JJ**	Jul-18
Communication & Engagement	Agree timeline of communications from LAs and CCGs to ensure this aligns with NHSE and delivers a steady stream of information throughout flu season	**CCG and LA flu leads, providers**	Dependent on NHS England flu plan
Communication & Engagement	Work with clinicians in Out-Patients to promote vaccine to <65 in risk groups -	**CCG Flu leads**	Aug-18
Communication & Engagement	Promote adjuvant flu as there is widespread knowledge now that the non- adjuvant vaccine is not effective in >65s	**CCG and LA flu leads, providers**	
Communication & Engagement	Localise posters / social media content using real staff members "I had a flu jab because…."	**NHS OH leads, LA flu leads**	
Communication & Engagement	Discussion with nursing and care home commissioners providers explore possibility of including a minimum uptake for flu uptake of staff into contract	**LA commissioners**	
Communication & Engagement	Promoting hand and respiratory hygiene as part of seasonal flu actions	**LA public health, CCG comms**	
Communication & Engagement	Communication across organisations – awareness raising of LA in schools, work with school governors	**LA public health**	
Communication & Engagement	Add to letters for school about student/staff absences and time lost – evidence from pilot that vaccine in students can reduce absence in teachers	**LA public health / LA education/PHE**	
Communication & Engagement	Identify LA champions within each LA to engage Directorates in "keeping well this winter" – use expertise and make fun	**LA Public Health**	

Category	Action	Owner	Due date
Communication & Engagement	Community clinics more accessible – add one in Maidenhead	**?? SS to find out if BCF action**	
Communication & Engagement	Share flu stories / myth-busting facts that have proved effective	**BHFT Flu lead**	Jul-18
Communication & Engagement	Working with RBFRS to promote flu vaccine to residents during home visits	**JJ / LA flu leads**	Jul-18
Communication & Engagement	Share resources to help people with LD to access flu vaccine with LD teams and local community groups – upload these to Berkshire health resource website PHE, NHSE resources, powerpoint	**LA flu leads**	
Communication & Engagement	Check ok to share Talkback UK resource via www.healthresourceberkshire.org/	**SW (RBC Flu lead)**	
Communication & Engagement	Ask new portfolio holder to get involved in the flu campaign in some way	**MW (West Berkshire Flu lead)**	
Communication & Engagement	Write to clerks of school governors to ask them to support imms teams	**Public Health Berkshire**	Jul-18
Communication & Engagement	Obtain PDF of leaflet for NHS stall to advocate vax to their at-risk patients and update / recirculate	**Public Health Berkshire**	Jul-18
Communication & Engagement	Social media – to share timetable and clinics with LA social media	**BHFT**	
Communication & Engagement	Identify how best to contact CQC to advocate for flu vaccine status to be part of inspections	**JJ / LA flu leads**	
Communication & Engagement	Update schools with PH about data sharing – importance of flu	**BHFT School Imms Team**	
Communication & Engagement	Communicate - Positive messages about vaccine efficacy	**All flu leads**	
Communication & Engagement	Children's Centres / schools, HV checks (ASQ), personalised letters to schools with CCG/LA logo. Dispel myths about viral shedding	**LA / CCG flu leads BHFT School Imms Team**	
Communication & Engagement	Engage – outpatient departments, online resources BHFT for children.	**BHFT / CCG flu leads**	

Category	Action	Owner	Due date
Communication & Engagement	Provide clear messaging about new vaccine for older people to public and to primary care	**NHSE Flu leads / comms, LA flu leads**	
Communication & Engagement	Ensure winter flu prep packs go to all schools and care homes before flu season starts	**PHE**	
Communication & Engagement	Meet target for immunisation in locality and ensure integrated service staff have equal opportunities to have flu immunisation	**BHFT / LAs**	
Communication & engagement	Develop and deliver Pharmacy Flu campaign	**NHSE / LPC / community pharmacies**	
Communication & engagement	Share stories that can be used to counter peoples reasons for NOT having a vaccine with other flu leads	**Catherine Greaves, BHFT**	
Communication & engagement	Create local posters with real staff members featured "I had my flu vaccine because ….."	**Trust/LAs/CCG**	
Communication & engagement	Link up comms more in order that messages can be pushed further with the voluntary and community sector	**Phil Cook, Involve Community Services / BF**	
Communication & engagement	Communicate uptake to give out something, i.e. fruit bowl to winning uptake wards	**BHFT/ RBHFT/ FHFT**	
Communication and engagement	Have a flu champions meeting – harness what they can do to keep flu vaccines and keeping well in winter among staff and their families and communities	**LA flu leads**	
Communication and engagement	Raise awareness of importance of hand & respiratory hygiene in nurseries primary schools by developing and delivering through a train the trainer model of delivery	**LA / CCG / PHE**	
Communication and engagement	Hand hygiene awareness of Children's Centres/nurseries – staff and children	**LA / CCG / PHE**	
Communication and engagement	Develop a targeted campaign and action plan specifically for care workers / care homes	**LA / CCG flu leads with care home representatives**	July - August 2018

Category	Action	Owner	Due date
Communication and engagement	Keep staff flu vaccinations and flu messaging on the agenda and advocate for their importance in the system	**LA**	July - August 2018
Communication and engagement	Take 2017-18 flu report and 2018-19 flu plan to HWBoards	**JJ and LA flu leads**	Sept-Nov 2018
Communication and engagement	Develop and share letter for schools to inform them of last years uptake and advocate for 2018-19	**TH (SBC Flu lead) / BHFT school Imms Team / PHE**	complete
Communication and engagement	Local adaption and cascade school letter to primary schools end of summer / start of new term	**LA flu leads via Education teams**	Sep-18
Communication and engagement	Set up LA-wide flu task group to develop LA flu action plan	**TH (SBC Flu lead)**	
Communication and engagement	Work with to HealthWatch to strengthen links with 'seldom heard' groups	**LA / CCG flu leads**	
Communication and engagement	Hold a Care Home Forum, to include presentation and discussion on flu prevention, containment and staff cover by the end of September	**Berkshire Care Home Association**	
Implementation	Implement flu vaccine to renal units in Berkshire	**NHS England**	
Implementation	Move to digital systems – improved data flow to GPs	**BHFT - CC**	
Implementation	Investigate cost and feasibility for contracting large pharmacies to visit premises to deliver to staff	**LA flu leads**	
Implementation	Share cost and feasibility for contracting large pharmacies to visit premises to deliver to staff with Care Home managers / commissioners	**LA flu leads**	
Implementation	Send survey to schools immediately after the flu session to get more timely feedback	**BHFT School Imms Team**	
Implementation	Provide guidance to practices and community pharmacy on three phases of availability for the adjuvanted vaccine for >65s	**NHS England (Harpal / Oasis)**	ASAP
Implementation	Request further information on vaccine for care home / nursing home staff from national team	**NHS England (Harpal / Oasis)**	ASAP

Category	Action	Owner	Due date
Implementation	Rewards / incentives for high uptake among staff	**NHS OH leads, LA flu leads**	
Implementation	Clarify commissioning arrangements and encourage HV to remind parents about flu vaccine for older children at 2 week check	**LA flu leads**	
Implementation	Flexible vaccine offer for staff vaccinations staff work 24/7 - make it easy for them to get their vaccine	**NHS OH / Flu leads**	
Implementation	Explore potential for joint commissioning flu vaccines for LA staff to deliver better value	**LA flu leads**	Jul-18
Implementation	Discussion with nursing and care home commissioners providers explore possibility of including a minimum uptake for flu uptake of staff into contract	**LA commissioners**	
Implementation	Share practice level uptake and numbers of unvaccinated patients in each risk group with practices	**NHS England (Harpal / Oasis) and CCG flu leads**	
Implementation	Support practices to offer clinics evening and weekends or through extended hours services	**CCG flu leads**	
Implementation	Work with RBFRS to explore possibility of enabling the BHFT school nurse team to offer mop-up sessions in the RBFRS outreach vehicle	**JJ / LA flu leads**	Jul-18
Implementation	Provide hand hygiene details to all schools via winter pack	**PHE/JJ/SD**	Oct-18
Implementation	Explore whether community midwives can be commissioned as flu vaccinators by CCGs?	**JG / VF to discuss with NHS England**	ASAP
Implementation	Try to arrange Maidenhead mop up for flu	**BHFT School Imms / RBWM Flu lead**	
Implementation	Flexible clinic times weekends / nights within Acute settings	**RBHFT / FHFT**	
Implementation	Explore possibility for GP flu clinics as part of Extended Hours services in Berkshire East	**East Berkshire CCG**	
Implementation	Explore possibility for GP flu clinics as part of Enhanced Access Services in Berkshire West	**Berkshire West CCG**	

Category	Action	Owner	Due date
Implementation	Help to increase child flu uptake within GP practice – promote flu vaccine in child imms clinics and at point of contact when booking an appointment for patients in risk groups	**CCG flu leads / NHSE commissioners**	
Implementation	Digital development. – electronic consent form	**BHFT School Imms Team**	Autumn
Implementation	Write flu uptake targets as a quality indicator in contracts with care providers	**LA and CCG care commissioners**	
Implementation	Share practice level uptake data with practices monthly to encourage uptake		
Implementation	Provide clarity on phased approach for adjuvanted vaccine delivery to GPs and Pharmacies	**NHS England**	
Implementation	Support practices to plan for mixed clinic approach spread out through September, October and November in order to offer adjuvanted vaccine to over 65s.	**CCG flu leads**	
Implementation	Set up and share dates for East Berkshire Flu Action Group	**JG**	complete
Monitoring & Evaluation	Agree what aims are for flu vaccine awareness campaigns – what does success look like, how will we measure it - social media engagement, surveys etc	**All Flu leads with comms teams**	Aug-18
Monitoring & Evaluation	Set out ambitions for LA staff flu uptake and gather denominator data before implmenting	**LA flu leads**	Jul-18
Monitoring & Evaluation	Share findings from flu survey in Berkshire East	**JG / TH**	Jul-18
Monitoring & Evaluation	Set up and share dates for Berkshire West Flu Action Group	**JJ**	Jul-18
Monitoring & Evaluation	Set up and share dates for Fortnightly NHSE teleconferences	**NHS England**	Aug-18
Secondary prevention	Ensure that outbreak response is discussed on fortnightly flu calls and as part of Berkshire Flu Action Groups	**NHS England / CCG /JJ**	From September 2018
Secondary prevention	Share guidance on occupational health responsibilities around antivirals for staff exposed to flu	**DGi**	ASAP
Secondary prevention	Get the antivirals commissioning arrangements in place by the beginning of the flu season	**CCG flu leads**	Aug-18

Category	Action	Owner	Due date
Secondary prevention	Clarify process for prophylaxis for exposed staff within BHFT	**BHFT flu leads / IPC leads**	
Secondary prevention	Find out about RDTs and bringing these into use locally	**CCG flu leads**	
	Get a job. Give a jab (pledge to donate to 3rd world vaccine programme)	**All**	

READING HEALTH AND WELLBEING BOARD

DATE OF MEETING:	**12th OCTOBER 2018**	**AGENDA ITEM:**	**11**
REPORT TITLE:	**CONSULTATION – PHARMACEUTICAL SERVICES APPLICATION**		
REPORT AUTHOR:	**MARION GIBBON**	**TEL:**	**0118 937 4538**
JOB TITLE:	**INTERIM CONSULTANT IN PUBLIC HEALTH**	**E-MAIL:**	**Marion.Gibbon@reading.gov.uk**
ORGANISATION:	**COMMISSIONING & WELLBEING TEAM**		

1. PURPOSE OF REPORT AND EXECUTIVE SUMMARY

1.1 This paper is to update the Health and Wellbeing Board (HWB) on an application received to consolidate Boots UK Ltd, 45 St Martins Precinct, Church Street Reading, Berkshire RG4 8BA and Day Lewis PLC, Rankin Pharmacy currently at 30 Church Street, Reading, Berkshire, RG4 8AU.

1.2 Paragraph 19 (5), Schedule 2 of the NHS (Pharmaceutical and Local Pharmaceutical Services) Regulations 2013 (as amended) requires the HWB to make representation on consolidation applications to NHS England.

1.3 Representation should be sent within 45 days of the date of the initial notice.

1.4 An application has been received (see Appendix A, B and C) and a response is needed by 29th October 2018.

2. RECOMMENDED ACTION

2.1 Note the impact on local provision (outlined in Section 4.2 and 4.3)of the application to consolidate (Appendix B).

2.2 To support the proposed response that if this application were to be granted, that the removal of premises from the local pharmaceutical list would not create a gap in local pharmaceutical service provision.

3. BACKGROUND

3.1 As outlined in the Health and Social Care Act 2012 – as of the 1st April 2013 every HWB has had a statutory responsibility to publish, and keep up to date, a statement of the needs for pharmaceutical services in their area. This is referred to as the Pharmaceutical Needs Assessment (PNA). The most recent PNA was endorsed by the HWB and published 1st April 2018.

3.2 Paragraph 19 (5), Schedule 2 of the NHS (Pharmaceutical and Local Pharmaceutical Services) Regulations 2013 (as amended) requires the HWB to make representations on consolidation applications to NHS England. Those representations must (in addition to any other matter about which the Health and Wellbeing Board wishes to make representations) indicate whether, if the application were granted, in the opinion of the Health and Wellbeing Board the proposed removal of premises from the pharmaceutical list would or would not create a gap in pharmaceutical services that could be met by a routine application (a) to meet a current or future need for pharmaceutical services, or (b) to secure improvements, or better access, to pharmaceutical services.

3.3 Applications to consolidate are dealt with as "excepted applications" under the 2013 Regulations, which means they are not assessed under the local PNA, rather they follow a simpler procedure. They key focus is whether or not a gap in pharmaceutical service provision will be created as a result of the consolidation.

3.4 Some provision is made in respect of continuity of services – for example, if the NHS Commissioning Board (NHSCB) intends to commission from the applicant "enhanced services" (additional pharmaceutical services, such as minor ailments schemes, that are commissioned locally) that have been provided at or from the closing premises, the applicant is required to provide undertakings to continue to provide those services (regulation 11). If the NHSCB is satisfied that the consolidation would create a gap in pharmaceutical services provision, it must refuse the application (regulation 7).

3.5 The opinion of the HWB on this issue must be given when the application is notified locally and representations are sought (regulations 12 and 13). If the application is granted and pharmacy premises are removed from the relevant pharmaceutical list, if the HWB does not consider that a gap in service provision is created as a consequence, it must publish a supplementary statement published alongside its pharmaceutical needs assessment recording its view (regulation 3).

3.6 Also, if the NHSCB does grant the application, it must then refuse any further applications known as "unforeseen benefits applications" by other chemists seeking inclusion in the pharmaceutical list, if the applicant is seeking to rely on the consolidation as a reason for saying there is now a gap in provision, at least until the next revision of the PNA (regulations 5 and 6).

3.7 The Health and Wellbeing Board's representations need to be returned within 45 days of an application being received. Comments submitted will be shared with other interested parties and the application, and may be shared under the Freedom of Information Act as requested.

4. CURRENT APPLICATIONS

4.1 The HWB received a letter from the NHSCB (Appendix A) dated 14th September 2018 notifying us of an application (Appendix B) for consolidation of Boots UK Ltd, 45 St Martins Precinct, Church Street Reading, Berkshire RG4 8BA and Day Lewis PLC, Rankin Pharmacy currently at 30 Church Street, Reading, Berkshire, RG4 8AU (see Appendix C for map).

4.2 If this application were to be granted, it is the opinion of Officers based on evidence from the PNA together with contractual information for locally commissioned services, that the proposed removal of premises from its pharmaceutical list would not create a gap in pharmaceutical service provision that could be met by a routine application by a routine application (a) to meet a current or future need for pharmaceutical services; or (b) to secure improvements, or better access to pharmaceutical services.

4.3 Both pharmacies provide locally commissioned services (LCS) for supervised consumption. The consolidation will have no impact on supervised consumption this is the proviso that staff delivering the services under the relevant patient group directives remain in post.

4.4 Both pharmacies have been offered contracts to deliver emergency hormone contraception [EHC] however only Rankin Pharmacy has a signed contract and has small activity. The consolidated site will have the opportunity to deliver this service, but this will be dependent on a signed contract and having appropriately trained staff onsite to deliver. There are other local provisions in the area which also deliver EHC but this is to be noted.

4.5 Neither site currently offer provision of needle exchange but should the need arise in the future a single provision would sufficiently meet the need in the community.

4.6 The consolidation will have no impact on opening hours nor will it create any significant additional travelling time to local residents.

4.7 The consolidation will have no impact on the community's access to a Health Living Pharmacy. Both sites are currently Healthy Living Pharmacies, and there is no plan to remove this function for the consolidated service.

4.8 Based on this evidence the sources of information available it is our assessment that the removal of this premises would not create a gap in local pharmaceutical service provision that will or could not be met.

5. SUPPORTING PAPERS

- Appendix A – Notification of Application to HWB 14.9.2018
- Appendix B – Consolidation Application
- Appendix C – attachments

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Our reference: PCC-201718-23

Sent via email

Nicky Simpson
Committee administrator
Reading Health and Wellbeing Board
Reading Borough Council

PCC
Suite 1A
West One
114 Wellington Street
Leeds
LS1 1BA
Email: consolidations@pcc-cic.org.uk
Phone: 0113 2124 180

14 September 2018

Dear Nicky

Consolidation onto the site at 45 St Martins Precinct, Church Street, Reading, Berkshire RG4 8BA of Boots UK Ltd already at that site and Day Lewis PLC, Rankin Pharmacy currently at 30 Church Street, Reading, Berkshire RG4 8AU

We have received the above application, a copy of which is enclosed, and have completed our preliminary checks. We are now notifying interested parties of the application.

Paragraph 19(5), Schedule 2 of the NHS (Pharmaceutical and Local Pharmaceutical Services) Regulations 2013 (as amended) requires the Health and Wellbeing Board to make representations on consolidation applications to NHS England.

Those representations must (in addition to any other matter about which the Health and Wellbeing Board wishes to make representations) indicate whether, if the application were granted, in the opinion of the Health and Wellbeing Board the proposed removal of premises from the pharmaceutical list would or would not create a gap in pharmaceutical services that could be met by a routine application (a) to meet a current or future need for pharmaceutical services, or (b) to secure improvements, or better access, to pharmaceutical services.

The Health and Wellbeing Board's representations should be sent to me via the above email address within 45 days of the date of this letter i.e. by 29 October 2018. You should note that any comments submitted will be shared with other interested parties and the applicant, and may be shared under the Freedom of Information Act as requested.

NHS England will consider all representations that are received and will arrange an oral hearing to determine the application if it identifies a matter on which it wishes to hear further evidence.

Yours sincerely

Charlotte Goodson
Adviser

Enc

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Chapter 12A

Annex 2

Draft Application Form

Application in respect of a consolidation onto an existing site

Application in respect of a consolidation onto an existing site in the area of:

....Reading Health and Wellbeing Board.....

A consolidation application must be in relation to pharmacy premises that are located within the area of a single health and wellbeing board.

This is an application in respect of a consolidation onto an existing site and as such is an excepted application under regulation 26A (1) of the NHS (Pharmaceutical and Local Pharmaceutical Services) Regulations 2013 (the "**Regulations**").

Please complete this form as legibly as possible.

Applicants should note that information provided in this form may be disclosed where this application is required to be notified to other parties or in response to a request made under the Freedom of Information Act 2000. Applicants are referred to paragraph 21 of Schedule 2 of the Regulations which sets out NHS England's responsibilities in relation to information provided in this application form which an applicant advises is confidential.

1 Information regarding the applicant

1.1 Full name and correspondence address of the applicant (i.e. the contractor who will continue to provide services)

Boots UK Limited NHS Contracts Team D90 East F08 Nottingham NG90 1BS

1.2 Applicant's legal entity

I/we am/are applying as a:
(Please tick relevant box. Only one box may be selected. GPhC registration numbers only need to be provided for pharmacy applications.)

Sole trader ☐ **My GPhC registration number is .....**

Partnership ☐

Please list each partner and their GPhC registration number: Please continue on a separate sheet if necessary.

Corporate Body ☑

Superintendent's name and GPhC registration number is	Mr Marc Donovan Registration Number: 2044958

I am/We are already included in the pharmaceutical list for the health and well-being board in whose area the premises listed in sections 2 and 2a below are located.

Yes ☑ No ☐

1.3 Relevant fee

I/we include the relevant fee for this application. ☑

2 Name of the current owner and address of listed premises site 1 (the continuing site)[1]

Boots UK Limited
45 St Martins Precinct, Church Street
Reading, Berkshire
RG4 8BA

I/we (the applicant) propose to carry on at site 1, the business in the course of which the above owner is providing pharmaceutical services at the above site.

These premises are currently in my/our possession* Yes ☑ No ☐

* by rental, leasehold or freehold

2a **Name of the current owner and address of listed premises site 2[3] * (the closing site)**

Day Lewis Rankin Pharmacy
30 Church Street
Reading, Berkshire
RG4 8AU

I/we confirm that, consequent on the consolidation of the listed chemist premises at site 1, the provision of pharmaceutical services from site 2 will cease. Yes ☑ No ☐

[1] This should be the name and address as it currently appears in the relevant pharmaceutical list.

If the current owners of listed premises site 1 and 2 are different, I/we confirm that this application is also an application to change the ownership of the listed premises for which I/we are not the owner.

Yes ☑ No ☐

Are either or both of the listed premises above distance selling premises or appliance contractor premises[2]? Yes ☐ No ☑

3 Opening hours

3.1 Proposed core opening hours[3]

Monday	Tuesday	Wednesday	Thursday	Friday	Saturday	Sunday	Total
09.30-14.00 15.00-17.30	09.30-14.00 15.00-17.30	09.30-14.00 15.00-17.30	09.30-14.00 15.00-17.30	09.30-14.00 15.00-17.30	09.30-14.00 15.00-15.30	Closed	40

3.2 Proposed total opening hours[4]

Monday	Tuesday	Wednesday	Thursday	Friday	Saturday	Sunday	Total
09.00am-18.00pm	09.00am-18.00pm	09.00am-18.00pm	09.00am-18.00pm	09.00am-18.00pm	09.00am-17.30pm	Closed	53.5

3.3 Current core opening hours for Site 1

Monday	Tuesday	Wednesday	Thursday	Friday	Saturday	Sunday	Total
09.30-14.00 15.00-17.30	09.30-14.00 15.00-17.30	09.30-14.00 15.00-17.30	09.30-14.00 15.00-17.30	09.30-14.00 15.00-17.30	09.30-14.00 15.00-15.30	Closed	40

3.4 Current total opening hours for Site 1

Monday	Tuesday	Wednesday	Thursday	Friday	Saturday	Sunday	Total
09.00am-18.00pm	09.00am-18.00pm	09.00am-18.00pm	09.00am-18.00pm	09.00am-18.00pm	09.00am-17.30pm	Closed	53.5

[2] NHS England must refuse a consolidation application if either or both sites are distance selling premises or appliance contractor premises.

[3] These should be the same as the current core opening hours for site 1.

[4] The total opening hours includes the core hours and any supplementary opening hours. These should be the same total opening hours as at the current site 1.

3.5 Current core opening hours for Site 2

Monday	Tuesday	Wednesday	Thursday	Friday	Saturday	Sunday	Total
09.00-13.00 13.30-17.30	09.00-13.00 13.30-17.30	09.00-13.00 13.30-17.30	09.00-13.00 13.30-17.30	09.00-13.00 13.30-17.30	Closed	Closed	40

3.6 Current total opening hours for Site 2

Monday	Tuesday	Wednesday	Thursday	Friday	Saturday	Sunday	Total
09.00-18.00	09.00-18.00	09.00-18.00	09.00-18.00	09.00-18.00	09.00-13.00	Closed	49

4 Pharmaceutical services and premises facilities to be provided at the consolidated premises - Site 1

Essential services (paragraphs 3 to 22, Schedule 4 – pharmacies) ☑

4.1 If you are undertaking to provide appliances, specify the appliances that you undertake to provide (or write 'none' if the pharmacy does not provide appliances).

Appliances will be provided as currently provided at site 1 (supplied by NWOS)

4.2 I/We confirm that the current pharmaceutical services provided at site 1 will continue to be provided consequent to the consolidation of the listed chemist premises at site 1.

Yes ☑ No ☐

4.3 Please give details of any advanced and enhanced services that are currently provided from both sites; and the services that you intend to provide from the consolidated site.

Details of NHS Pharmaceutical Services relevant to the applications	**Currently Provided at site 1 (Y/N)**	**Currently provided at site 2 (Y/N)**	**To be provided at Site 1 after consolidation (Y/N)**
Medicine Use reviews	Y	Y	Y
New Medicines Service	Y	Y	Y
Influenza vaccination service	Y	Y	Y
Supervised administration	Y	Y	Y
Minor Ailments	Y	N	Y
Emergency Hormonal Contraception	Y	Y	Y
Emergency Supply of Medicines (NHSE North Midlands)	Y	N	Y
EPS	Y	Y	Y
Malaria Prevention Service	Y	N	Y
Stop Smoking Service	Y	Y	Y
Champix	N	Y	TBC

All services currently provided at site 2 will continue to be provided at site 1 should the relevant commissioners continue to commission these services.

Please continue on a separate sheet if necessary.

4.4 These details should include a floor plan showing the consultation area where you propose to offer the services, where relevant. Where a floor plan showing the consultation area cannot be provided please set out the reasons for this.

Floor plan showing consultation area

Enclosed

4.5 Please give details of any premises facilities that are currently provided from both sites; and the services that you intend to provide from the consolidated site. Examples are listed but include others that are considered relevant.

Details of NHS Pharmaceutical Services relevant to the applications	Currently Provided at site 1 (Y/N)	Currently provided at site 2 (Y/N)	To be provided at Site 1 after consolidation (Y/N)
Access for wheelchair users	Y	Y	Y
Access without steps	Y	Y	Y
Toilet for wheelchair user	N	N	N
Induction loop	Y	Y	Y
Signing service	N	N	N
Translation service	N	N	N
Parking	Y Rear of store	N	Y Rear of store
Disabled car parking	Y Rear of store	N	Y Rear of store
Other – automatic doors	Y	N	Y

Please continue on a separate sheet if necessary.

5 Information in support of the application

5.1 Please confirm that you are/will be accredited to provide all the services included in section 4 to be provided from site 1 after consolidation where that accreditation is a prerequisite for the provision of the services. Yes ☑ No ☐

5.2 Please confirm that the premises are/will be accredited to provide all the services included in section 4 to be provided from site 1 after consolidation where that accreditation is a prerequisite for the provision of the services. Yes ☑ No ☐

5.3 Will there be any interruption to service provision? Yes ☐ No ☑

5.4 If the answer to question 5.1 or 5.2 is "no" or the answer to question 5.3 is "yes" please give full details in the box below:

Please continue on a separate sheet if necessary.

5.5 Please use the box below to explain why granting the application would not create a gap in pharmaceutical services provision that could be met by a routine application to meet a current or future need for pharmaceutical services, or to secure improvements or better access to pharmaceutical services. Applicants may wish to refer to the guidance on determining consolidation applications in Annex 20A of Chapter 12A of the Pharmacy Manual.

We believe that granting the application will not cause a gap in the provision of pharmaceutical services for the following reasons:

1 – The two sites are located a very short distance apart and only one minute or 190 foot walk from one another. Car parking facilities (including disabled parking) and bus services are accessible from both pharmacies.

2 – The Boots Pharmacy (site 1) currently provides longer total opening hours than Day Lewis Pharmacy currently at site 2. Therefore, patients will not experience a reduction in the hours pharmaceutical services are currently available.

3 – The Boots Pharmacy (site 1) will continue to provide all the services it currently provides along with any currently provided at site 2.

4 – Patients will continue to have a choice of pharmaceutical services in the locality as well as a choice of service provider. There are a further 8 pharmacies within a mile of site 1 and site 2 including extended hours access and 100 hour pharmacy operated by Tesco.

5 – The Reading Pharmaceutical Needs Assessment 2018 has not highlighted any gap in provision in Caversham.

6- We have enclosed a map showing the walk and distance between the two sites and also a map from the 2018 Reading PNA showing pharmacies in Reading.

Please continue on a separate sheet if necessary.

6 Declaration to be signed by the current owner of site 1

I/we confirm that this application is being made with my/our full knowledge and consent.

If I/we am/are not the applicant I/we will withdraw from the pharmaceutical list in respect of the premises listed in section 2 (site 1) consequent upon the consolidation of the listed chemist premises onto site 1 and the applicant being included in the list at site 1.

Signature .. ..

Name ..... Claire Brittain.....

Position ....Assistant NHS Contracts Manager....

Date 17/8/18

On behalf of the company/partnership ..... Boots.UK Ltd

6a Declaration to be signed by the current owner of site 2 (only required where the current owner of site 2 is different to the current owner of site 1)

I/we confirm that this application is being made with my/our full knowledge and consent, and that I/we will withdraw from the pharmaceutical list in respect of the premises listed in section 2a (site 2) consequent upon the granting of this application.

Signature .....

Name: Heena Patel

Position: Director

Date: 16 August 2018

On behalf of the company/partnership: Day Lewis plc

7 Undertakings

By virtue of submitting this application I/we undertake to provide pharmaceutical services at the premises listed at section 2 (site 1):

- that are already listed chemist premises,

I/We also undertake to notify the Commissioner within 7 days of any material changes to the information provided in this application (including any fitness information provided under paragraph 3 or 4, Schedule 2) before:

- the application is withdrawn,
- while the application remains the subject of proceedings, the proceedings relating to the application reach their final outcome and any appeal through the courts has been disposed of, or
- if the application is granted, I/we commence the provision of the services to which this application relates,

whichever is the latest of these events to take place.

I/We also undertake to notify the Commissioner if I/we am/are included, or apply to be included, in any other relevant list before:

- the application is withdrawn,
- while the application remains the subject of proceedings, the proceedings relating to the application reach their final outcome and any appeal through the courts has been disposed of, or
- if the application is granted, I/we commence the provision of the services to which this application relates,

whichever is the latest of these events to take place.

I/We also undertake:

- to comply with all the obligations that are to be my/our terms of service under Regulation 11 if the application is granted, and
- in particular to provide all the services and perform all the activities at the premises listed above that are required under the terms of service to be provided or performed as or in connection with essential services.

The following only applies where the applicant is seeking to provide directed services. I/We:

- undertake to provide the directed services mentioned in this application if they are commissioned within 3 years of the date of grant of this application or, if later, the listing of the premises to which this application relates,
- undertake, if the services are commissioned, to provide the services in accordance with an agreed service specification, and
- agree not to unreasonably withhold my/our agreement to the service specification for each directed service I/we are seeking to provide.

I confirm that to the best of my knowledge the information contained in my/our application is correct.

Signature .....

Name ...Claire Brittain .....

Position ... Assistant NHS Contracts Manager.....

Date 8/1/18.....

On behalf of the company/partnership ...Boots UK Limited.....

Contact phone number in case of queries... .....

Contact email number in case of queries . .....

Registered office

Boots UK Ltd
Thane Road
Nottingham NG2 3AA

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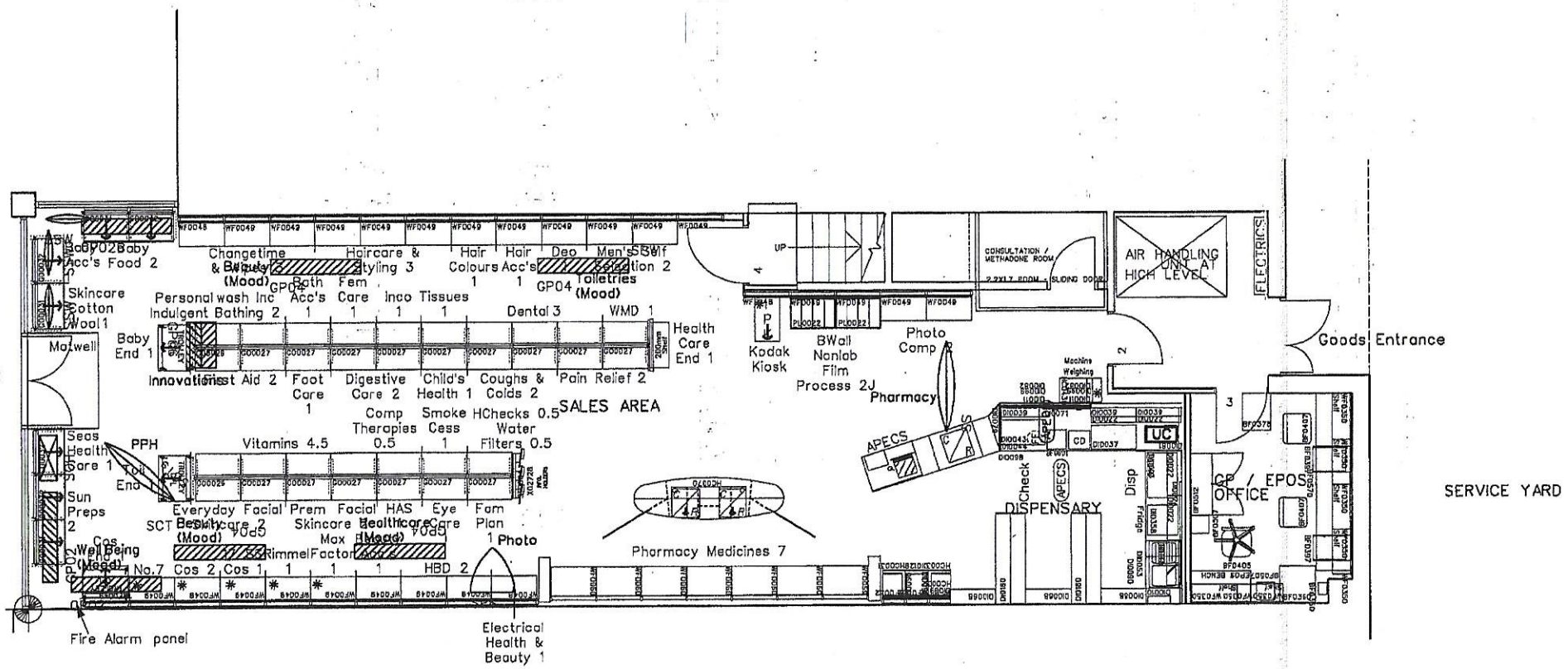
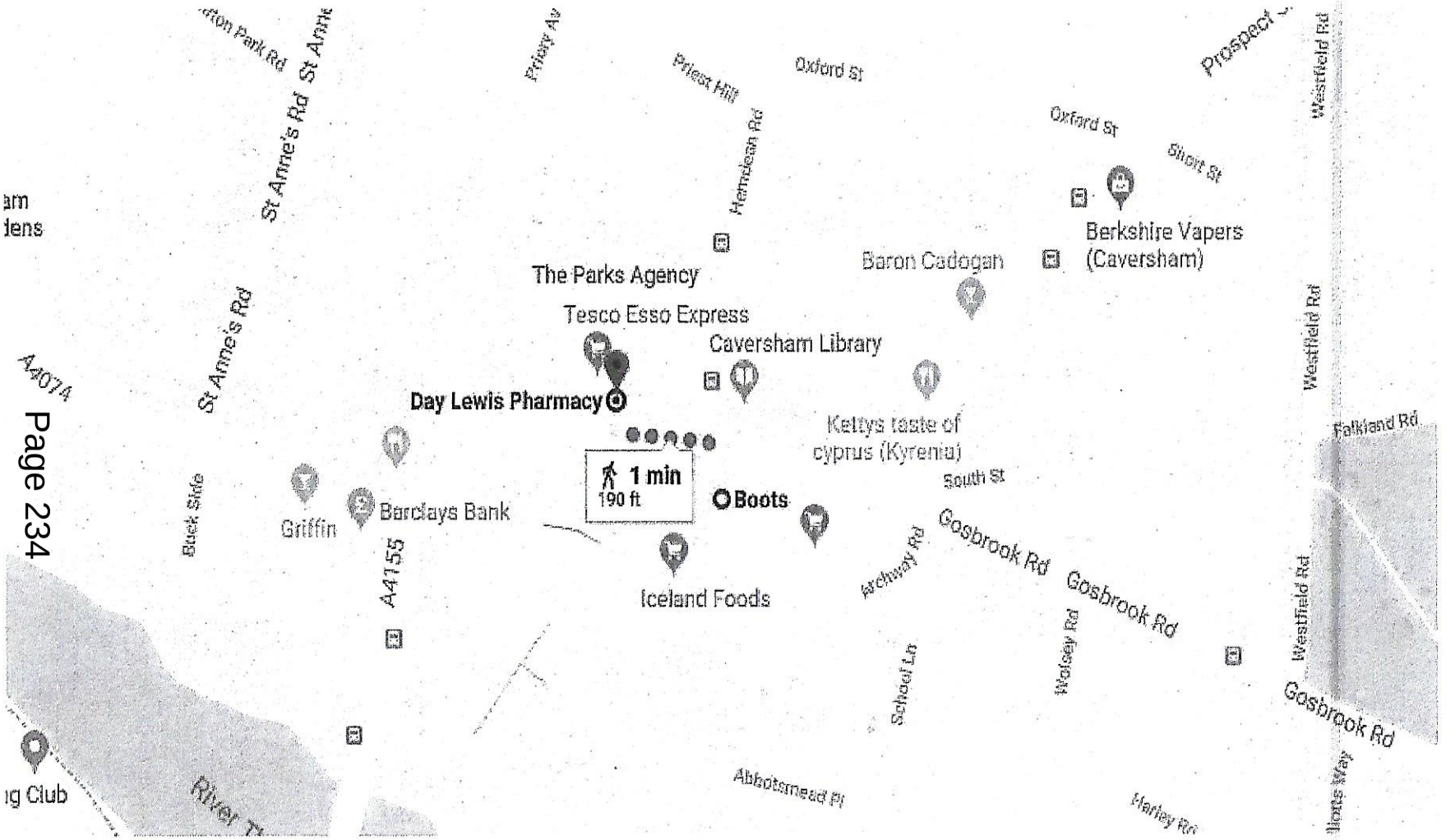


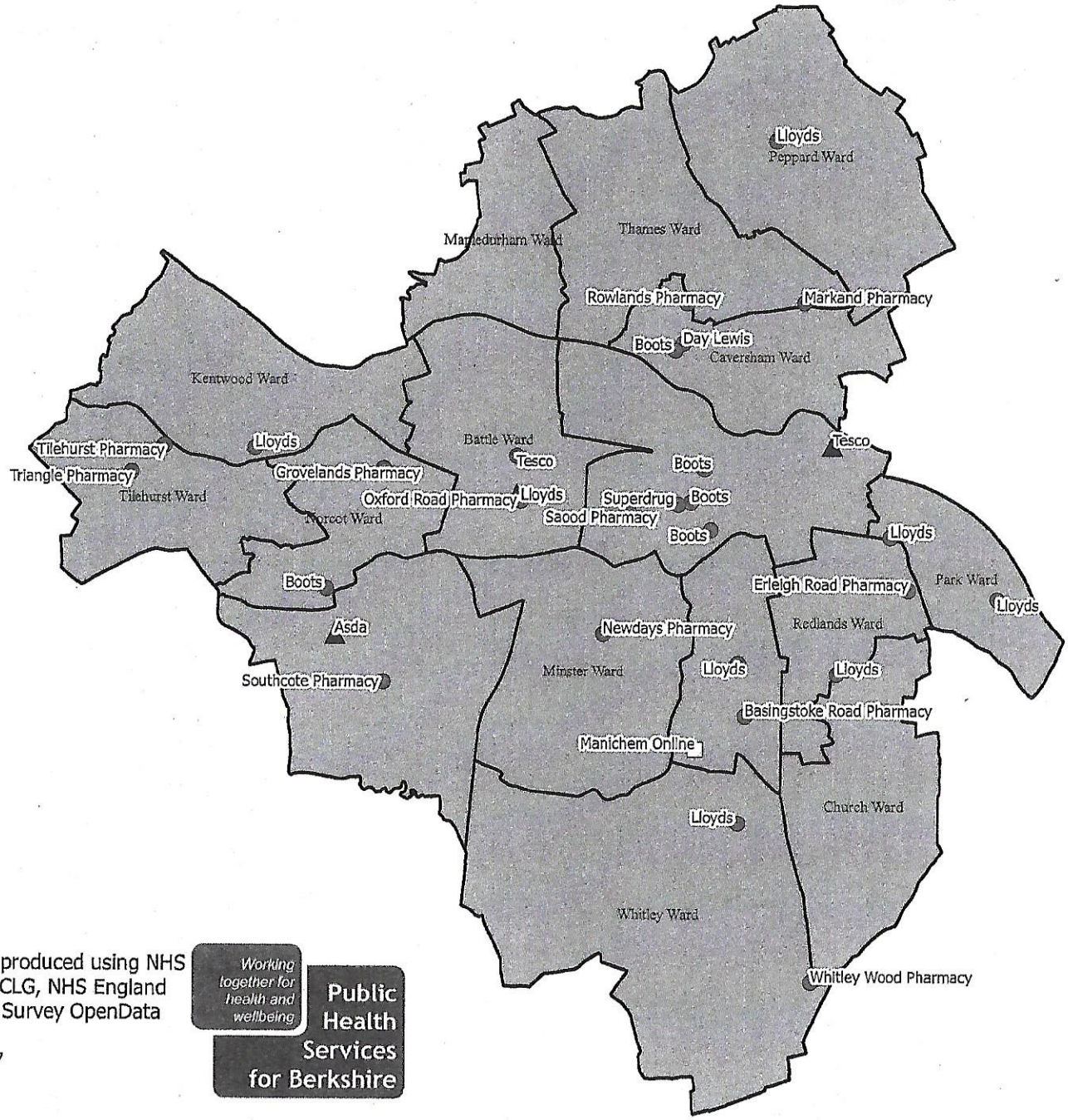
GROUND FLOOR PLAN

Boots UK Ltd - Caversham Branch floorplan

Map showing distance between Boots and Day Lewis Pharmacies.



Map 1: Pharmaceutical Services in Reading - (Oct 2017)



Legend

- Pharmacy
- 100 Hour Pharmacy
- Distance Selling Pharmacy

This map has been produced using NHS Digital ODS data, DCLG, NHS England data and Ordnance Survey OpenData (2017).
Created:14/10/2017
By:NW

Working together for health and wellbeing

Public Health Services for Berkshire

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READING HEALTH AND WELLBEING BOARD

DATE OF MEETING:	**12 OCTOBER 2018**	**AGENDA ITEM:**	**12**
REPORT TITLE:	**INTEGRATION PROGRAMME UPDATE**		
REPORT AUTHOR:	**MICHAEL BEAKHOUSE**	**TEL:**	**01189 373170**
JOB TITLE:	**INTEGRATION PROGRAMME MANAGER**	**E-MAIL:**	**MICHAEL.BEAKHOUSE@READING.GOV.UK**
ORGANISATION:	**READING BOROUGH COUNCIL / BERKSHIRE WEST 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 performance against the national BCF targets within the financial year 2018/2019.

1.2 Of the 4 national BCF targets:

- Performance against three (limiting the number of new residential placements, increasing the effectiveness of reablement services, and reducing the number of delayed transfers of care) is strong, with key targets met.
- 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 The BCF Operating Guidance for 2017/2019 was refreshed in late July to include information on the revised targets for 2018/2019. These are now in effect and are detailed below, alongside an overview of our performance against them.

DTOC

4.2 Under our revised target for 2018/2019, we have aspired to having no more than 419.75 bed days lost per month broken down as follows:

- Health attributable – no more than 211 bed days lost
- ASC attributable – no more than 175 bed days lost
- Both attributable – no more than 33 bed days lost

4.3 Our results across the financial year to date are as follows:

- April = 421 (of which 315 Health, 106 ASC, 0 joint)
- May = 322 (of which 250 Health, 62 ASC, 10 joint)
- June = 272 (of which 236 Health, 2 ASC, 34 joint)
- July = 348 (of which 210 Health, 63 ASC, 75 joint)

4.4 Within each month, there has been a greater volume of Health delays (in each case exceeding the health-attributable days delayed target set by NHSE). The predominant reason for Health delays is "awaiting further non-acute NHS care".

4.5 In terms of our local schemes' impact on the DTOC rates:

- *Community Reablement Team (CRT)* - the service appears to have engaged with 24 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 24 delayed transfers of care. When taking the average length of stay in the service into account, and working on the assumption that clients would've spent an equivalent amount of time in hospital had they not accessed CRT, it would appear that the service has prevented 468 delayed days in hospital. Assuming a cost of £400 per NHS bed/day, this would equate to a cost avoidance of £187,200.
- *Discharge to Assess (D2A)* - the service appears to have engaged with 15 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 15 delayed transfers of care. When taking the average length of stay in the service into account, and working on the assumption that clients would've spent an equivalent amount of time in hospital had they not accessed D2A, it would appear that the service has prevented 282 delayed days in hospital. Assuming a cost of £400 per NHS bed/day, this would equate to a cost avoidance of £112,800.

4.6 We continue to proactively address DTOC performance by:

- Holding a weekly Directors' meeting – during which the ASC Directors from the 3x Berkshire West Local Authorities, the Director of Berkshire West CCGS, and senior managers from Berkshire Healthcare Foundation Trust and Royal Berkshire Hospital review and sign-off the weekly delays. Trends in delays are discussed and remedial actions agreed.

- Working with the Berkshire West 10 Delivery Group to implement the High Impact Model across the Berkshire West system.

Residential Admissions

4.7 Our target is to have no more than 116 new residential admissions for older people. Under the revised BCF Operating Guidance, we have been offered the chance to revise / relax our targets, but due to the strong performance in 2017/2018 we have opted not to do so.

4.8 We have had 36 new residential admissions in the financial year, and based on performance we estimate 106 admissions in total by the close of the year.

4.9 In terms of our local schemes' impact on the rate of residential admissions:

- *CRT* – 38 clients were living at home prior to entering the service, and subsequently returned home rather than progressing to a residential or nursing placement upon leaving the service. The service could therefore be argued to have prevented 38 entrances into residential care. Taking the average cost of a residential / nursing placement, this could equate to full-year effect cost avoidances of around £1,420,744.

- *D2A* – 20 clients were living at home prior to entering the service, and subsequently returned home rather than progressing to a residential or nursing placement upon leaving the service. The service could therefore be argued to have prevented 20 entrances into residential care. Taking the average cost of a residential / nursing placement, this could equate to full-year effect cost avoidances of around £747,760.

Reablement

4.10 Our target is to maintain an average of 93% of people remaining at home 91 days after discharge from hospital into reablement / rehabilitation services. This is an increase from the 88% target set for 2017/2018.

4.11 Based on our performance to date, we have achieved an average of 97% of service users remaining at home 91 days after discharge from hospitals into our Community Reablement Service and Discharge to Assess service.

Non-Elective Admissions (NELs)

4.12 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 15,190 NELs in 2018-2019 (or no more than 1266 per month).

4.13 Based on our most recent performance data, we are projecting a total of 16,048 NELs across 2018-2019. This equates to an increase of 5.59% compared to the target reduction of 0.97%.

4.14 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.

4.15 In terms of our local schemes' impact on the rate of NELs:

- *CRT* - by engaging with 82 "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 82 NELs[1].

- *D2A* - by engaging with 9 "rapid referrals" (all of which did not progress onwards to hospital following discharge from the service), the service appears to have prevented 9 NELs.

4.16 Further actions to improve NEL performance are being progressed by the Berkshire West 10 Integration schemes that are designed to reduce NELs.

Note on CRT performance against local targets

4.17 The RAG-rating system used to summarise a project or service's overall performance status will be coded "amber" if there are one or more "amber" areas of performance (where performance is up to 20% off the target performance level), or "red" if there are one or more "red" areas of performance (where performance is over 20% off the target performance level).

4.18 Performance against CRT's local targets is "red" in the following areas:

- Average staff utilisation level per month – the projected annual performance (based on performance to date) stands at 49%, compared to the target of 90%. This will be addressed through the review of CRT that is currently being completed by the Commissioning and Social Care Manager.

- Proportion of returned service user feedback forms – the projected annual performance (based on performance to date) stands at 14%, compared to the target of 50%. The service has had initial conversations with Healthwatch to discuss methods of increasing the volume of returned service user feedback forms, and this will inform future strategies that are generated by the review of CRT that is currently being completed by the Commissioning and Social Care Manager.

Note on D2A performance against local targets

4.19 The RAG-rating system used to summarise a project or service's overall performance status will be coded "amber" if there are one or more "amber" areas of performance (where performance is up to 20% off the target performance level), or "red" if there are one or more "red" areas of performance (where performance is over 20% off the target performance level).

4.20 Performance against D2A's local targets is "red" in the following areas:

- Cumulative number of Step up / Step down beds throughput– the projected annual performance (based on performance to date) stands at 67, compared to the target of not less than 120.

- Average bed occupancy levels – the projected annual performance (based on performance to date) stands at 37%, compared to the target of 88%.

[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.*

- We believe that these performance levels reflect a decreasing demand for the service, as referrers are exploring "home first" discharge opportunities for clients who are discharged from hospital – rather than seeking bed-based reablement. We are currently exploring alternative methods of delivering Discharge to Assess and reablement (proposals for which are currently being consulted on), and we believe that these have the potential to match the D2A service offer with established demand for the service.

5. PROGRAMME UPDATE

5.2 Since March, the following items have been progressed:

- **Joint working between Adult Social Care (ASC) and North/West and South Reading GP Alliances** – The planned start date for piloting this work has been deferred due to the need to develop new information sharing / information governance arrangements. We aim to finalise these and begin the pilot in the Autumn.

- Conversations with stakeholders are ongoing regarding new methods of **delivering reablement** within Reading. A set of proposals have been reviewed with the CCG and will be presented to senior managers and Councillors within Reading Borough Council for review and decision.

- Developing, seeking/receiving sign-off for, and beginning to progress the delivery of Reading Borough Council's plan to **deliver against NHS England's expectations for integration**.

- Preparing a joint workshop for health partners, the voluntary sector and Reading Borough Council to agree how the Reading System would **deliver wider integration**. Please note that this has been indefinitely postponed following the BW10 Chief Officers' steer that integration should be approached on a Berkshire West-wide basis.

- **Redesigning the Reading Integration Board** in light of the BW10 Chief Officers' steer that Local Integration Boards should reconfigure (or replace) themselves with a forum which is most helpful for local needs

6. NEXT STEPS

6.1 The planned next steps for October - January include:

- 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.

- Supporting Berkshire West 10-wide discussions and plans regarding opportunities for wider integration across Berkshire West.

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 has been covered by the CCG and the underspend on LA items was, in agreement with the CCG, carried forward to 2018-19 and shared between the LA and CCG for use on Better Care Fund priorities.

12. BACKGROUND PAPERS

12.1 September's Performance Dashboard.

Integration Dashboard

Month: August 2018

BCF Target 1: NELS	Total Non-elective spells (specific acute) per 100,000 population
Status	Amber
Status change since last month	↑
BCF Target 2: Residential Admissions	Long-term support needs of older people (aged 65 and over) met by admission to residential and nursing care homes, per 100,000 population
Status	Green
Status change since last month	↑
BCF Target 3: 91 Days	Proportion of older people (65 and over) who were still at home 91 days after discharge from hospital into reablement / rehabilitation services
Status	Green
Status change since last month	↑
BCF Target 4: DTOC	Delayed transfers of care from hospital per 100,000 population
Status	Green
Status change since last month	↓
iBCF Quarterly performance	To support the aims of the Integration and BCF Policy Framework
Status	Amber
Status change since last month	→

Local Services (overall performance status):

Step up / Step down beds (The Willows)	
Status	Red
Status change since last month	→
Community Reablement Team (CRT)	
Status	Red
Status change since last month	→
Disable Facilities Grant (DFG)	
No targets are set for this provision	
Mental Health Social Worker in Prospect Park Hospital	
Status	Amber
Status change since last month	→

BCF Target 1: NELs

BCF Target:	Reduction in total Non-elective spells (specific acute) per 100,000 population - NELS
Related services / schemes:	Community Reablement Team; Discharge to Assess
Reporting Period:	Month 4 (July 2018)
Status:	Amber

Target description:

New Target calculates every year as a **0.97%** reduction of the previous year's actual NELs number

Actual NELs 2017/18

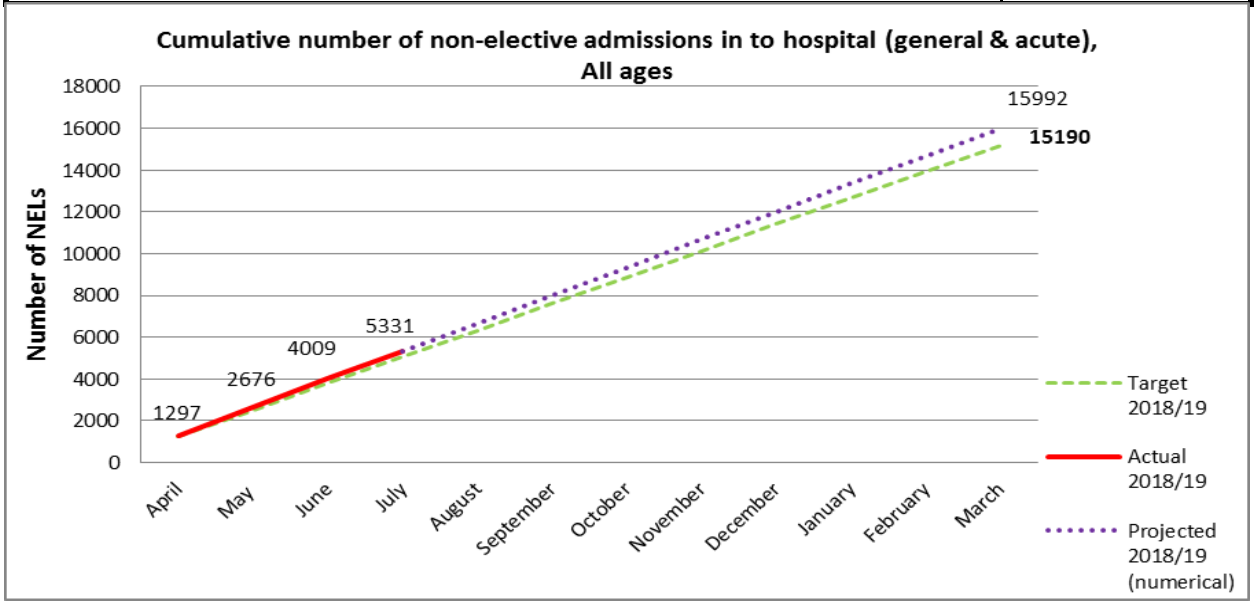
Per year	**15339**
Per calendar month (average)	**1278**

Target NELs 2018/19 based on 0.97% reduction of Actual NELs in 2017/18

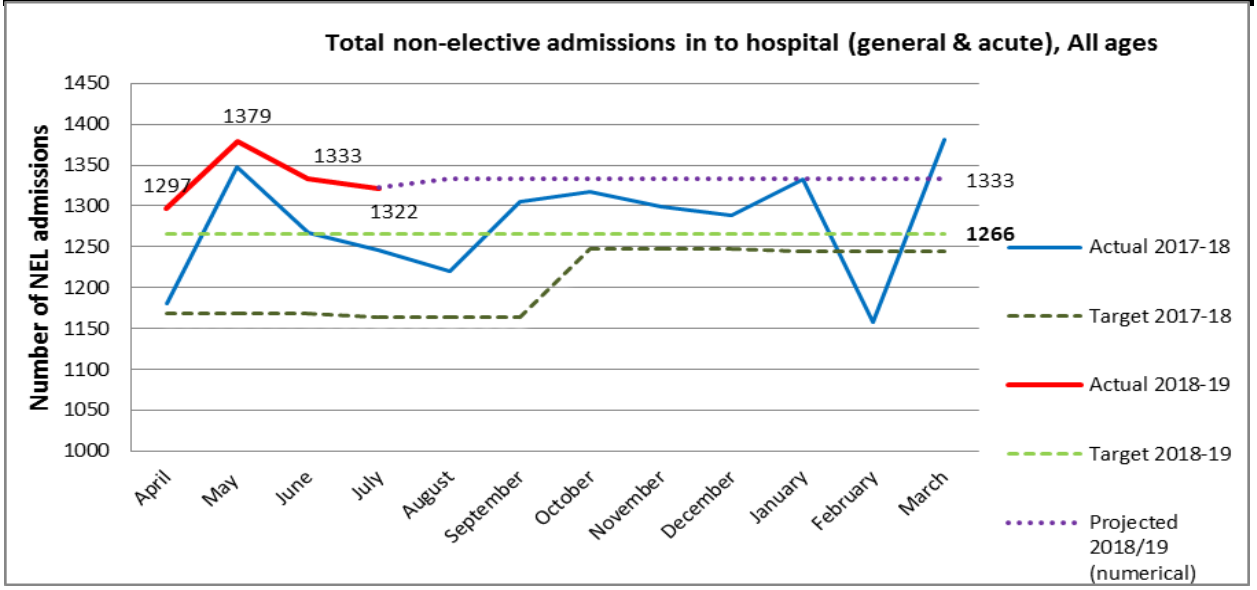
Per year	**15190**
Per calendar month (average)	**1266**

Main target:

Cumulative number of non-elective admissions in to hospital (general & acute), All Ages	
Target performance per year (no more than)	15190
Actual performance	5331
Projected annual performance (based on performance to date) - numerical	15992
increase/decrease	5.22%
Status	Amber
Status change since last month	↑



Total non-elective admissions in to hospital (general & acute), All ages	
Target performance per month (no more than)	1266
Actual performance	1322
Projected annual performance (based on performance to date) - numerical	1333
increase/decrease	5.22%
Status	Amber
Status change since last month	↑



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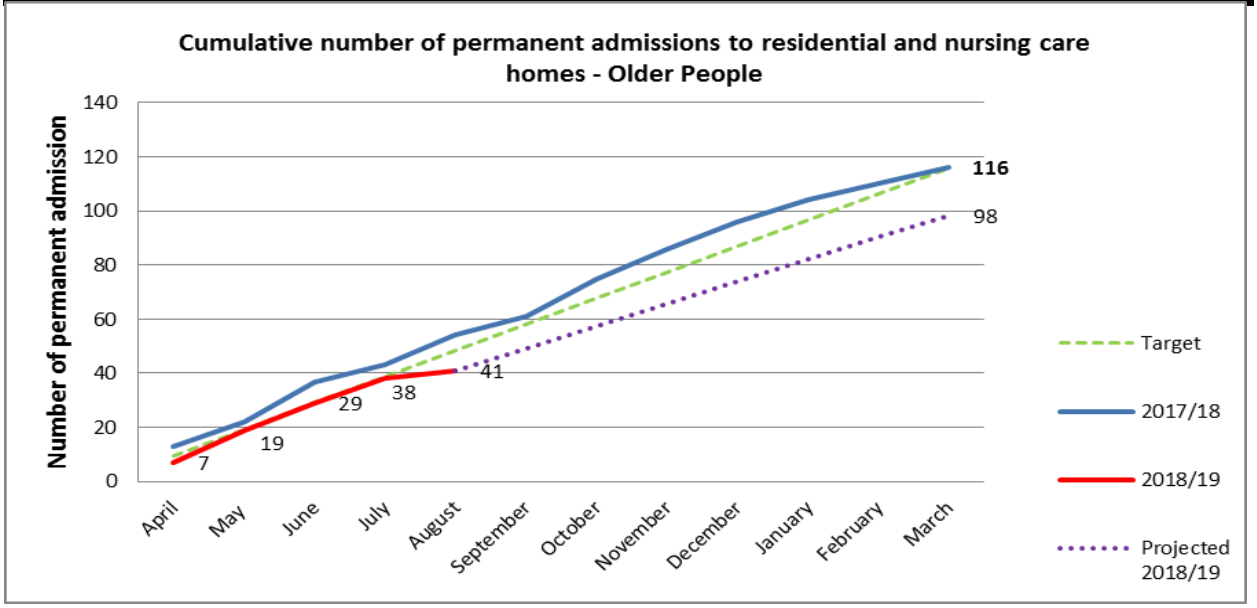
BCF Target 2: Residential Admissions

BCF Target:	Long-term support needs of older people (aged 65 and over) met by admission to residential and nursing care homes, per 100,000 population
Related services / schemes:	Community Reablement Team; Discharge to Assess
Reporting Month:	Month 5 (August 2018)
Status:	Green

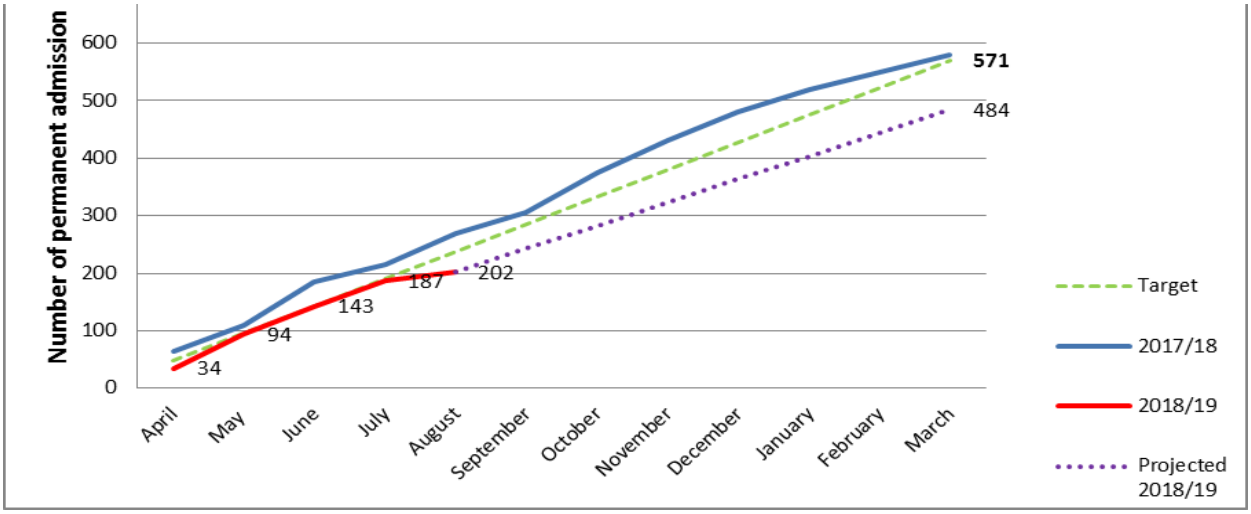
Main target:

Cumulative number of permanent admissions to residential and nursing care homes - Older People	
Target performance per annum (no more than)	116
Actual performance	41
Projected annual performance (based on performance to date)	98
Status	Green
Status change since last month	↑



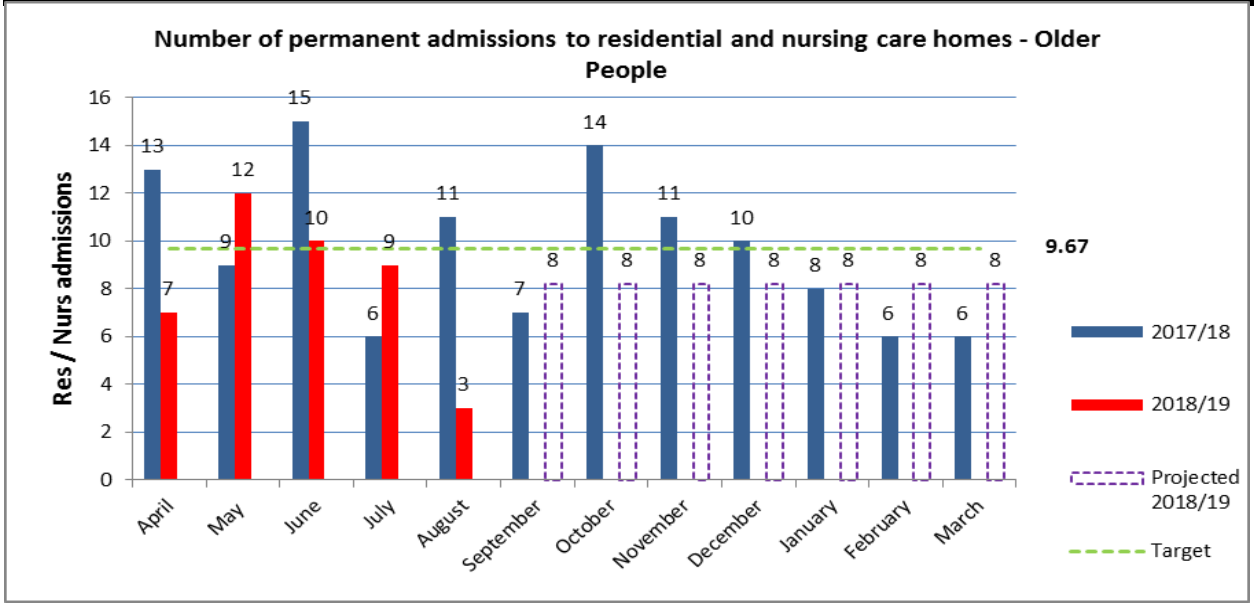
Additional analysis:

Cumulative number of permanent admissions to residential and nursing care homes per 100,000 population - Older People	
Target performance per annum (no more than)	571
Actual performance	202
Projected annual performance (based on performance to date)	484
Status	Green
Status change since last month	↑



** In calculations for Metric Two Reading over 65 population value is equal in 2018/17 to 19,993 and 2018/19 to 20,318*

Number of permanent admissions per month to residential and nursing care homes - Older People	
Target performance per month (no more than)	9.67
Actual performance	3
Projected annual performance (based on performance to date)	8
Status	Green
Status change since last month	↑



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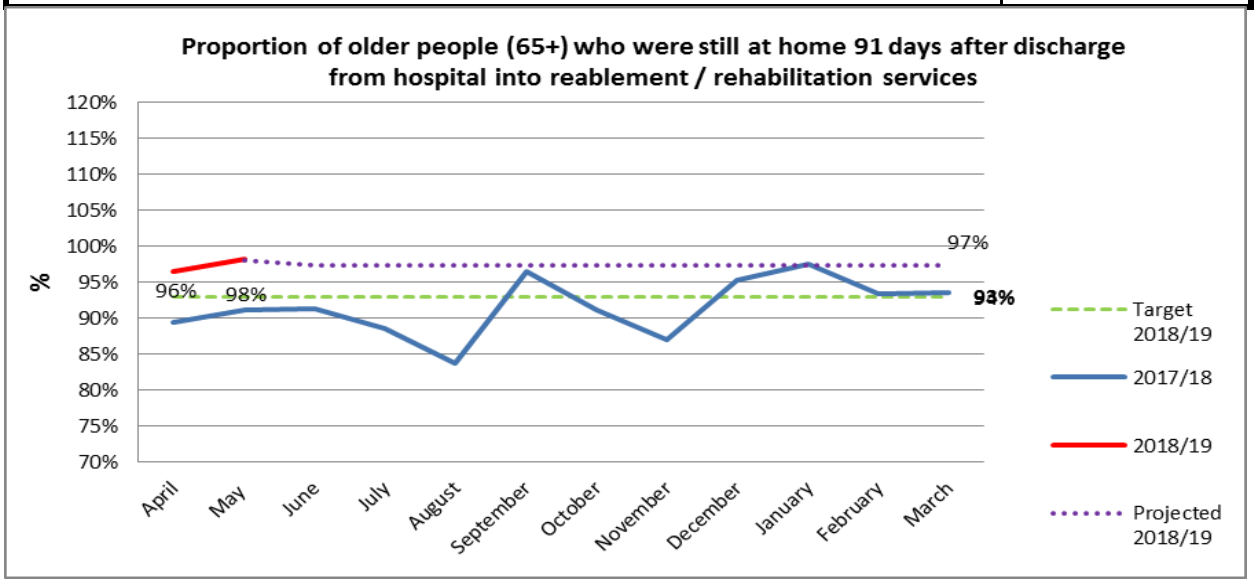
BCF Target 3: At Home 91 Days After Discharge

BCF Target:	Long-term support needs of older people (aged 65 and over) met by admission to residential and nursing care homes, per 100,000 population
Related services / schemes:	Community Reablement Team; Discharge to Assess
Reporting Month:	Month 2 (May 2018)
Status:	Green

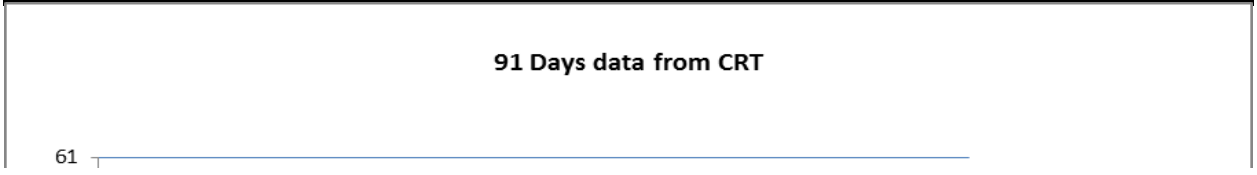
Main target:

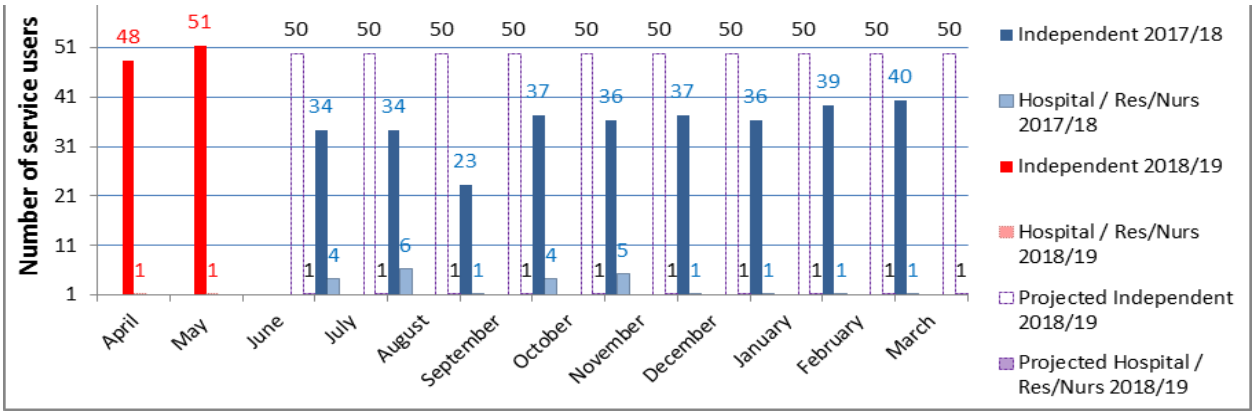
reablement / rehabilitation services	
Target performance	93%
Total no. of people departing reablement 91 days ago (numerical)	56
Of those, no. at home 91 days later (numerical) this month	55
Actual performance (%) this month	98%
Projected annual performance (based on performance to date)	97%
Status	Green
Status change since last month	↑



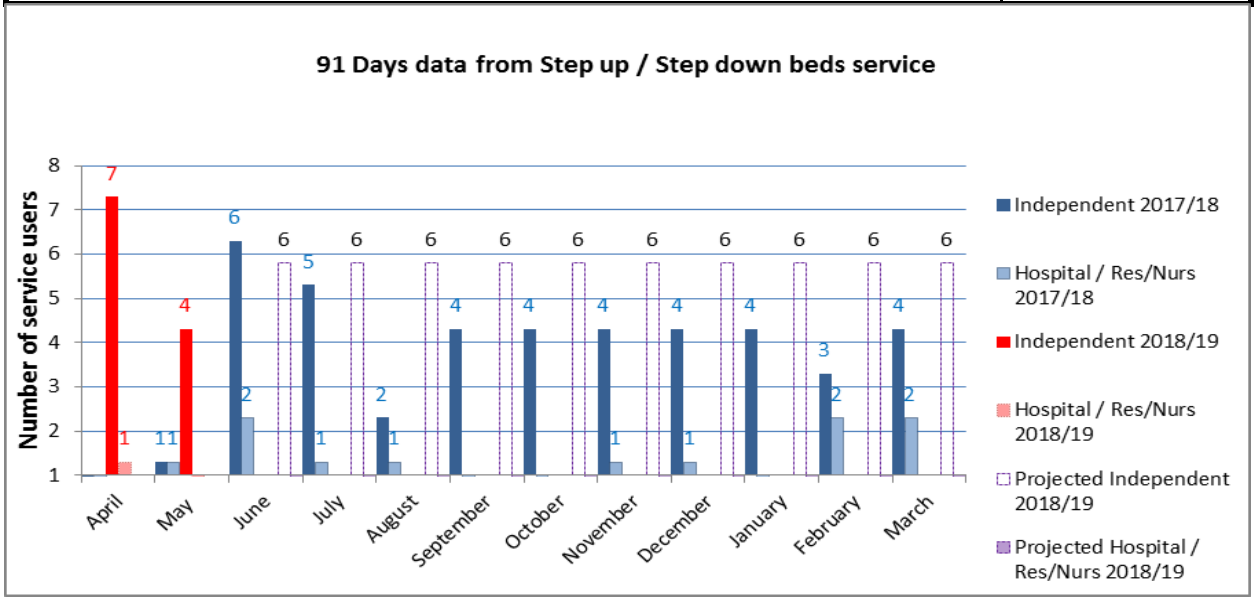
Breakdown of the above data:

91 Days data from CRT	
Total no. of people departing reablement 91 days ago (numerical)	52
Of those, no. at home 91 days later (numerical) this month	51
Actual performance (%) this month	98%
Status	Green
Status change since last month	↑





91 Days data from Step up / Step down beds service	
Total no. of people departing reablement 91 days ago (numerical)	4
Of those, no. at home 91 days later (numerical) this month	4
Actual performance (%) this month	100%
Status	Green
Status change since last month	↑



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BCF Target 4: Delayed Transfers of Care

BCF Target:	Delayed transfers of care from hospital per 100,000 population (DToC)
Related services / schemes:	Community Reablement Team; Discharge to Assess
Reporting Month:	Month 4 (July 2018)
Status:	Green

Target description:

From 01/07/2018 DToC target's calculation has been changed to no more than 13.77 delays per day

Target per day		Target per month		Target per day per 100k population	
NHS	6.93	NHS	211.00	NHS	5.50
ASC	5.77	ASC	175.00	ASC	4.57
Joint	1.08	Joint	33.00	Joint	0.85
Total	13.77	Total	419.75	Total	10.93

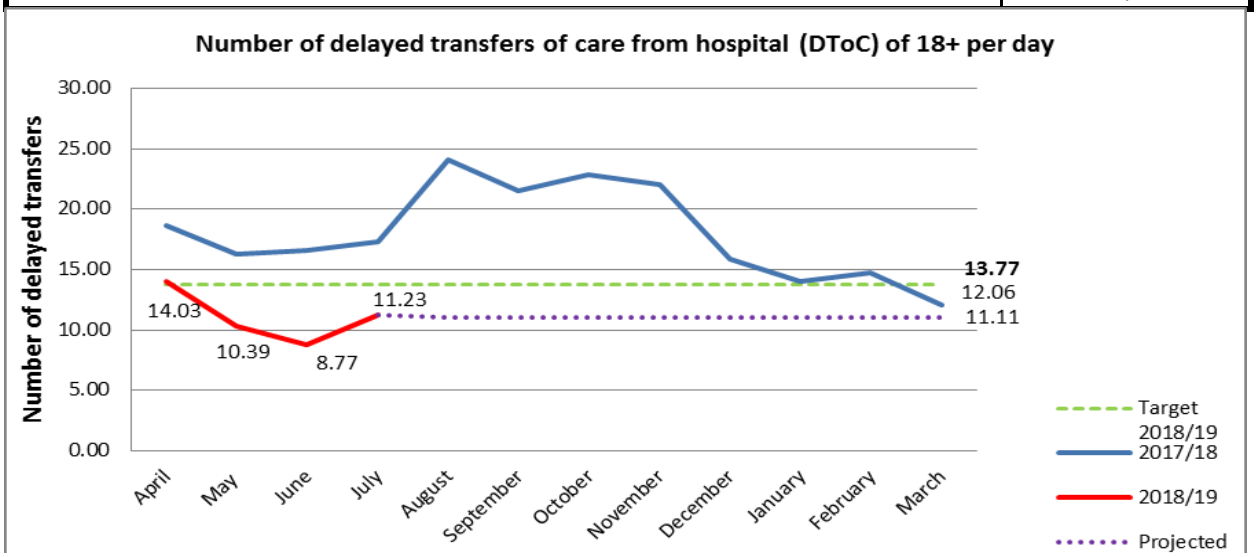
(In calculations for Metric Four Reading over 18+ population value is equal in 2018/19 to 126,045)

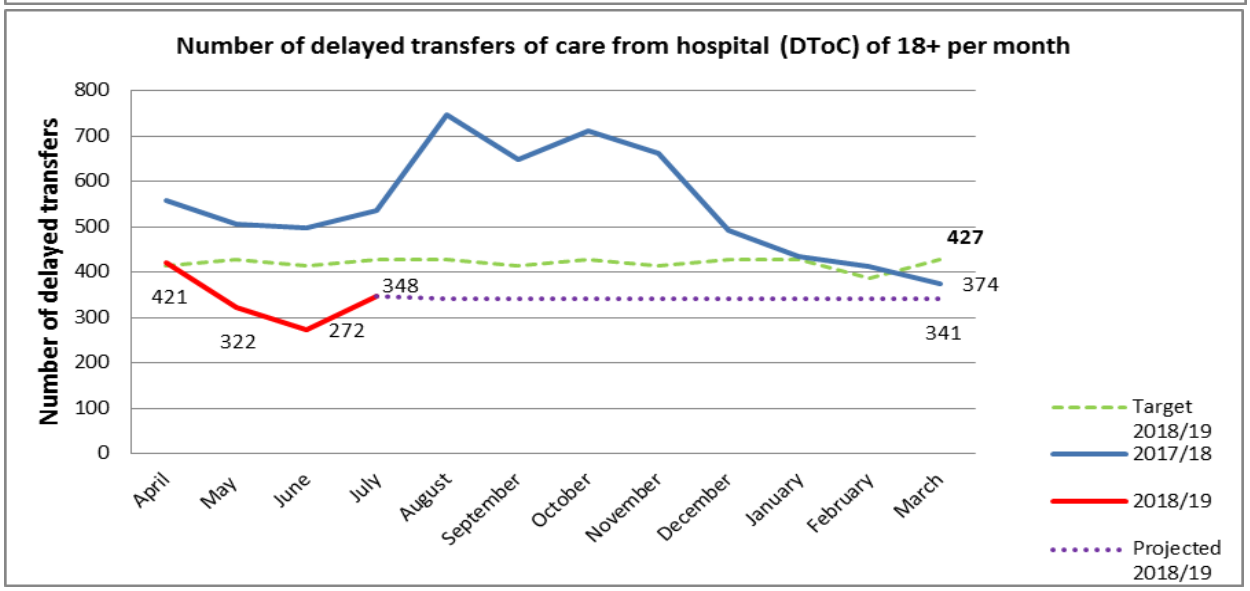
Ranking targets	Red	100 to 150	Amber	66 to 99	Green	1 to 65

Main target:

Health and ASC joint DTOC ranking (out of 150, 1 being the highest)	78
Status	Amber
Status change since last month	↓

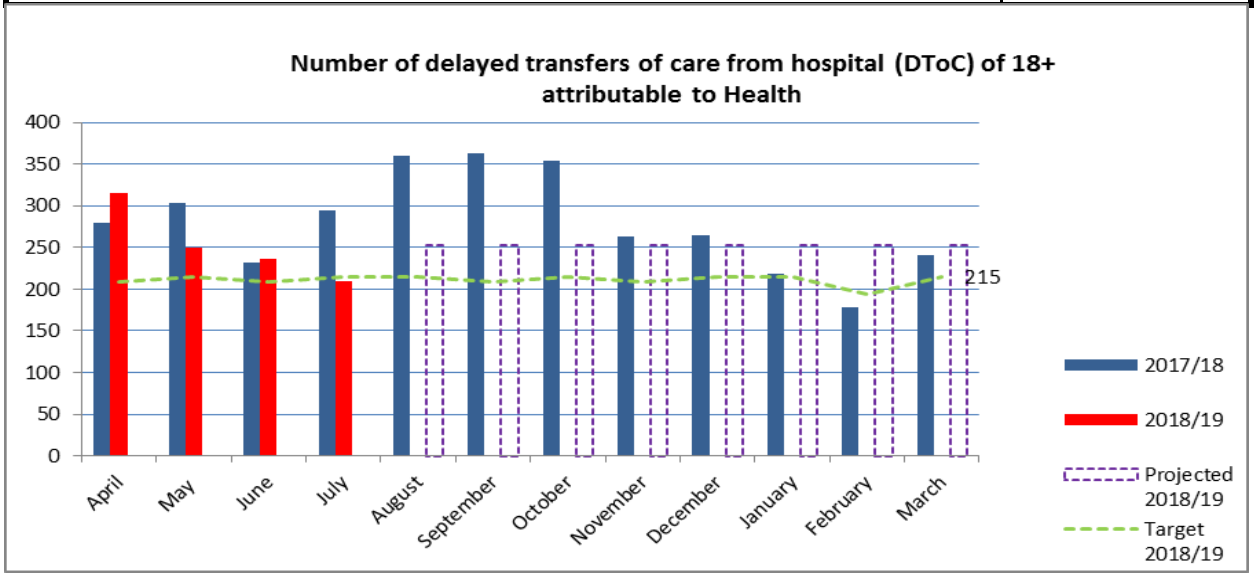
Average number of delayed transfers of care from hospital (DToC)	**Per Day**	**Per Month**
Target performance per day / month (no more than)	13.77	427
Actual performance per day / month	11.23	348
Projected average annual performance (based on performance to date)	11.11	341
Status	Green	
Status change since last month	↓	

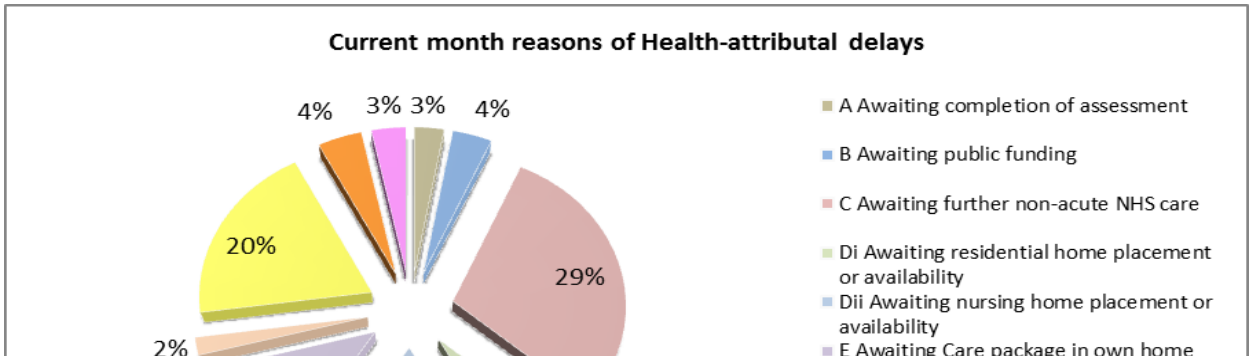




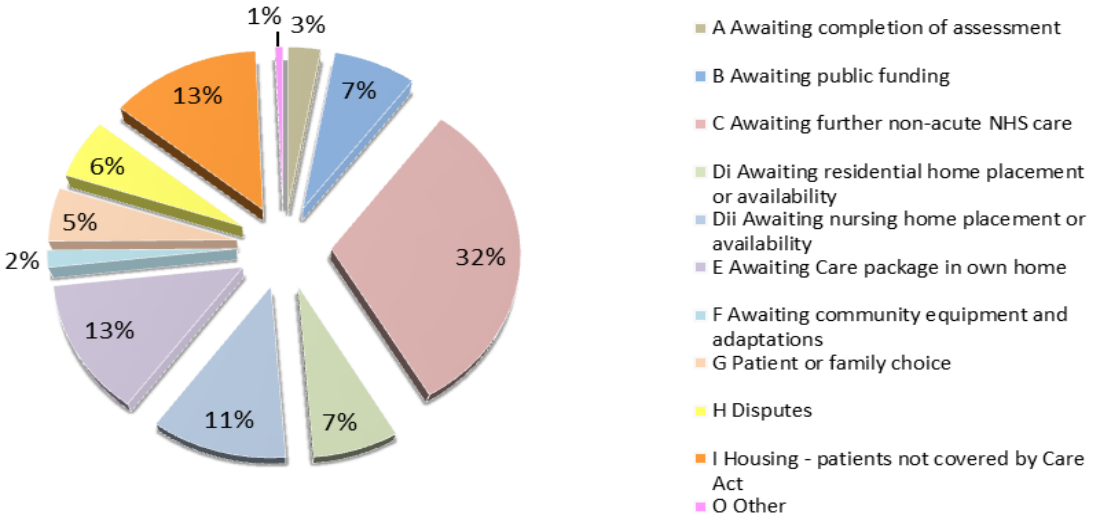
Attributions:

Number of Health-attributal delays	Per Day	Per Month
Target performance (no more than)	6.93	215
Actual performance	6.77	210
Projected average annual performance (based on performance to date)	8.31	253
Status	Green	
Status change since last month	↑	



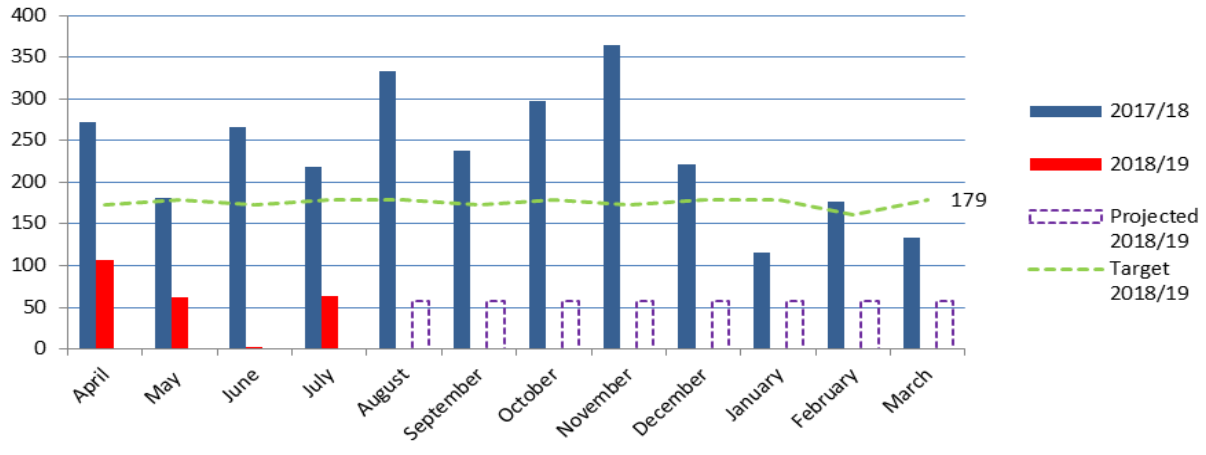


Overall reasons of Health-attributal delays, FY to date

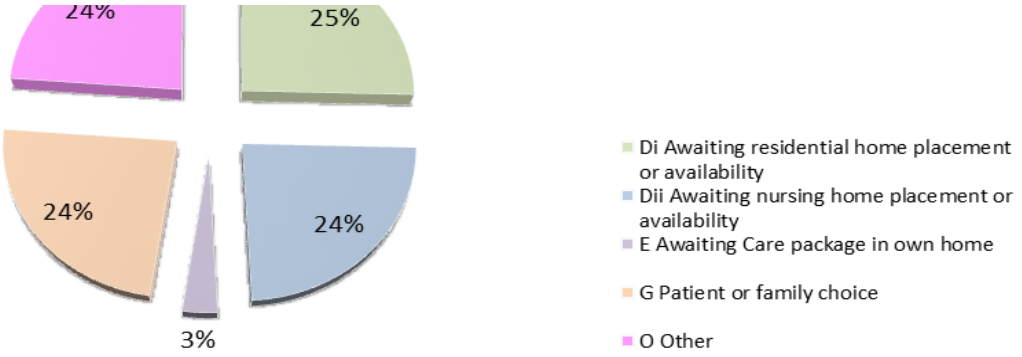


Number of ASC-attributal delays	Per Day	Per Month
Target performance (no more than)	5.77	179
Actual performance	2.03	63
Projected average annual performance (based on performance to date) per day	1.92	58
Status	Green	
Status change since last month	↓	

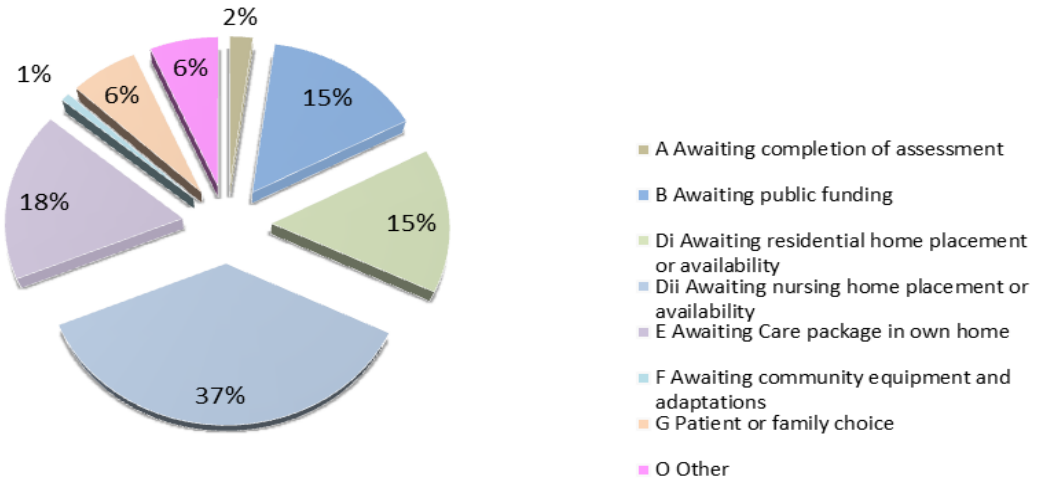
Number of delayed transfers of care from hospital (DToC) of 18+ attributable to ASC



Current month reasons of ASC-attributal delays

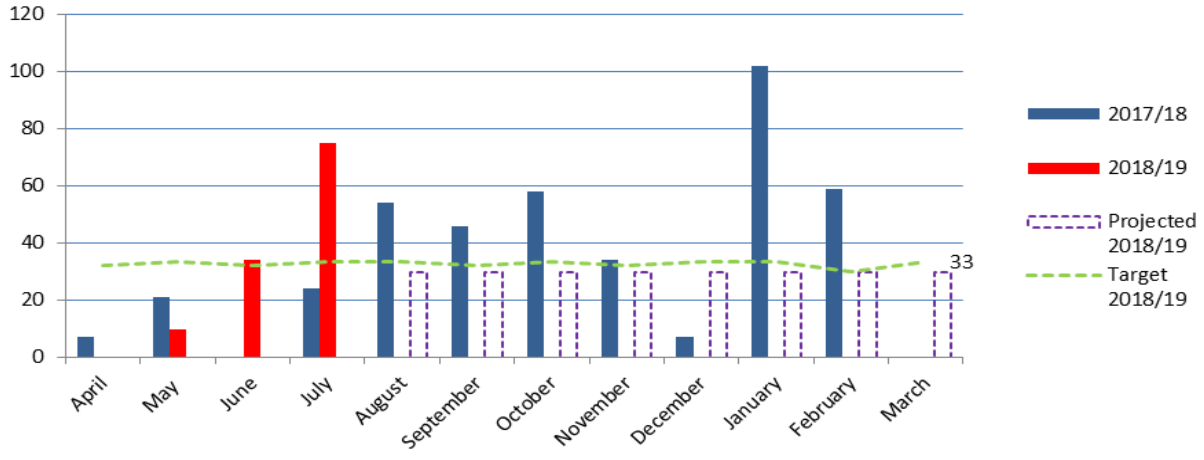


Overall reasons of ASC-attributal delays, FY to date

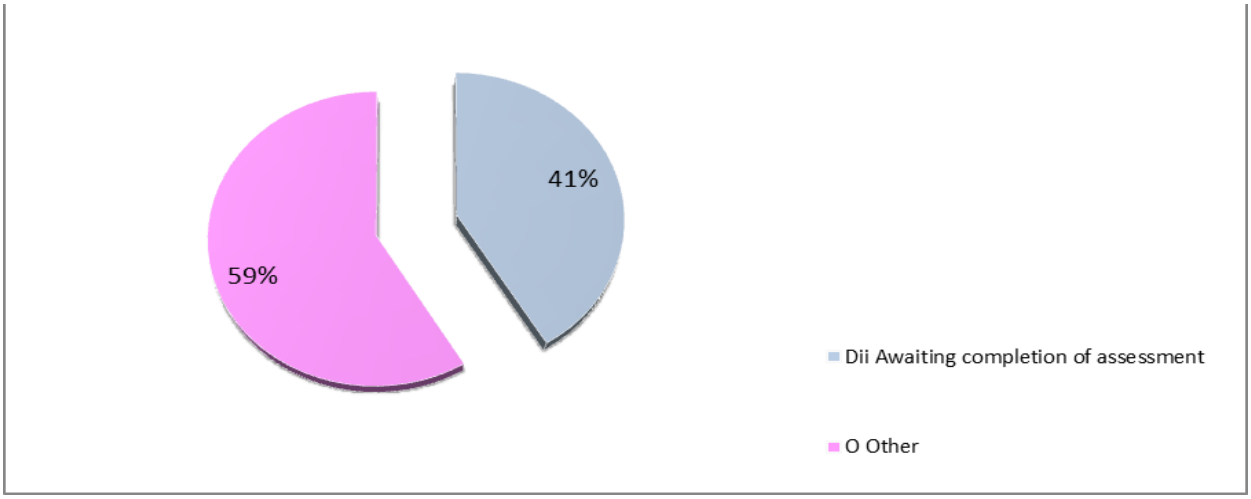


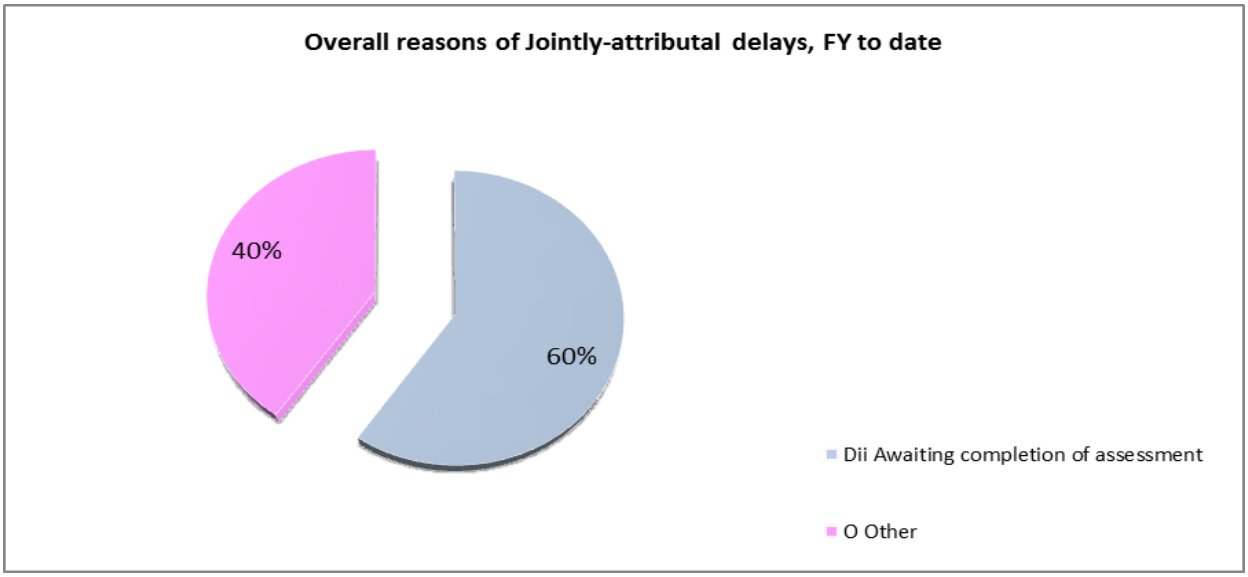
Number of Jointly-attributal delays	Per Day	Per Month
Target performance (no more than)	1.08	33
Actual performance	2.42	75
Projected average annual performance (based on performance to date) per day	0.98	30
Status	Red	
Status change since last month	↓	

Number of delayed transfers of care from hospital (DToC) of 18+ attributable to Both



Current month reasons of Jointly-attributal delays





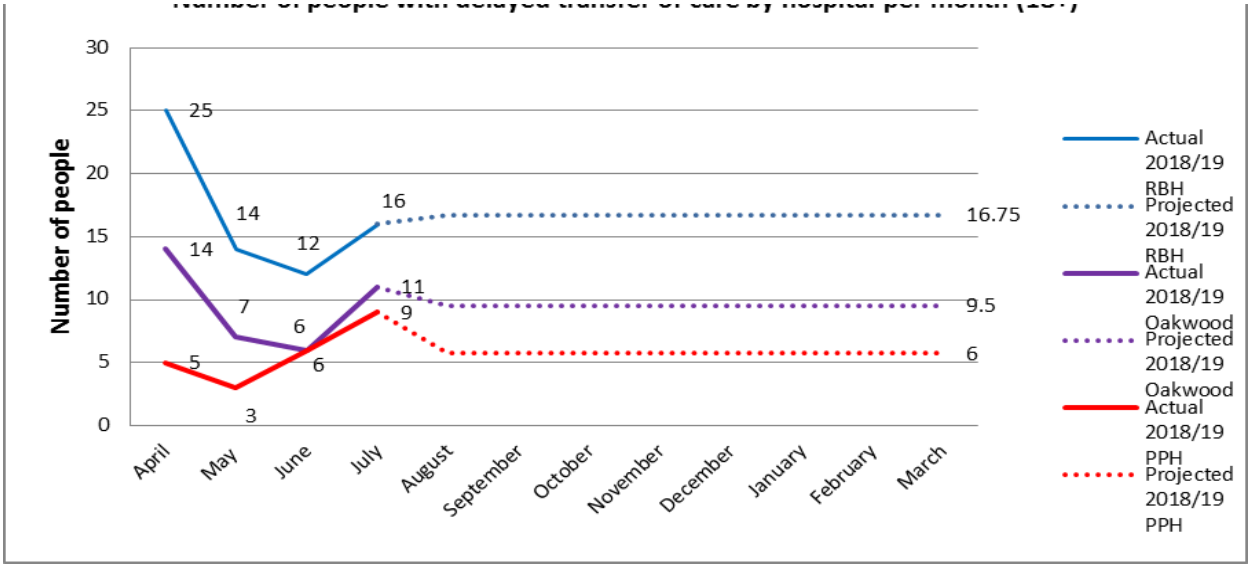
By hospital:

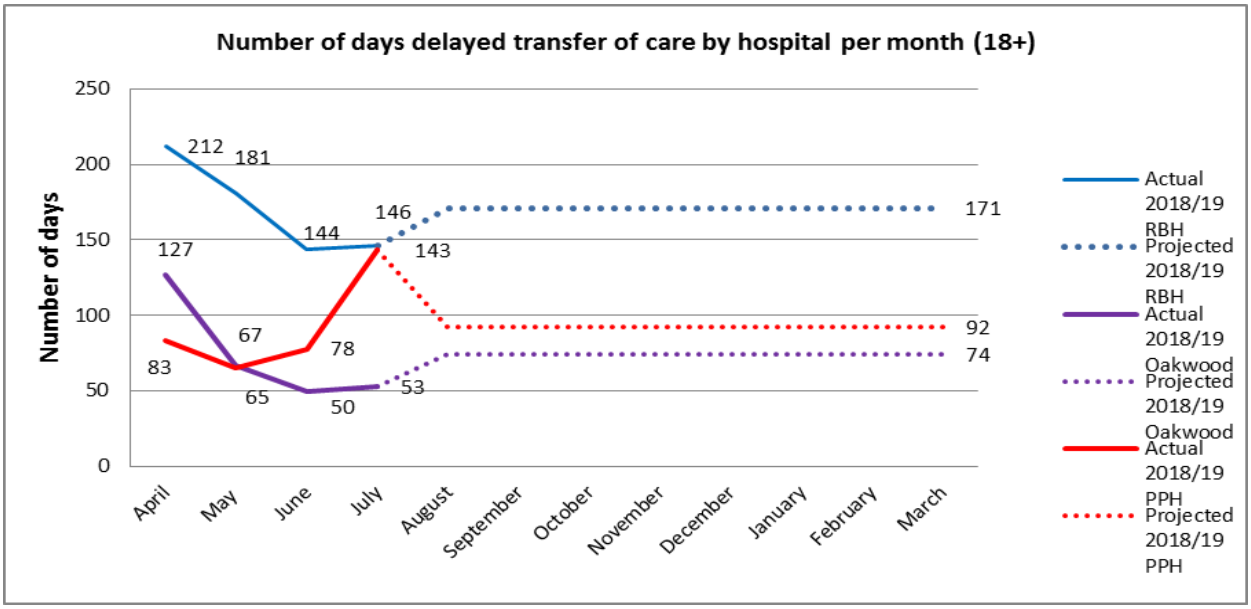
Acute (RBH)	DTOC (no. people)	DTOC (no. days)
Actual performance	16	146
Projected annual performance (based on performance to date)	17	171

Community (Oakwood)	DTOC (no. people)	DTOC (no. days)
Actual performance	11	53
Projected annual performance (based on performance to date)	10	74

MH (Prospect Park)	DTOC (no. people)	DTOC (no. days)
Actual performance	9	143
Projected annual performance (based on performance to date)	6	92

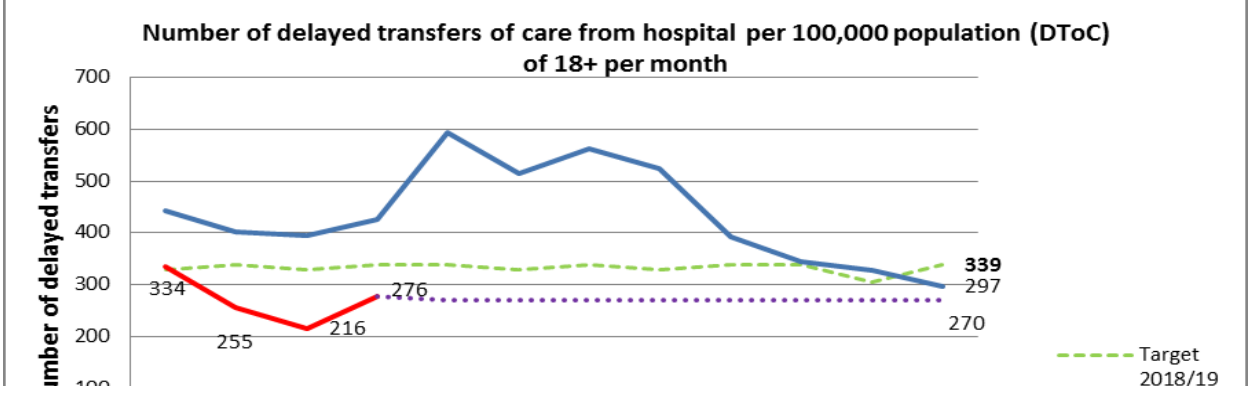
Number of people with delayed transfer of care by hospital per month (18+)

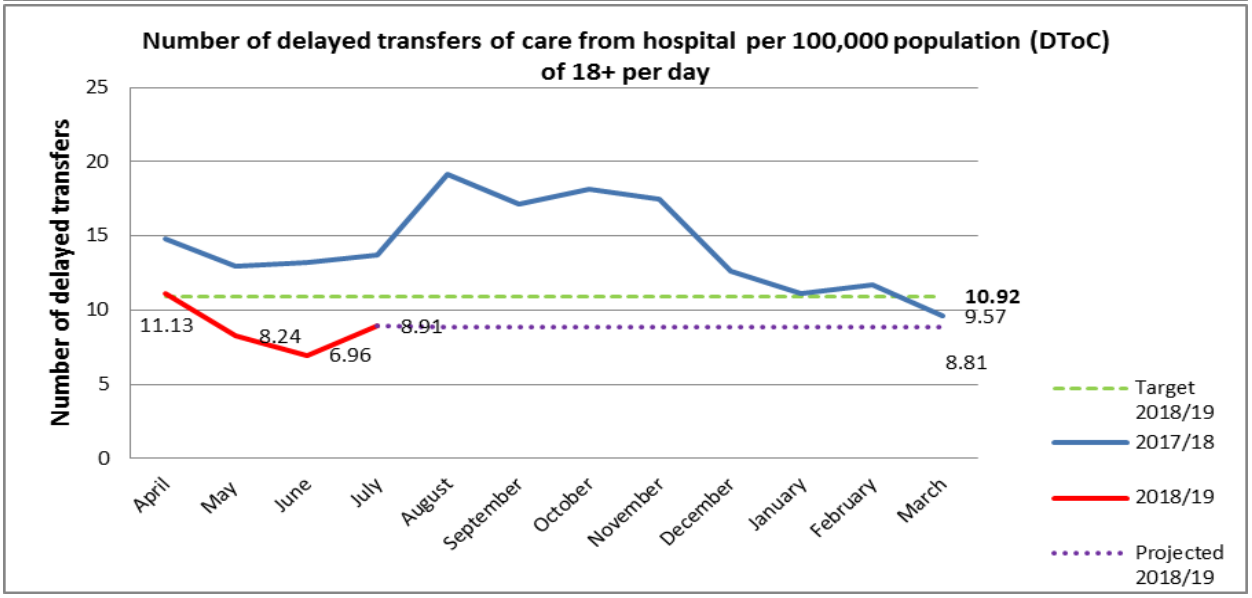




Additional analysis:

Number of delayed transfers of care from hospital per 100,000 population (DToC) of 18+	Per day	Per Month
Target performance (no more than) per day / month	10.92	328
Actual performance per day / month	8.91	276
Projected average annual performance (based on performance to date)	8.81	270
Status	Green	
Status change since last month	↓	





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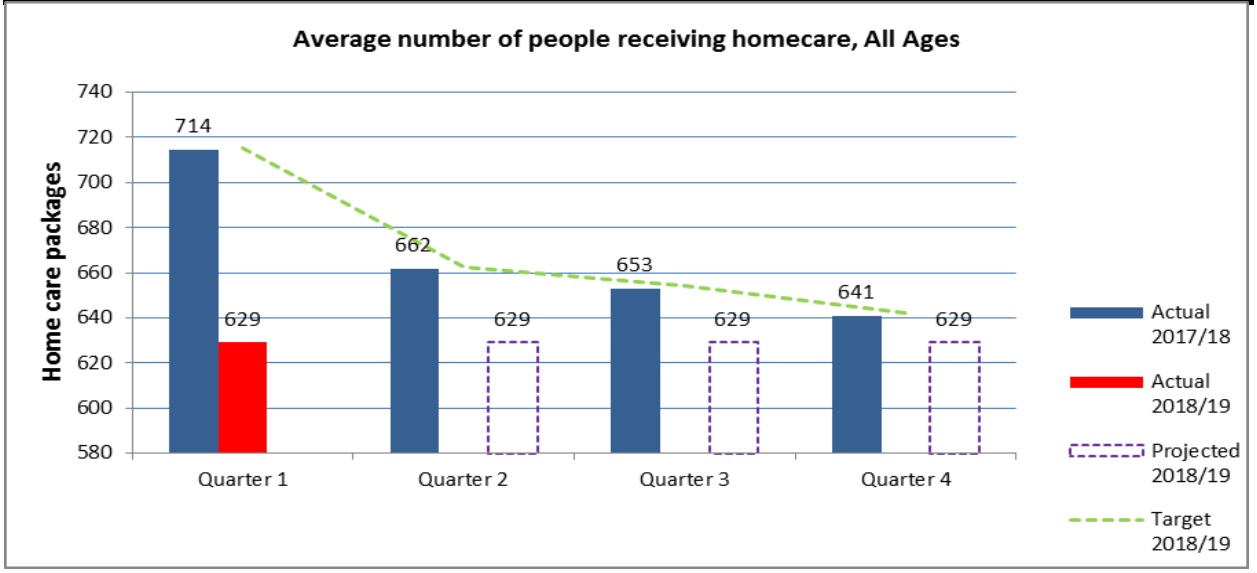
iBCF Quarterly performance

BCF Target:	To support the aims of the Integration and BCF Policy Framework
Related services / schemes:	Community Reablement Team; Discharge to Assess
Reporting Period:	Quarter 1 (April - June 2018)
Status:	Amber

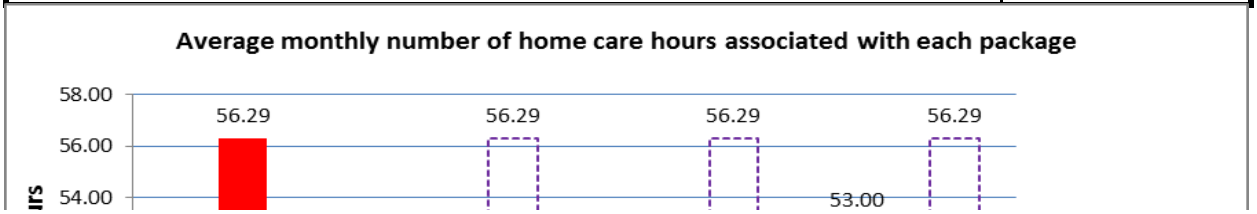
Target description:

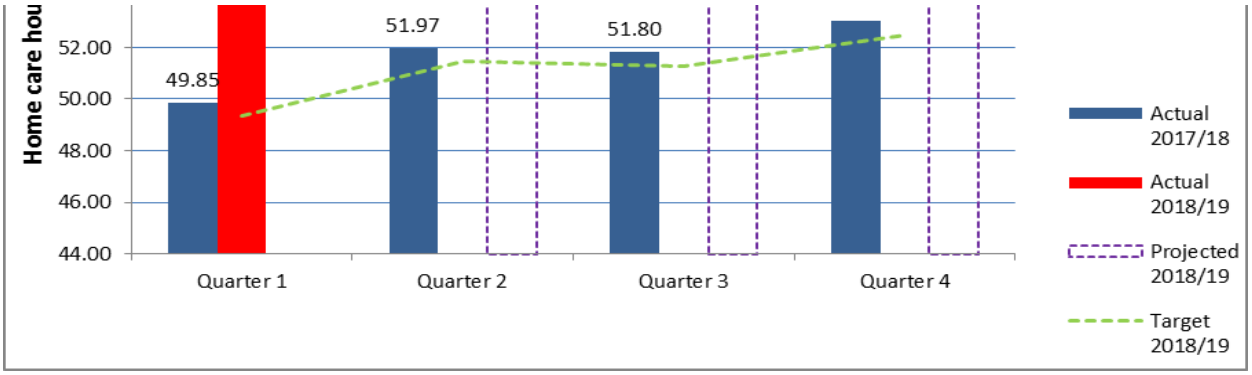
In Q1 2017/2018, Reading set the following targets that were designed to reflect the impact of the iBCF funding's investment in reablement services. We are obligated to report on our progress against these targets in our quarterly iBCF returns to DCLG

Marginal increase in home care packages	
Target performance per month (not less than)	715
Actual performance	629
Projected annual performance (based on performance to date)	629
Status	Amber
Status change since last month	↓

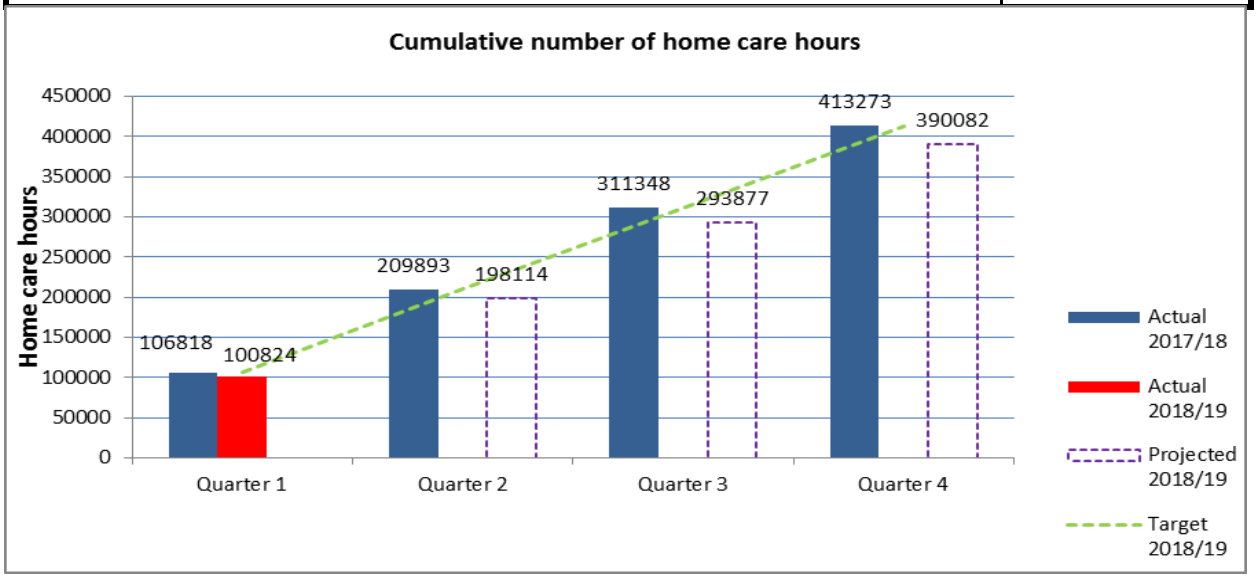


Reduction in overall number of hours of care associated with each home care package	
Target performance per month (not more than)	49.35
Actual performance	56.29
Projected annual performance (based on performance to date)	56.29
Status	Amber
Status change since last month	↑

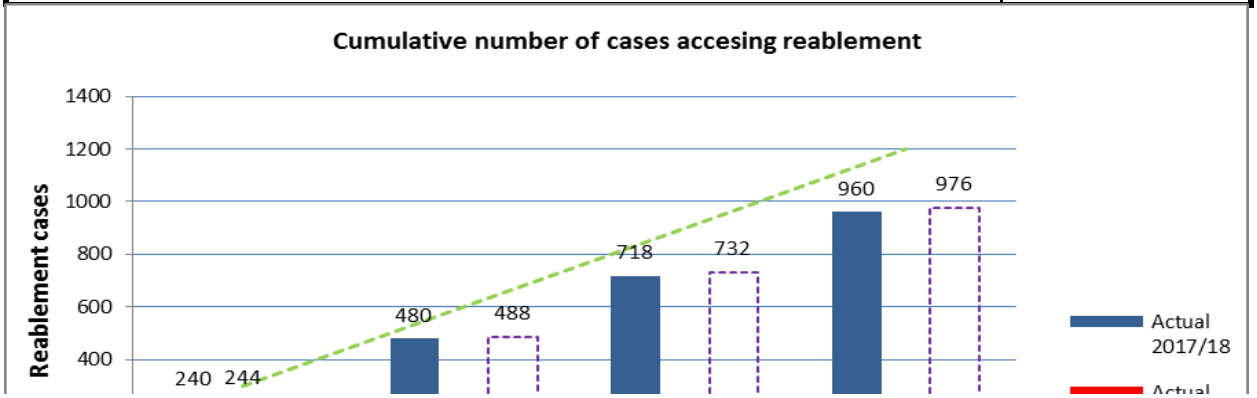


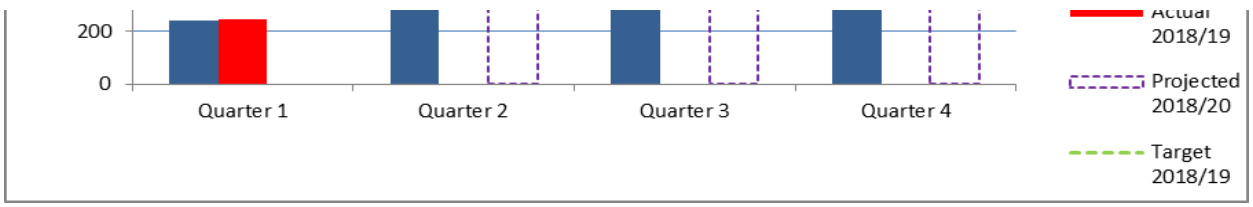


No overall increase in the total number of home care hours - cumulative	
Target performance per quarter (not more than)	106817
Actual performance	100824
Projected annual performance (based on performance to date)	390082
Status	Green
Status change since last month	↑



Increase in Community Reablement Team's engagement levels to 1200 service users - cumulative	
Target performance per annum (not less than)	1200
Actual performance	244
Projected annual performance (based on performance to date)	976
Status	Amber
Status change since last month	→





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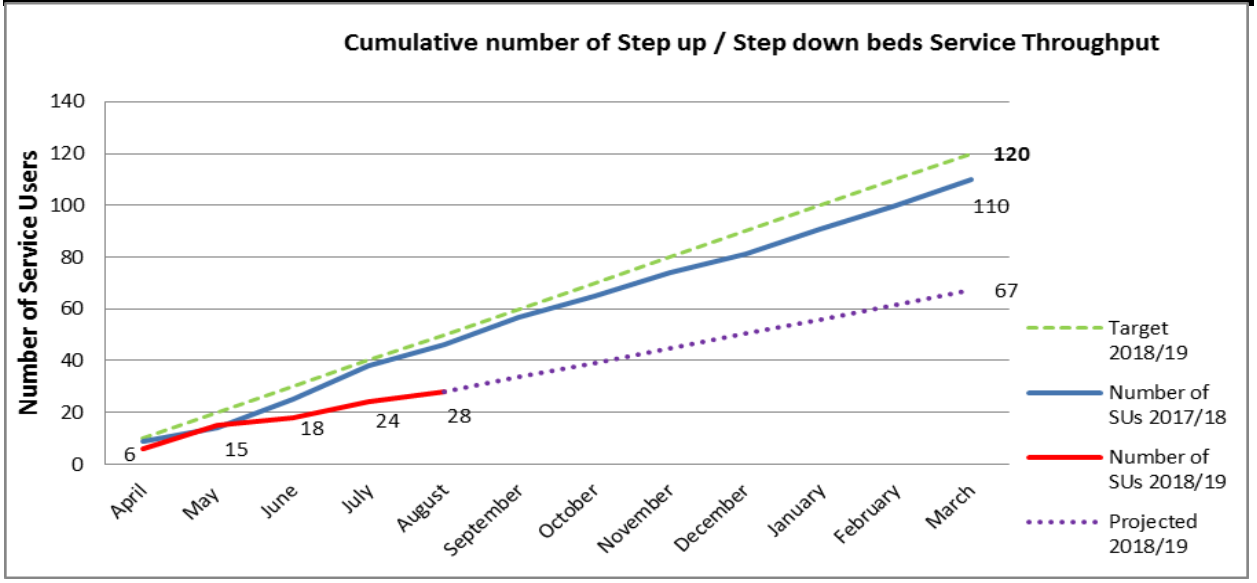
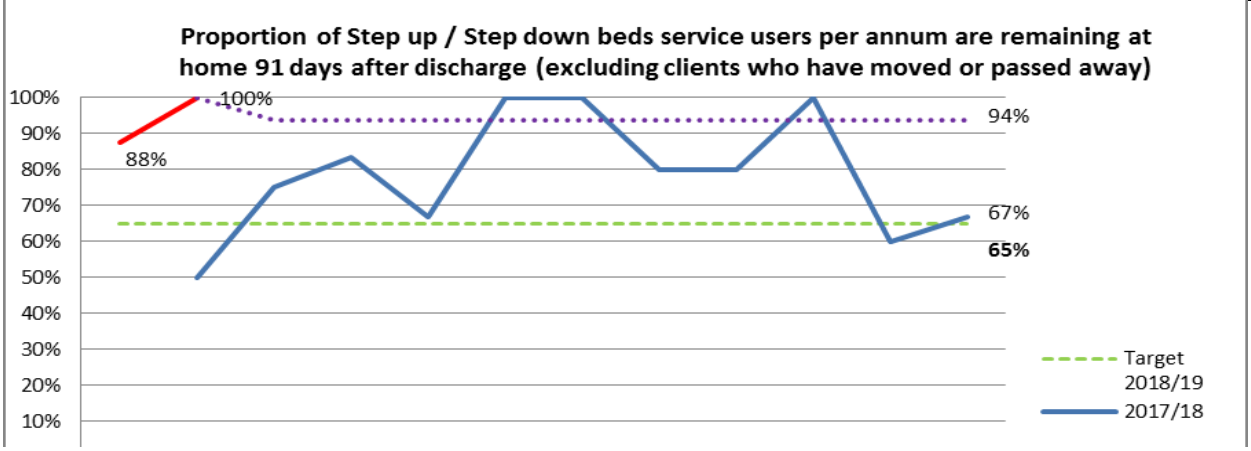
Local Target: Step up / Step down beds

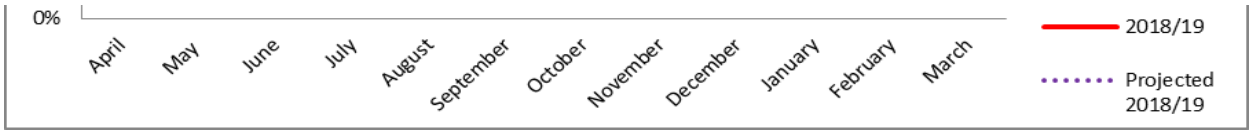
Local Targets:	Step up / Step down beds (reablement service at The Willows)
Reporting Month:	Month 5 (August 2018)
Status:	Red

Cumulative number of Step up / Step down beds Throughput	
Target performance per year (not less than)	120
Actual performance (based on performance to date)	4
annum	67
Status	Red
Status change since last month	↓

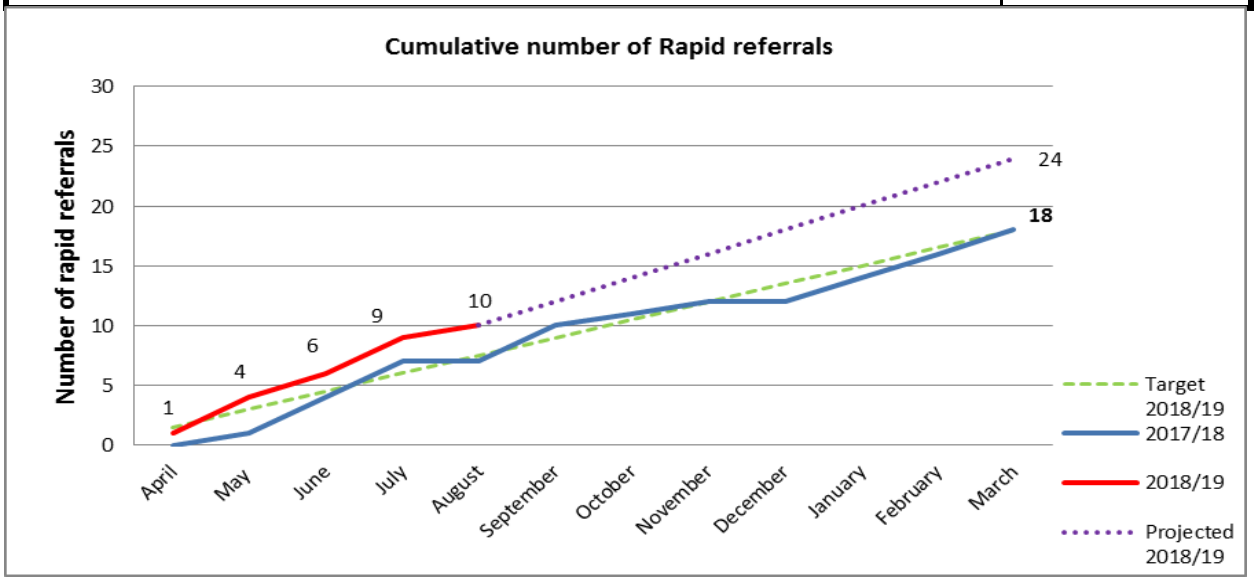


Proportion of Step up / Step down beds service users per annum are remaining at home 91 days after discharge (excluding clients who have moved or passed away)	
Target performance per annum (not less than)	65%
Actual performance this month	100%
Projected average performance (based on performance to date) per annum	94%
Status	Green
Status change since last month	↑

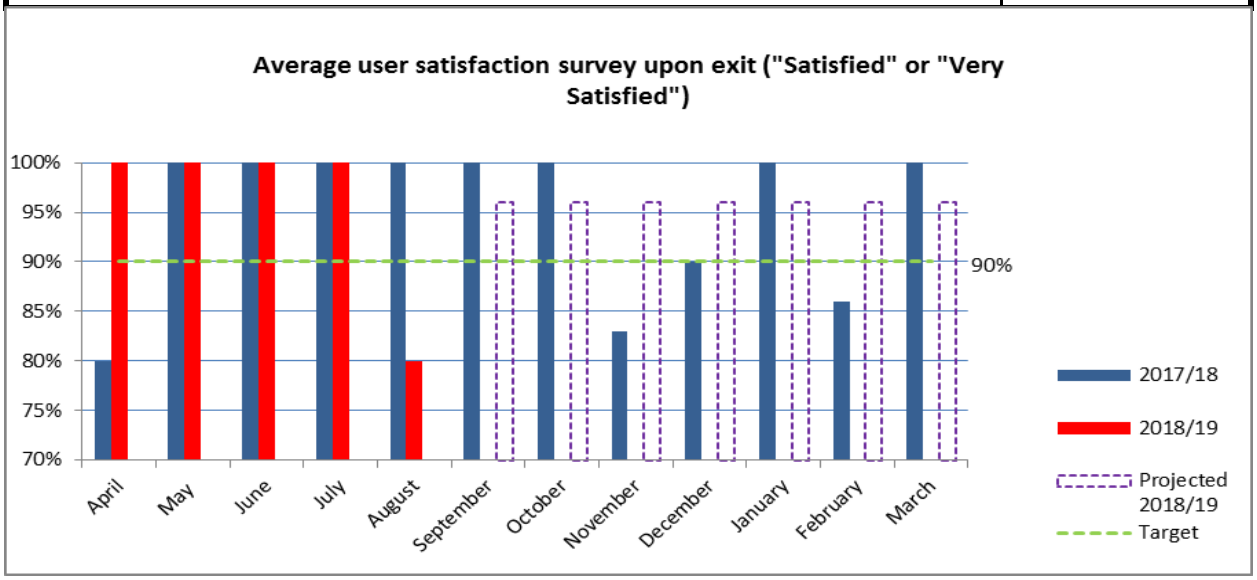




Cumulative number of Rapid referrals	
Target performance per annum (not less than)	18
Actual performance this month	1
Projected average performance (based on performance to date)	24
Status	Green
Status change since last month	↓

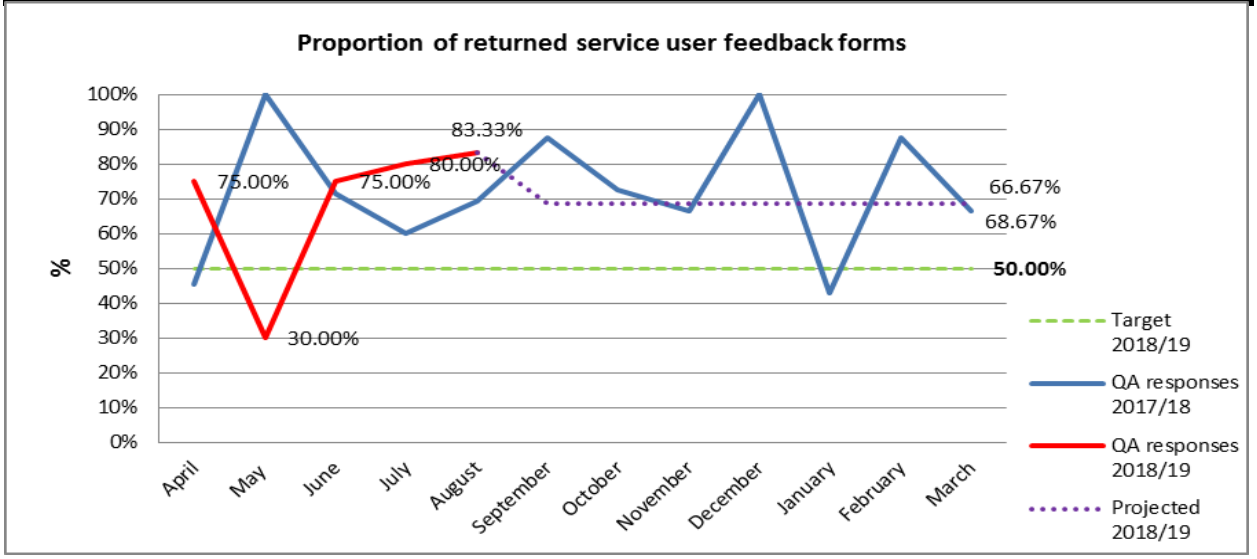


Average user satisfaction survey upon exit ("Satisfied" or "Very Satisfied")	
Target performance (not less than)	90%
Actual performance this month	80%
Projected average performance (based on performance to date)	96%
Status	Amber
Status change since last month	↓

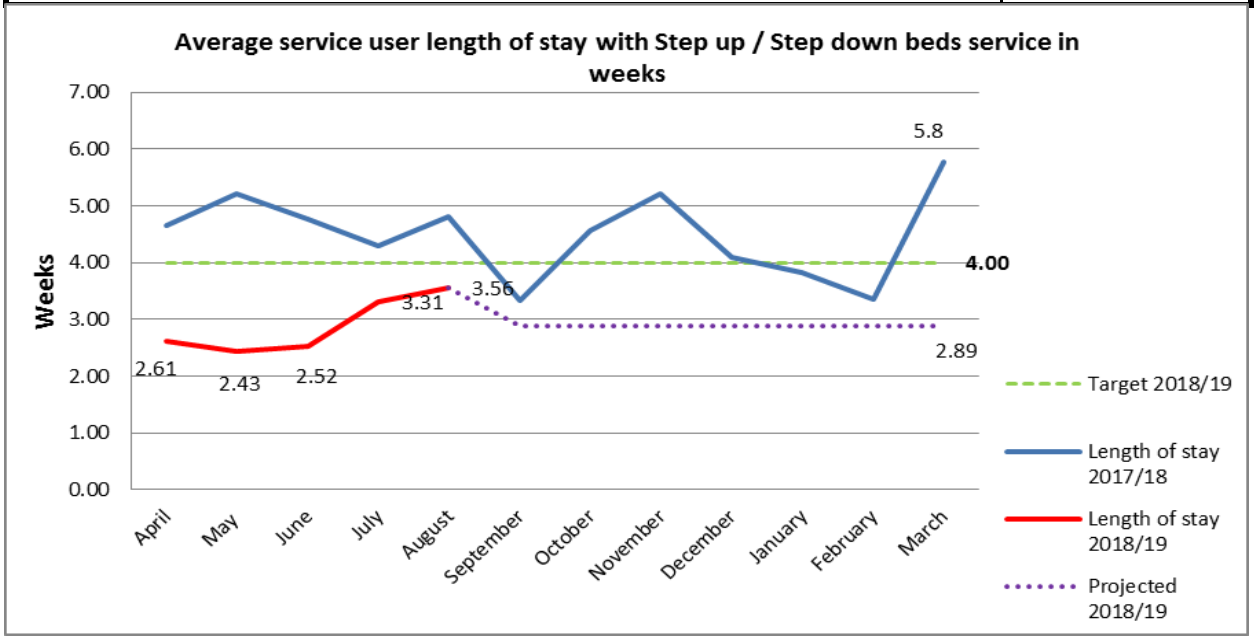


Proportion of returned service user feedback forms	
Target performance (not less than)	50%

Actual performance this month	83%
Projected average performance (based on performance to date)	69%
Status	Green
Status change since last month	↑

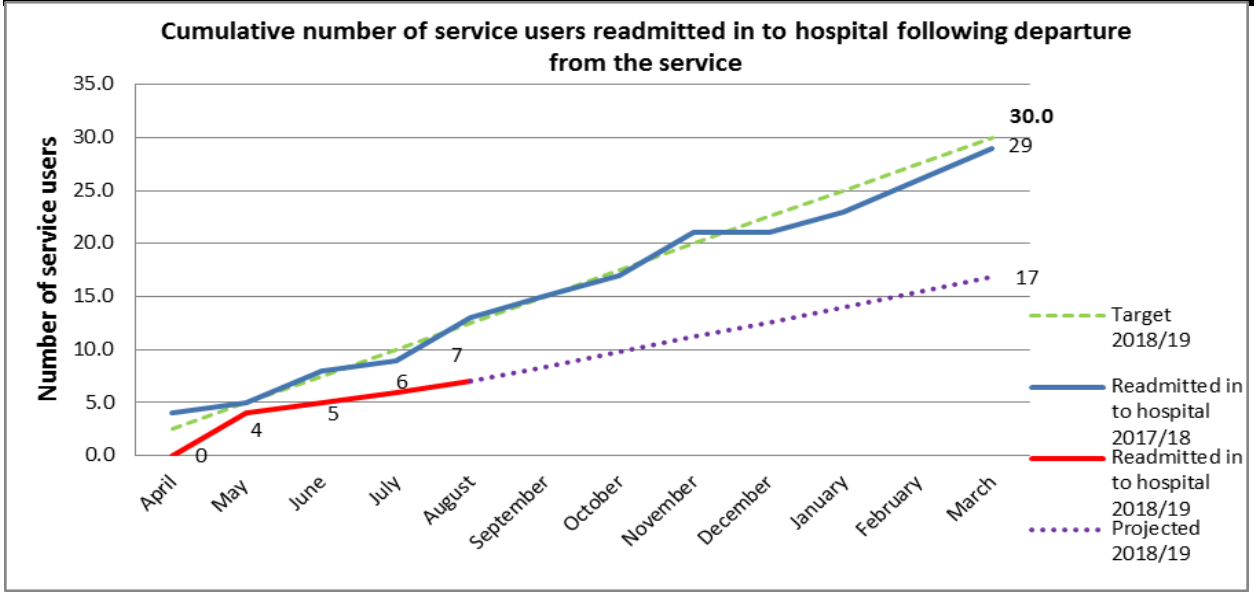


Average service user length of stay with Step up / Step down beds service in weeks	
Target performance (no more than)	4.0
Actual performance this month	3.6
Projected average performance (based on performance to date)	2.9
Status	Green
Status change since last month	↓

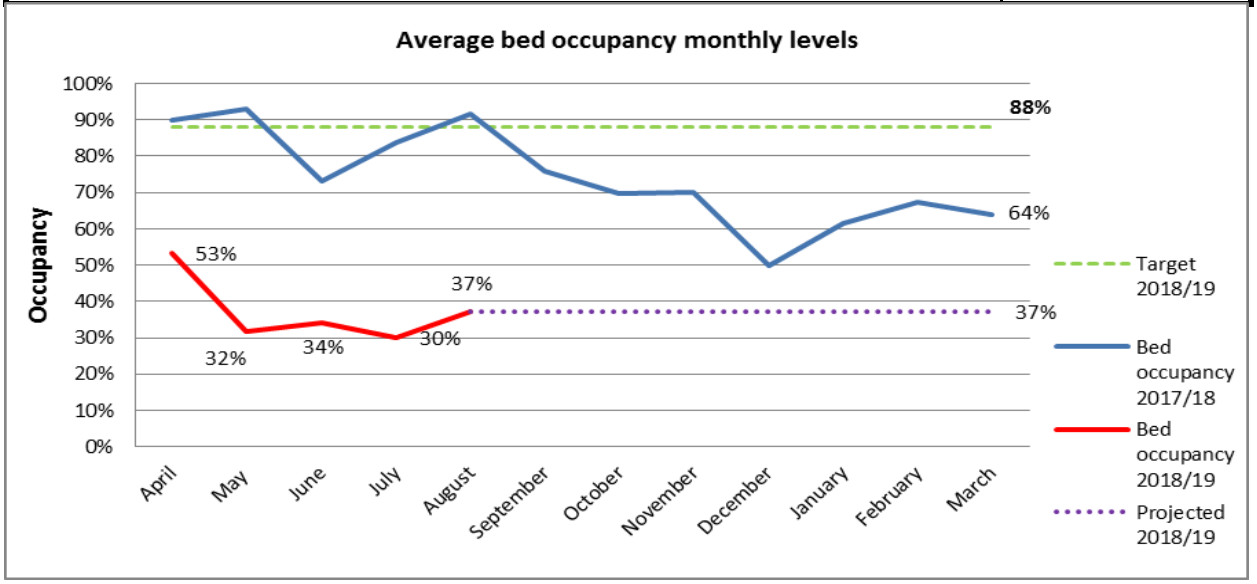


Cumulative number of service users readmitted in to hospital following departure from the service	
Target performance per annum (no more than)	30
Actual performance per month	1
Projected average performance (based on performance to date) per annum	17
Status	Green

Status change since last month	→

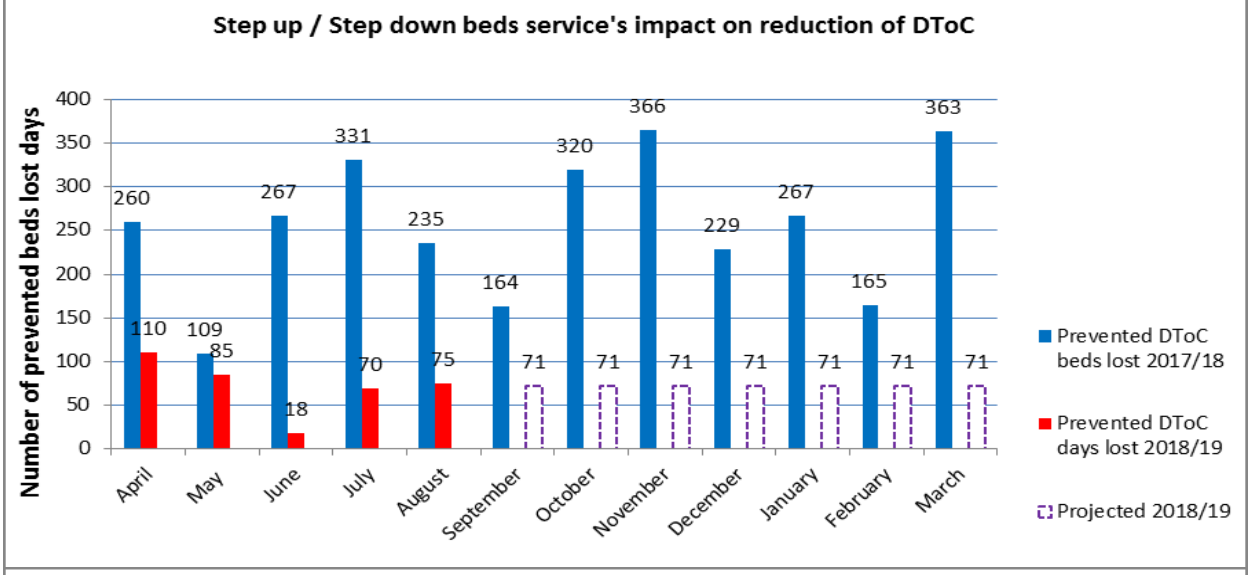


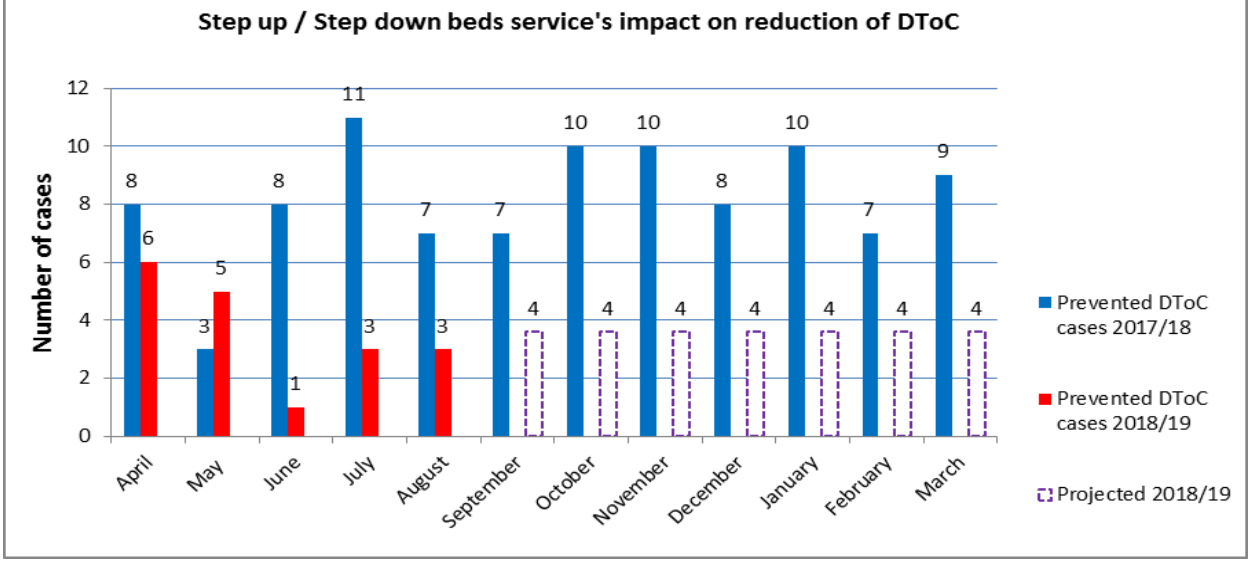
Average bed occupancy levels per month	
Target performance (not less than)	88%
Actual performance this month	37%
Projected average performance (based on performance to date)	37%
Status	Red
Status change since last month	↑



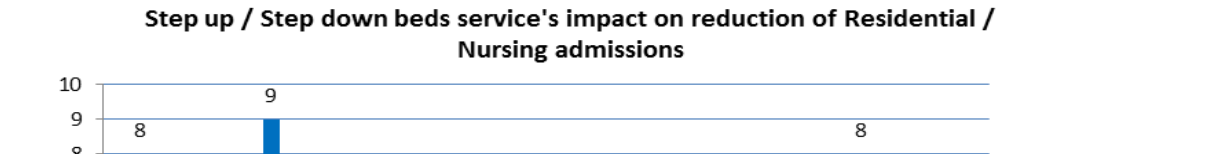
Step up / Step down beds service's impact on reduction of DToC	
Actual performance this month (Number of referrals from hospitals)	3
Projected average performance (based on performance to date)	4
Average length of stay with the service (days)	25
Actual performance this month (Overall days that hospital referrals have spent in a service outside of a hospital FY to date (no. referrals x average length of stay in service))	75
Projected average performance (based on performance to date)	71

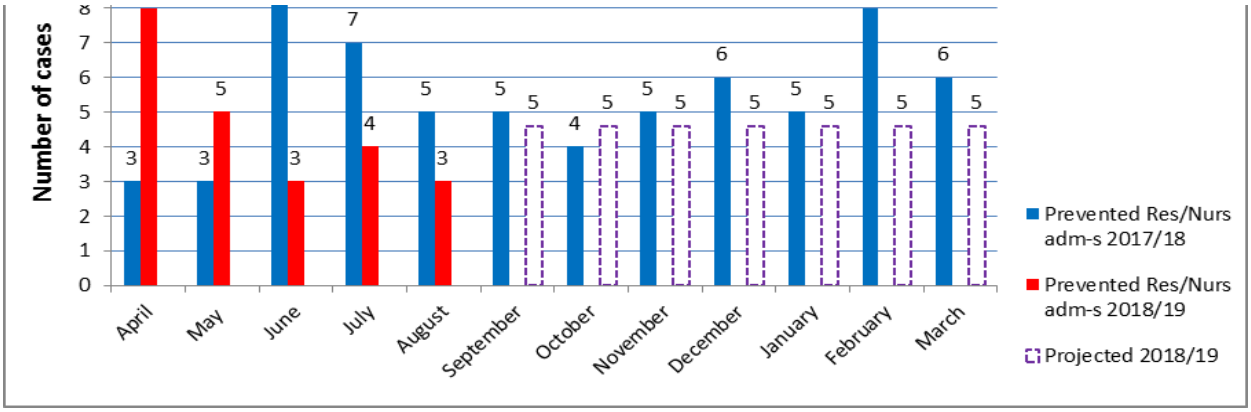
Cumulative overall number of days that hospital referrals have spent in a service outside of hospital	357
Cumulative cost avoidance to hospital FY to date (average length of stay x £400 per day cost of stay with a hospital)	£142,800



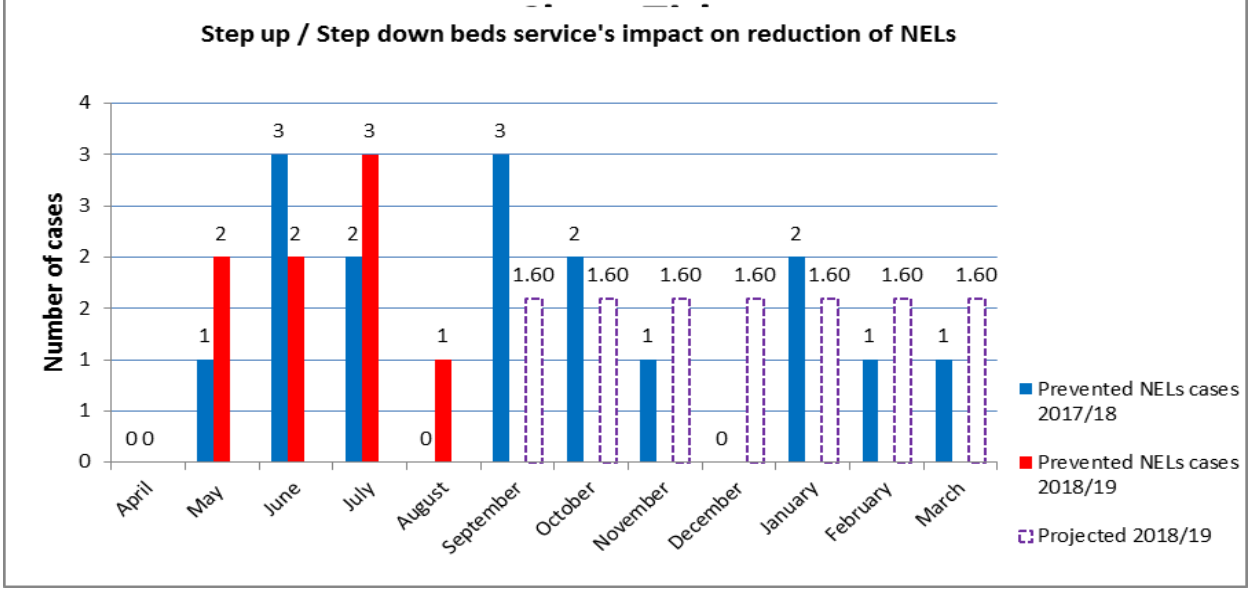


Step up / Step down beds service's impact on reduction of Residential / Nursing admissions	
Actual performance this month (number of cases)	3
Projected average performance (based on performance to date)	5
Cumulative overall number of clients that returned home following discharge FY to date	23
Cumulative estimated cost avoidance to the system FY to date (number of admissions avoided x £719 average cost of a residential / nursing placement per week)	£252,266





Step up / Step down beds service's impact on reduction of NELs	
Actual performance this month (number of cases)	1
Projected average performance (based on performance to date)	2



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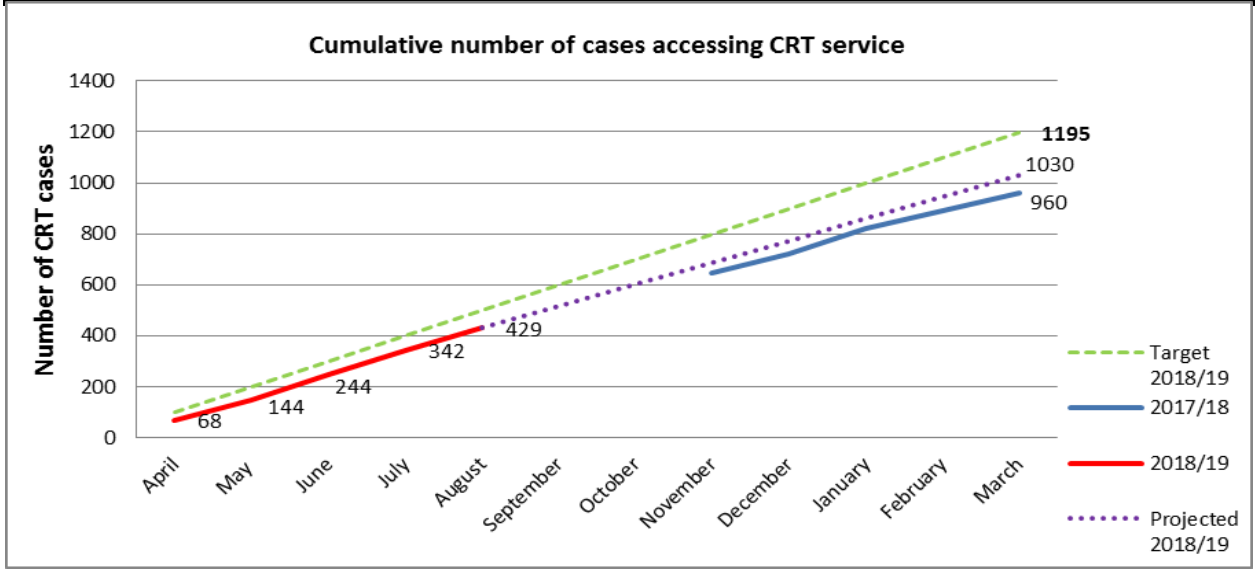
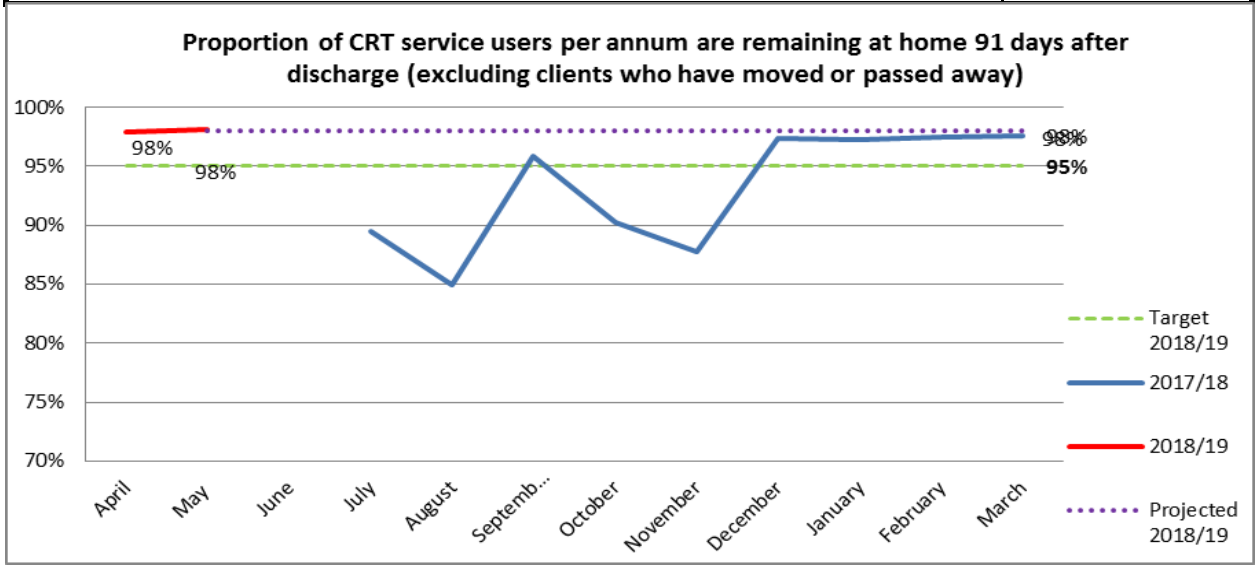
Local Target: Community Reablement Team

Local Targets:	Community Reablement Team (CRT)
Reporting Month:	Month 5 (August 2018)
Status:	Red

Cumulative number of cases accessing CRT service	
Target performance per year (not less than)	1195
Actual performance this month	87
Projected average performance (based on performance to date)	1030
Status	Amber
Status change since last month	↓

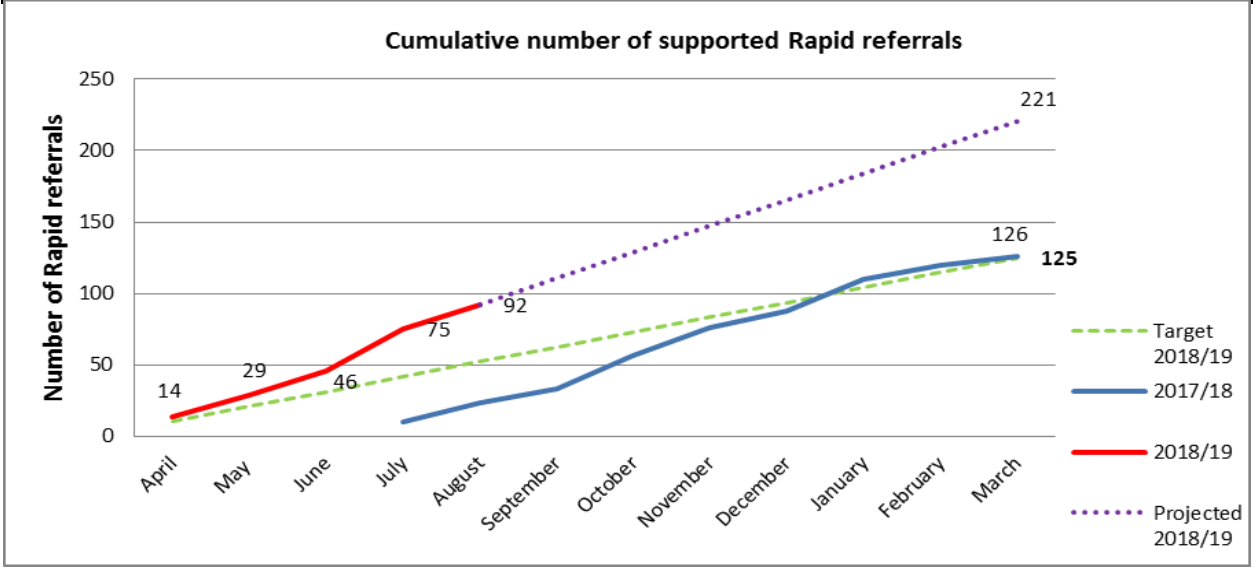


Proportion of CRT service users per annum are remaining at home 91 days after discharge (excluding clients who have moved or passed away)	
Target performance (not less than)	95%
Actual performance this month	98%
Projected average performance (based on performance to date)	98%
Status	Green
Status change since last month	↑

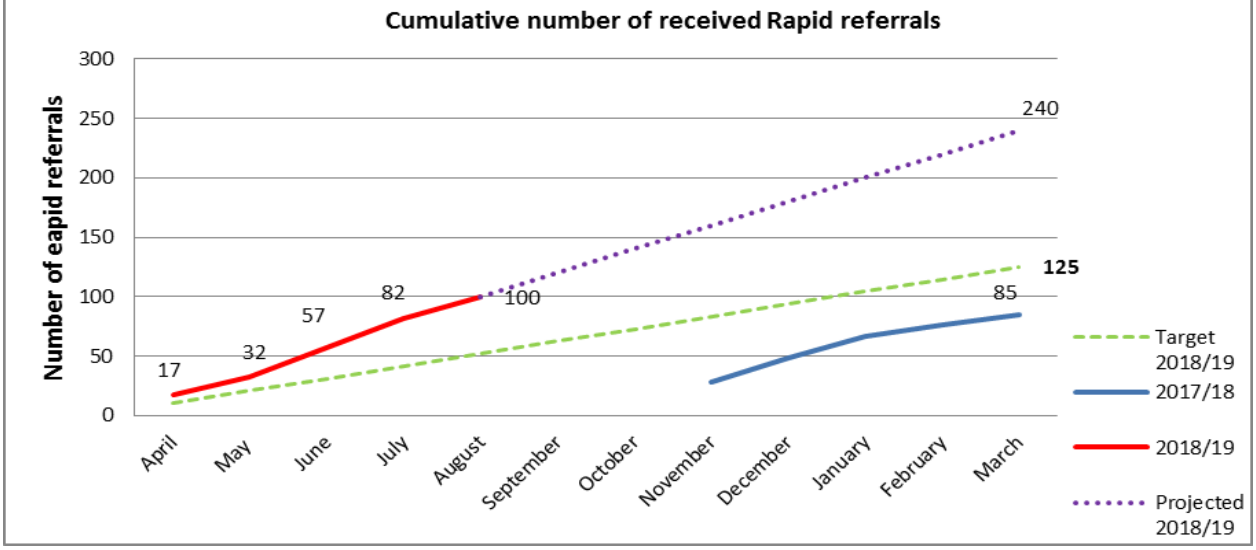


Cumulative number of supported Rapid referrals	
Target performance per annum (not less than)	125
Actual performance this month	17

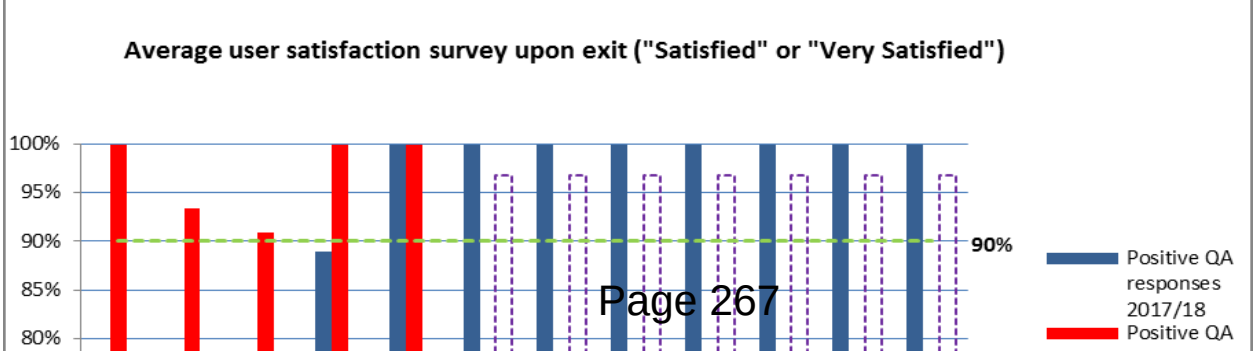
Projected average performance (based on performance to date)	221
Status	Green
Status change since last month	↓

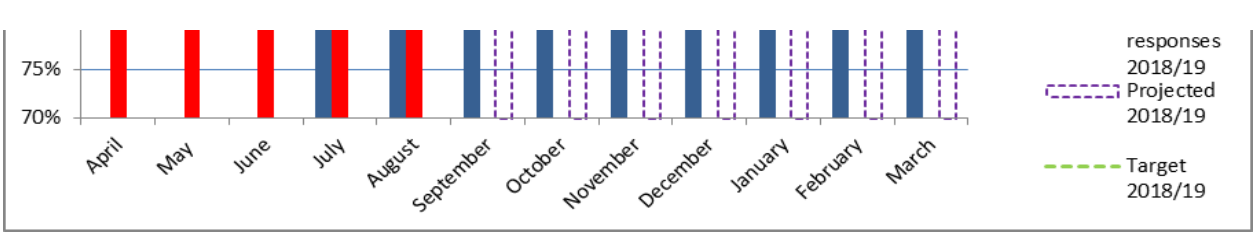


Cumulative number of received Rapid referrals	
Target performance per annum (not less than)	125
Actual performance this month	18
Projected average performance (based on performance to date)	240
Status	Green
Status change since last month	↓

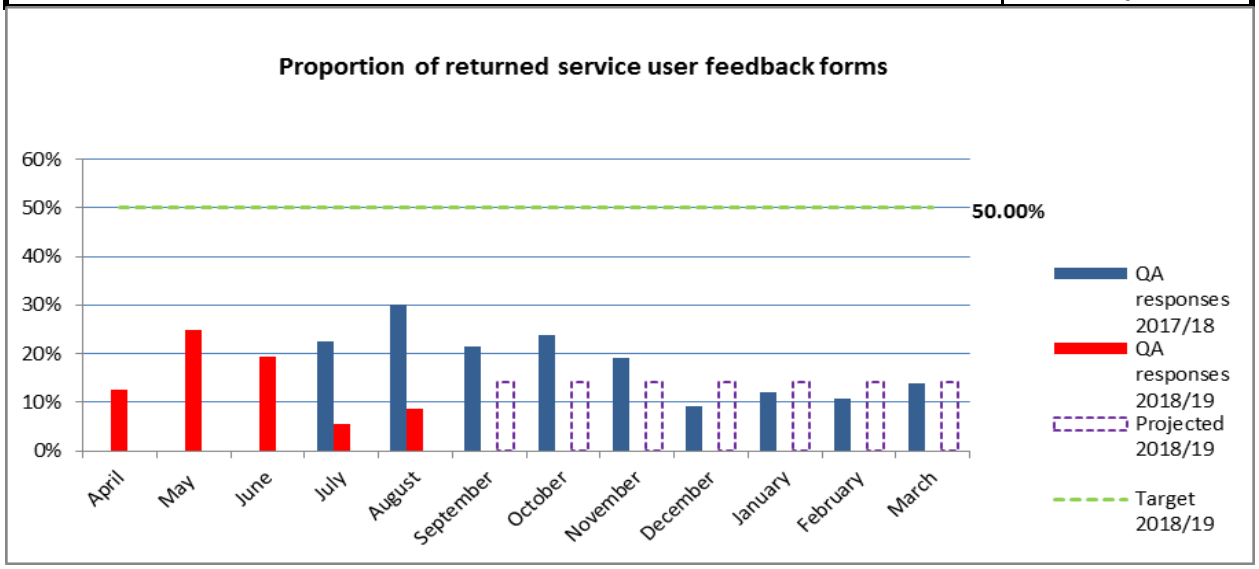


Average user satisfaction survey upon exit ("Satisfied" or "Very Satisfied")	
Target performance (not less than)	90%
Actual performance this month	100%
Projected average performance (based on performance to date)	97%
Status	Green
Status change since last month	→

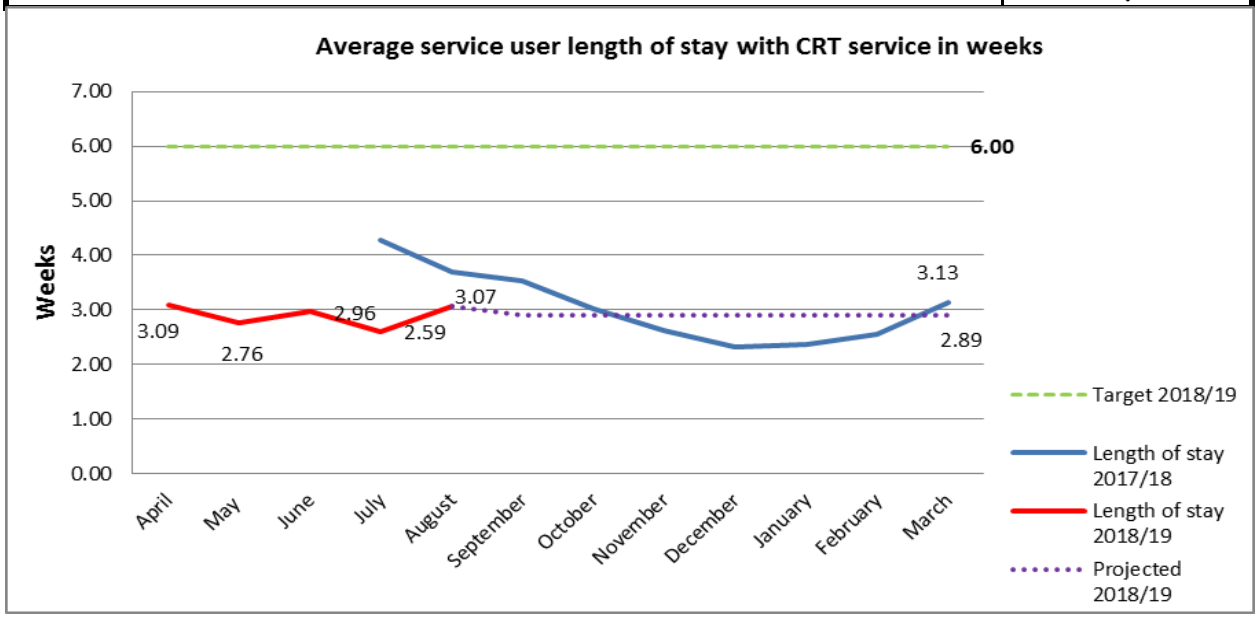




Proportion of returned service user feedback forms	
Target performance (not less than)	50%
Actual performance this month	9%
Projected average performance (based on performance to date)	14%
Status	Red
Status change since last month	↑

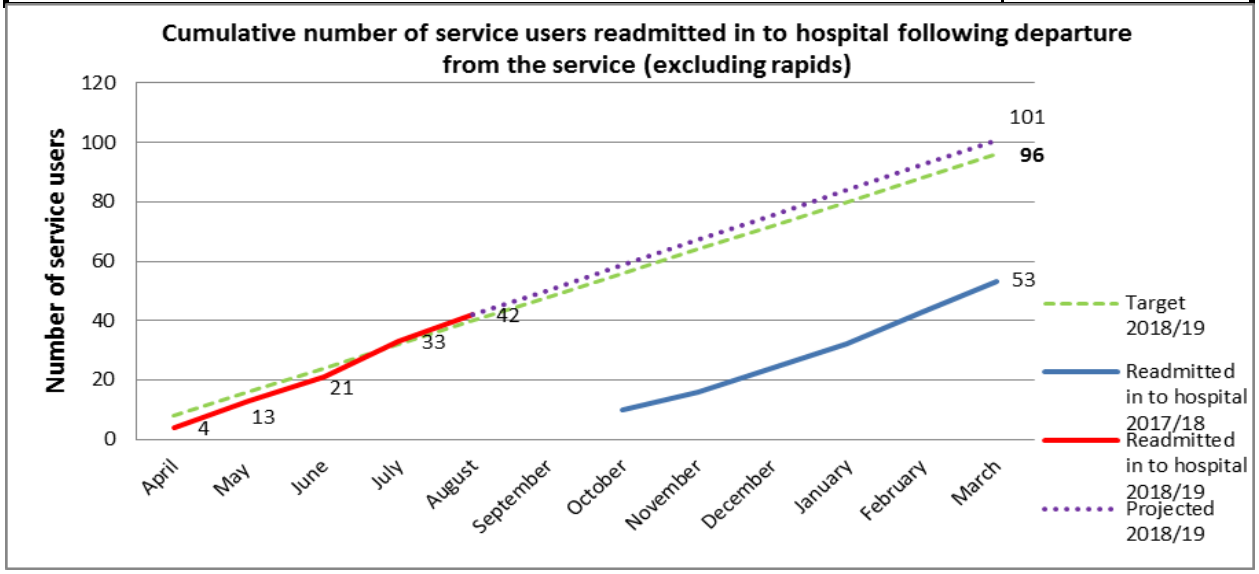


Average service user length of stay with CRT service in weeks	
Target performance per month (no more than)	6.00
Actual performance this month	3.07
Projected average performance (based on performance to date)	2.89
Status	Green
Status change since last month	↓

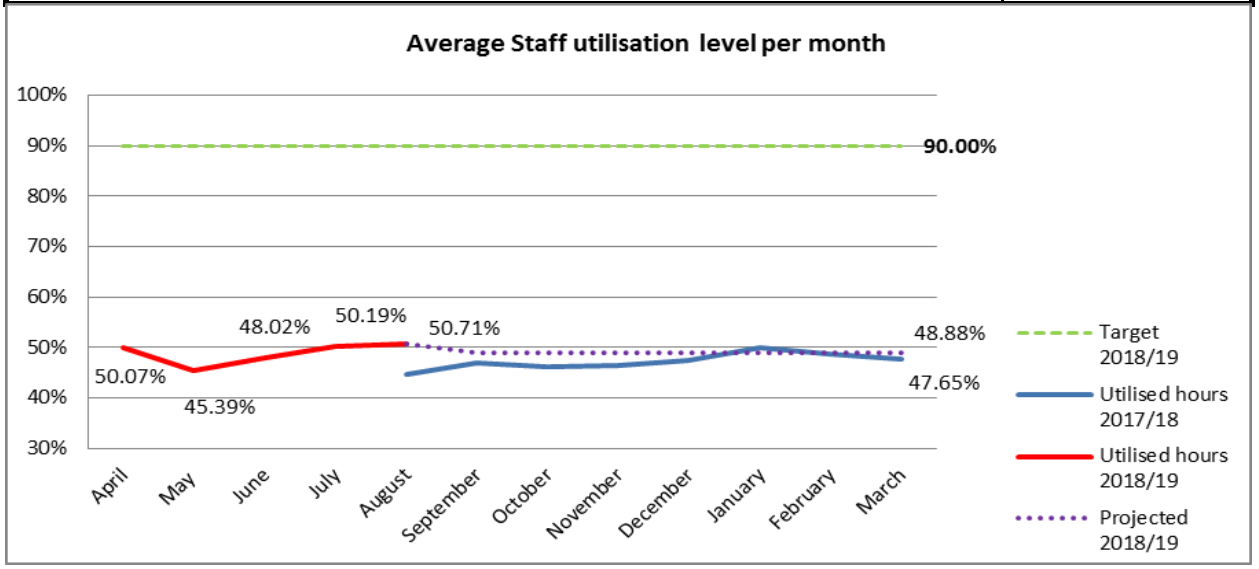


Cumulative number of service users readmitted in to hospital following departure from the service (excluding rapids)	
Target performance per annum (no more than)	96
Actual performance per month	9
Projected average performance (based on performance to date)	101
Status	Amber

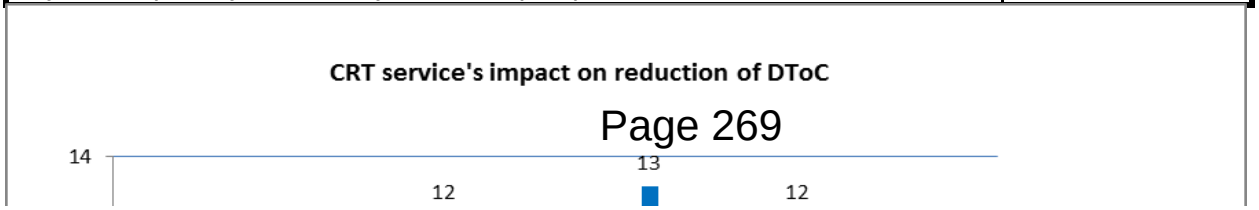
Status change since last month	↑

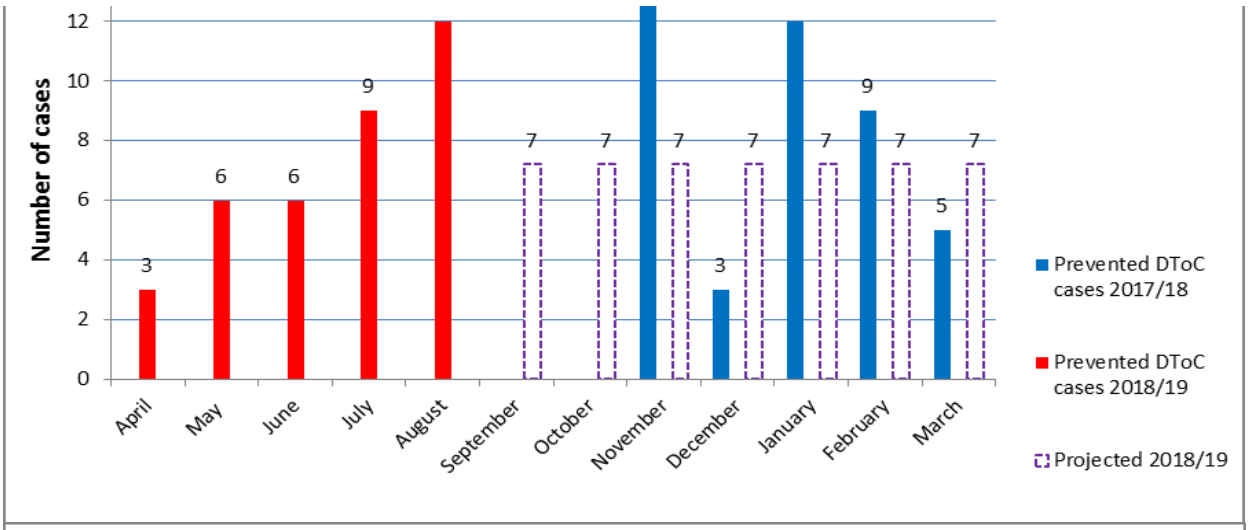


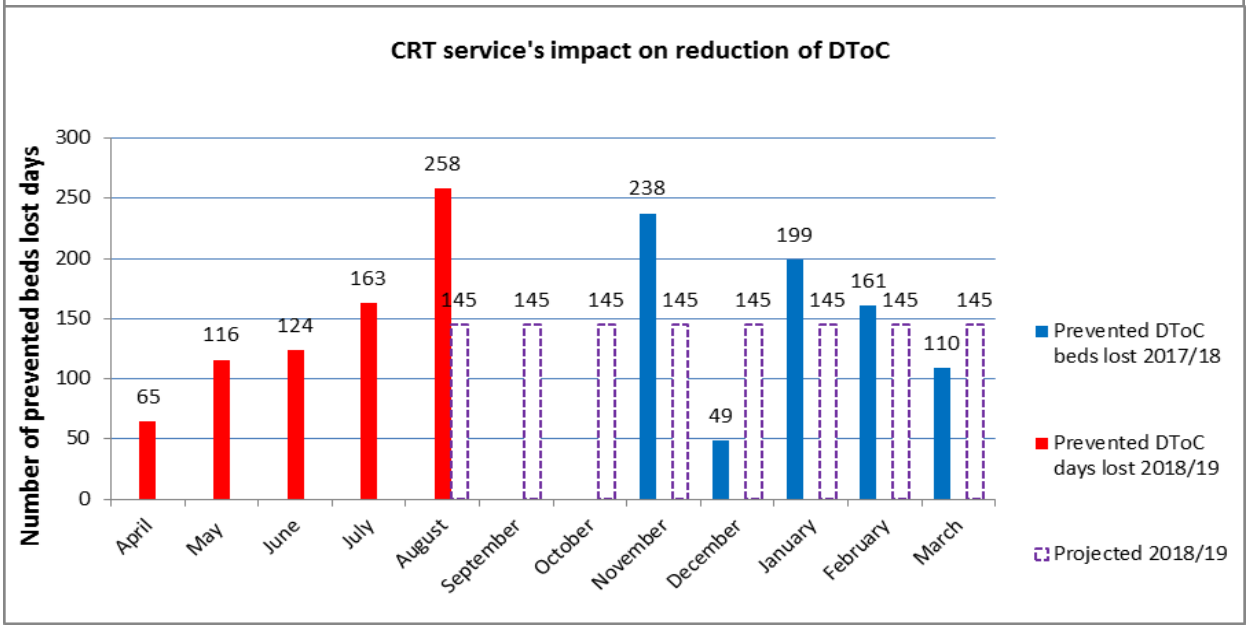
Average Staff utilisation level per month	
Target performance (not less than)	90%
Actual performance this month	51%
Projected average performance (based on performance to date)	49%
Status	Red
Status change since last month	↑



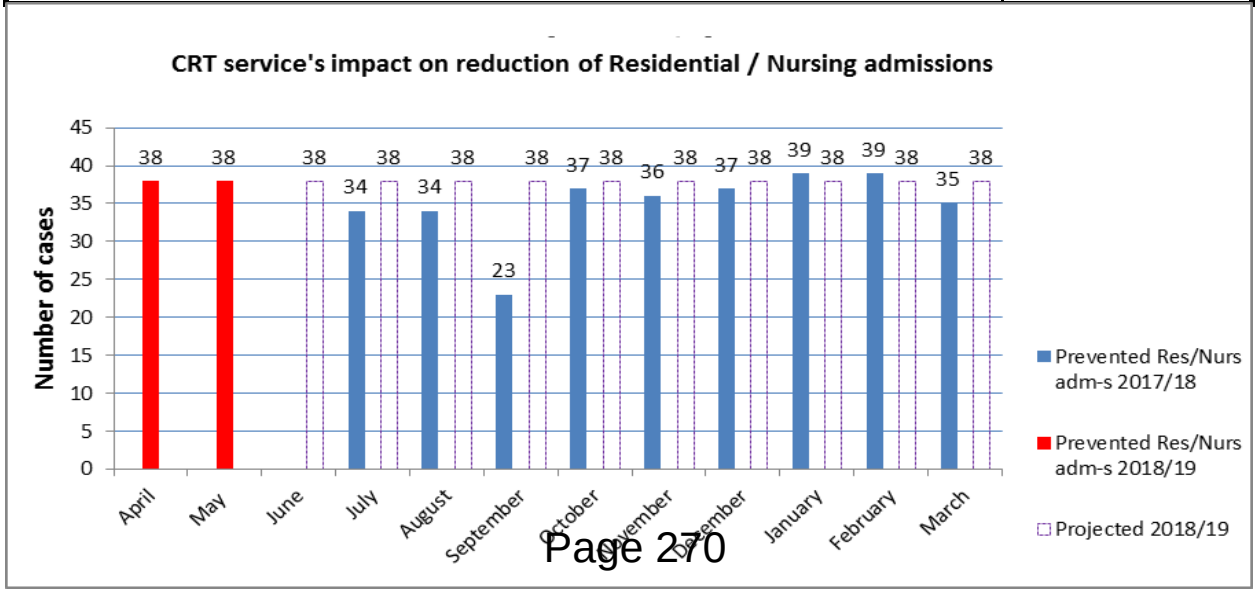
CRT service's impact on reduction of DToC	
Actual performance this month (Number of referrals from hospitals)	12
Projected average performance (based on performance to date)	7
Average length of stay with the service (days)	21
Actual performance this month (Overall days that hospital referrals have spent in a service outside of a hospital FY to date (no. referrals x average length of stay in service))	258
Projected average monthly performance (based on performance to date)	145
Cumulative overall number of days that hospital referrals have spent in a service outside of hospital	726
Cumulative estimated cost avoidance to hospital FY to date (average length of stay x £400 per day cost of stay with a hospital)	£290,400



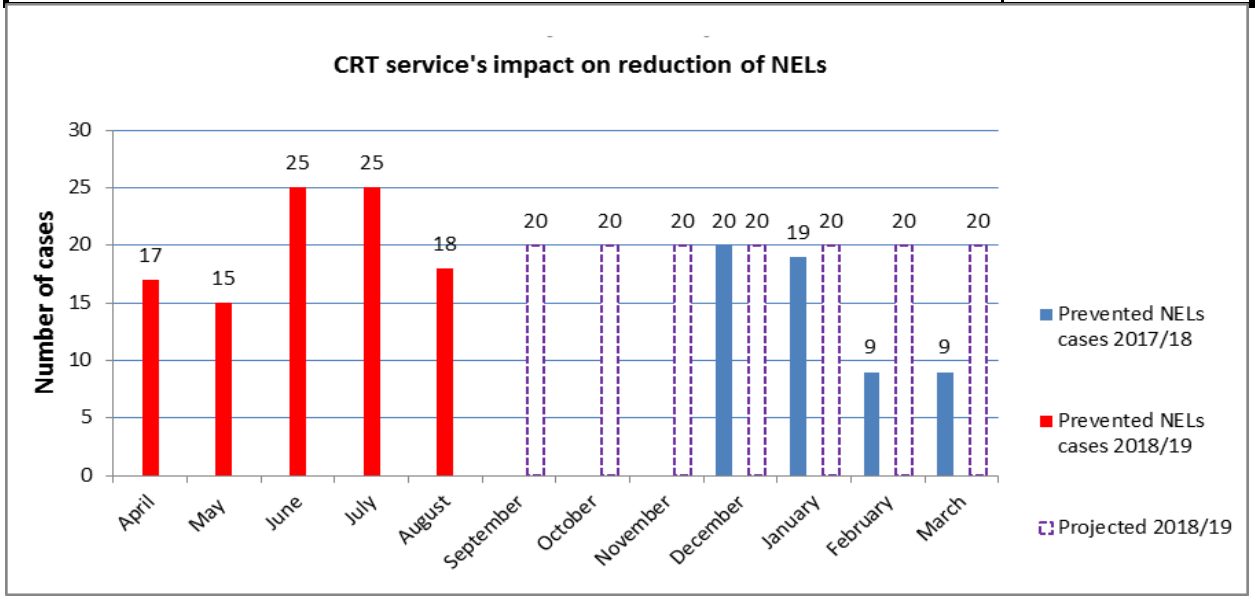




CRT service's impact on reduction of Residential / Nursing admissions	
Actual performance this month (number of clients that returned home following discharge (rather than entering residential / nursing))	38
Projected average performance (based on performance to date)	38
Cumulative overall number of clients that returned home following discharge FY to date	76
Cumulative estimated cost avoidance to the system FY to date (number of admissions avoided x £719 average cost of a residential / nursing placement per week)	£359,089



CRT service's impact on reduction of NELs	
Actual performance this month (number of cases)	18
Projected average performance (based on performance to date)	20



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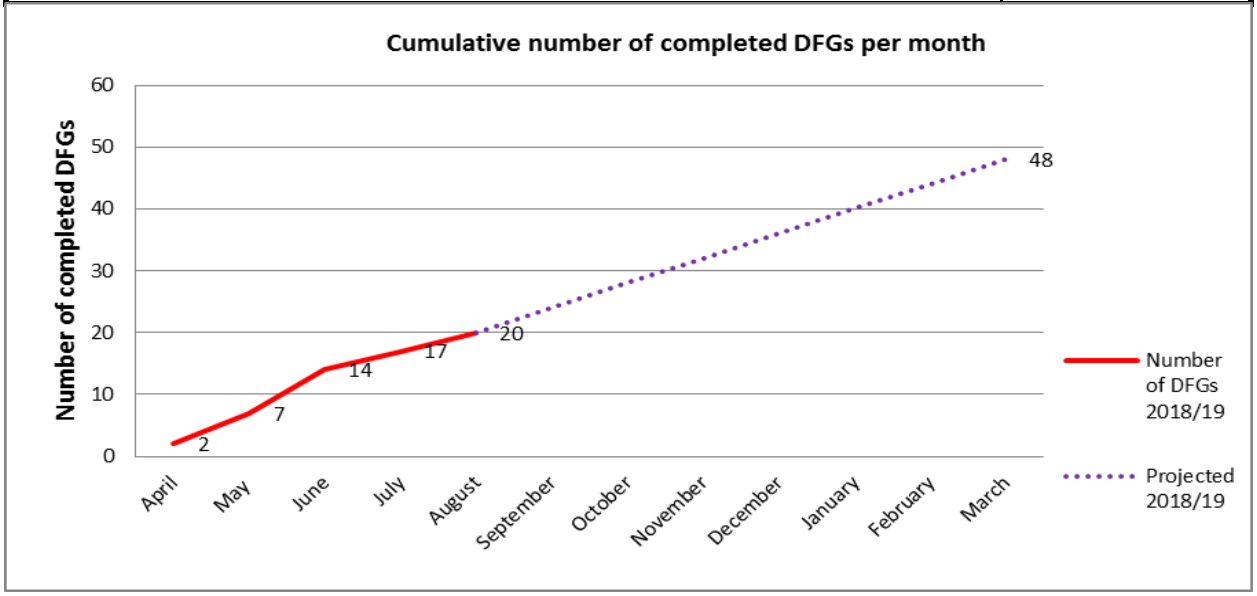
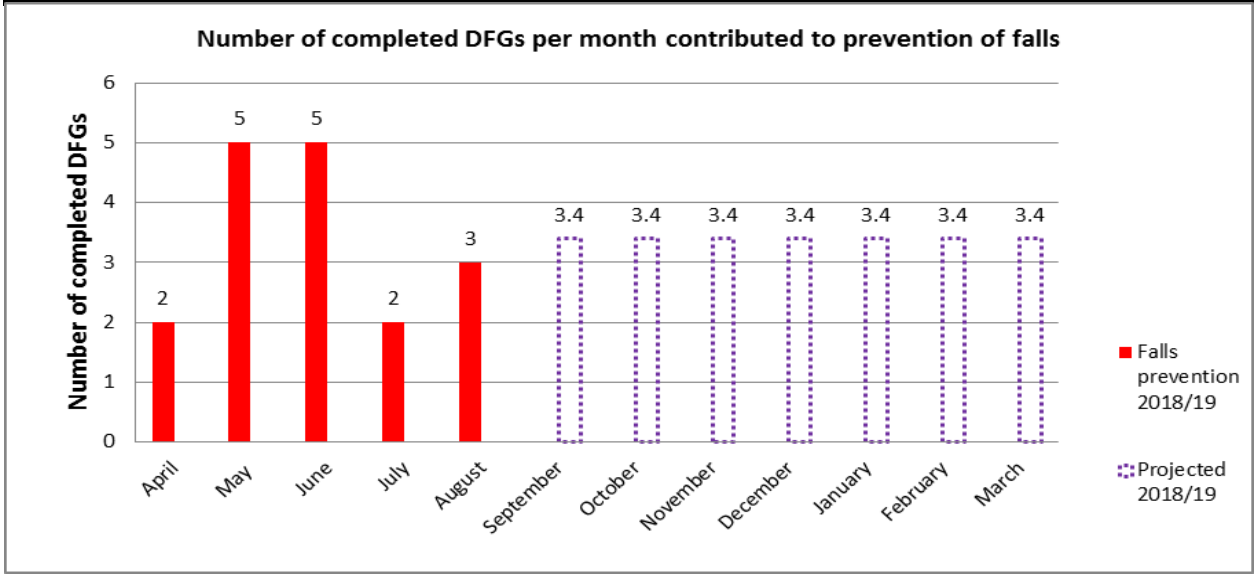
Local Targett: Disable Facilities Grant

Local Targets:	Disable Facilities Grant (DFG)
Reporting Month:	Month 5 (August 2018)

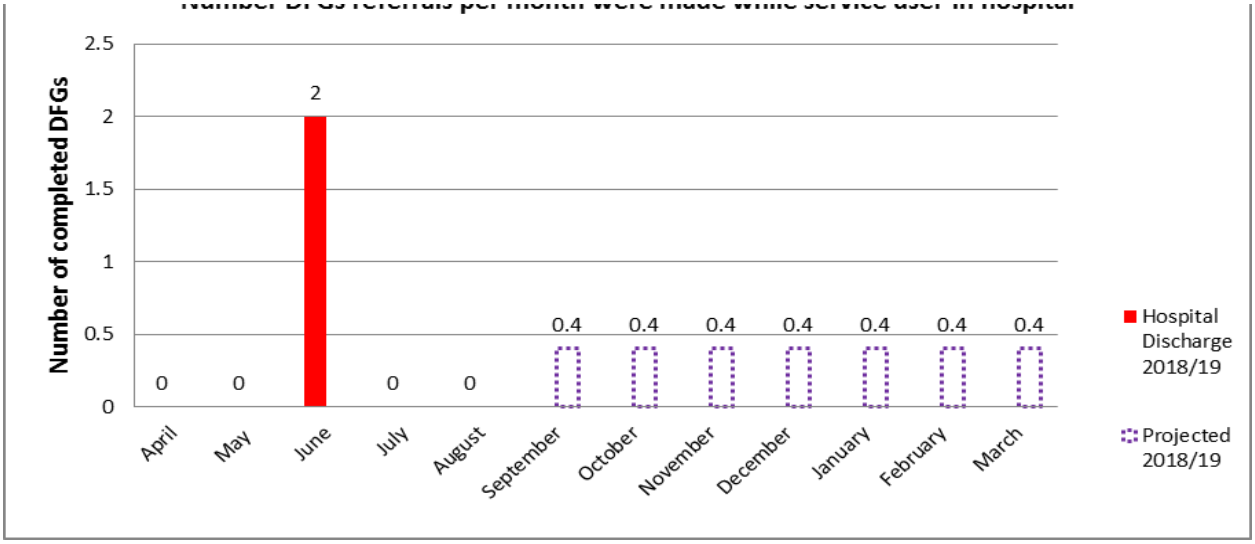
Number of completed DFGs per month	
Number of completed DFGs (per month)	3
Projected average performance (based on performance to date) per annum	48



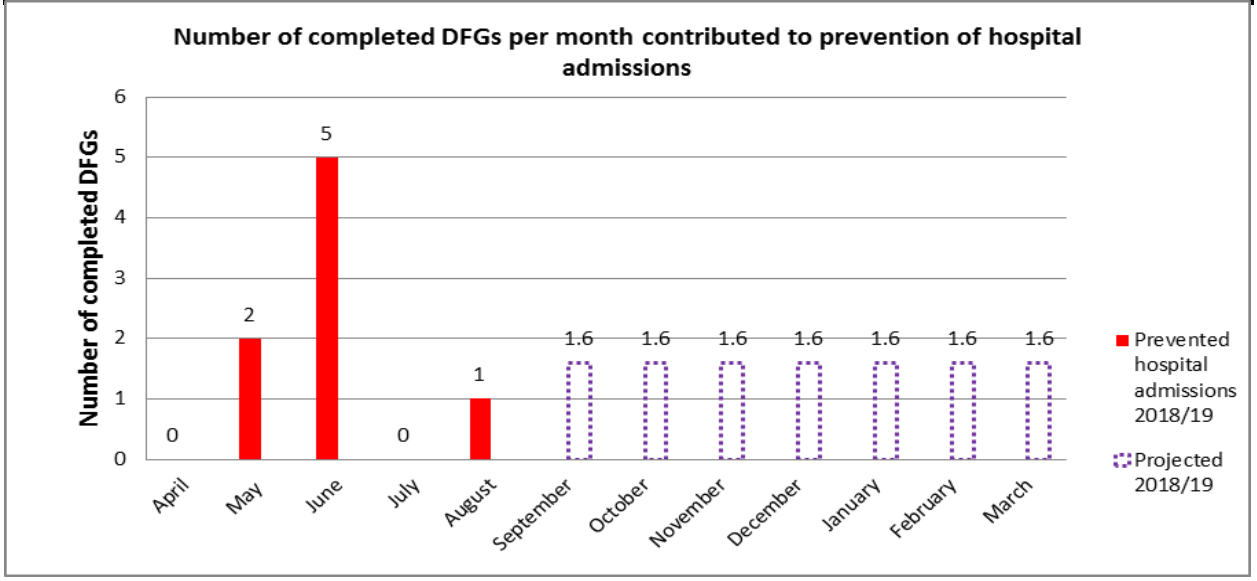
Number of completed DFGs per month contributed to prevention of falls	
Number of completed DFGs contributed to prevention of falls (per month)	3
Projected average monthly performance (based on performance to date)	3.4



Number DFGs referrals per month were made while service user in hospital	
Number DFGs referrals were made while service user in hospital (per month)	0
Projected average monthly performance (based on performance to date)	0.4

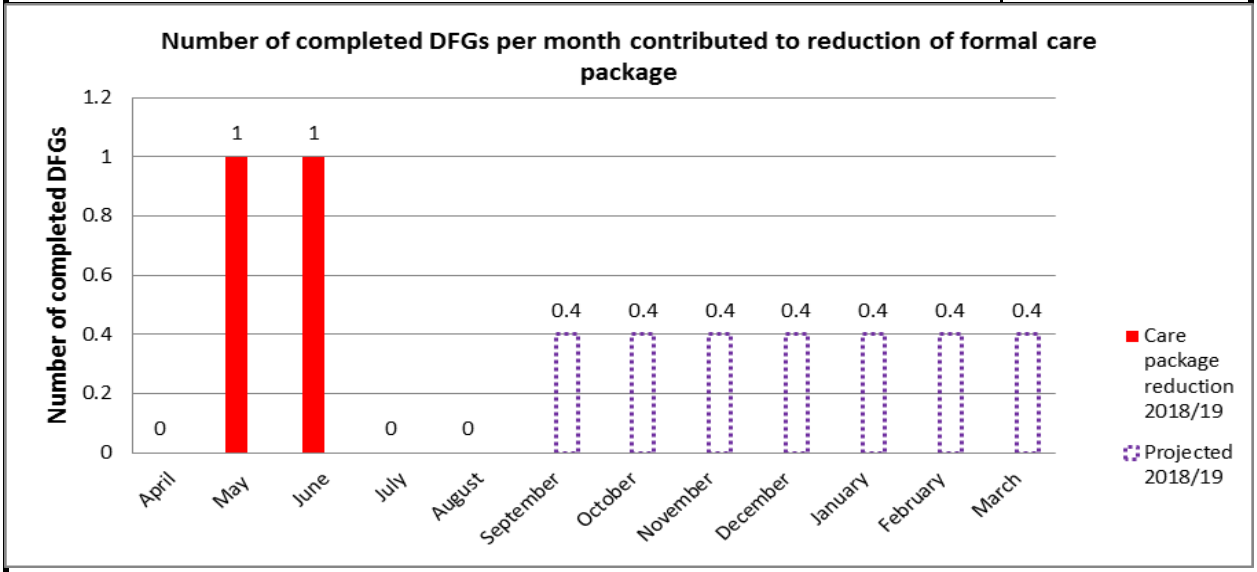


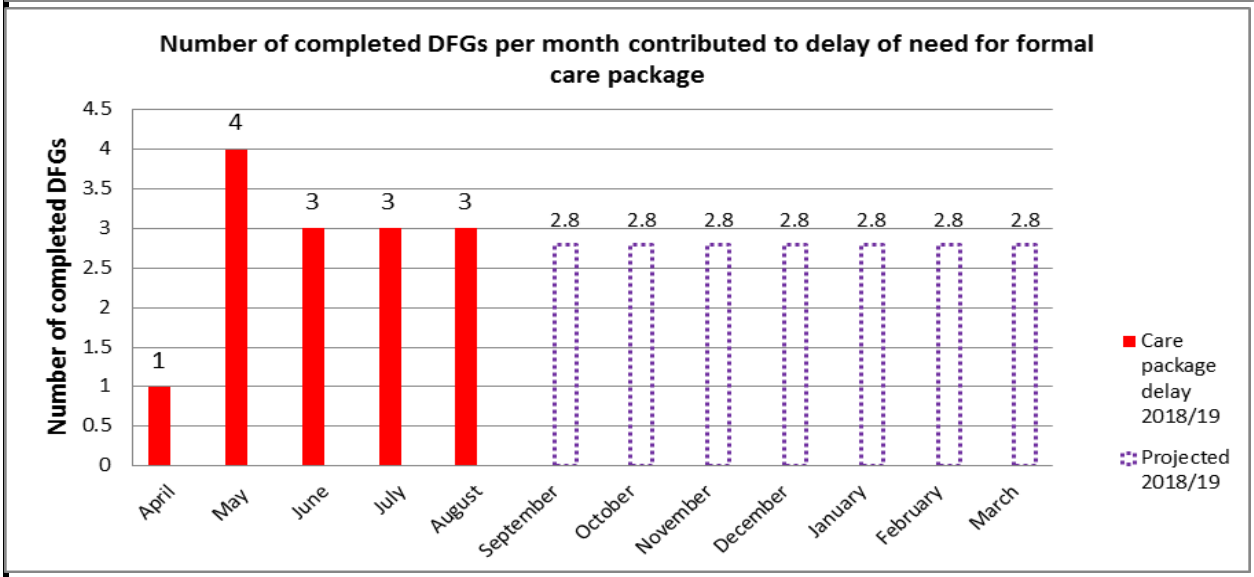
Number of completed DFGs per month contributed to prevention of hospital admissions (based on number of DFG referrals for people who've had a previous hospital admission in the preceding 12 months)	
Number of completed DFGs contributed to prevention of hospital admissions (per month)	1
Projected average monthly performance (based on performance to date)	1.6



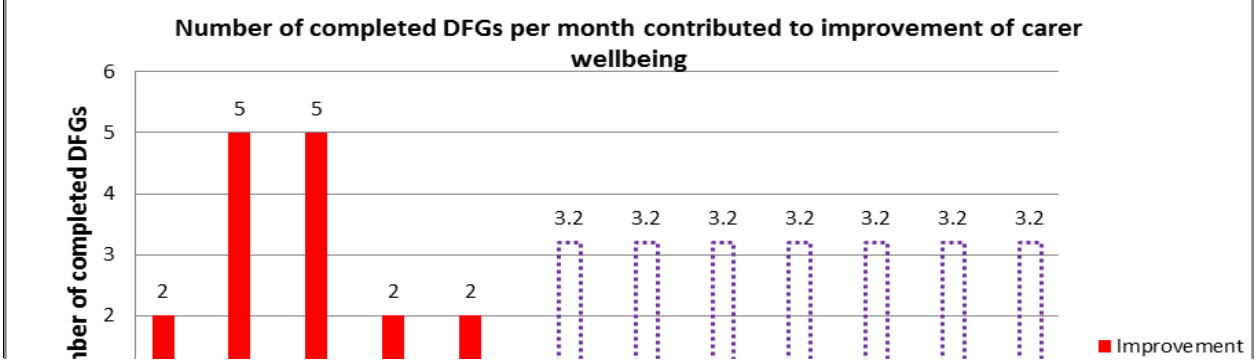
Number of completed DFGs per month contributed to reduction of formal care package / prevention of need for formal care package	
Number of completed DFGs contributed to reduction of formal care package (per month)	0
Projected average monthly performance (based on performance to date)	0.4
Cumulative number of DFGs contributed to reduction of formal care package (FY to date)	2
Cumulative estimated total reductions in care package cost (FY to date)	£3,893
Number of completed DFGs contributed to delay of need for formal care package (per month)	3
Projected average monthly performance (based on performance to date)	2.80

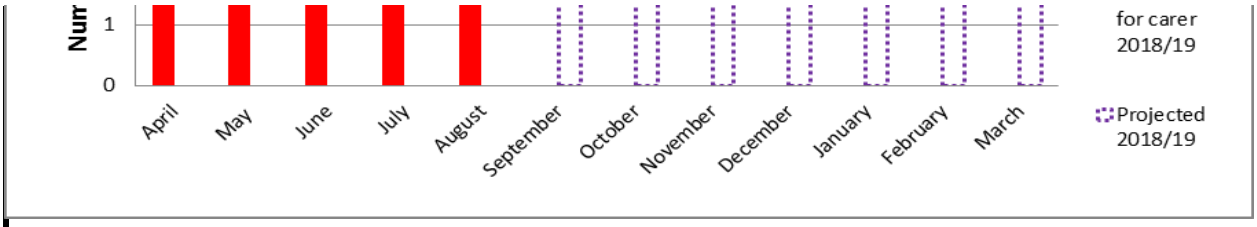
Cumulative number of DFGs contributed to to delay of need for formal care package (FY to date)	14
Cumulative estimated total reductions in care package cost (FY to date (number of formal care packages delayed x £230 average cost of a home care placement per week))	£39,049



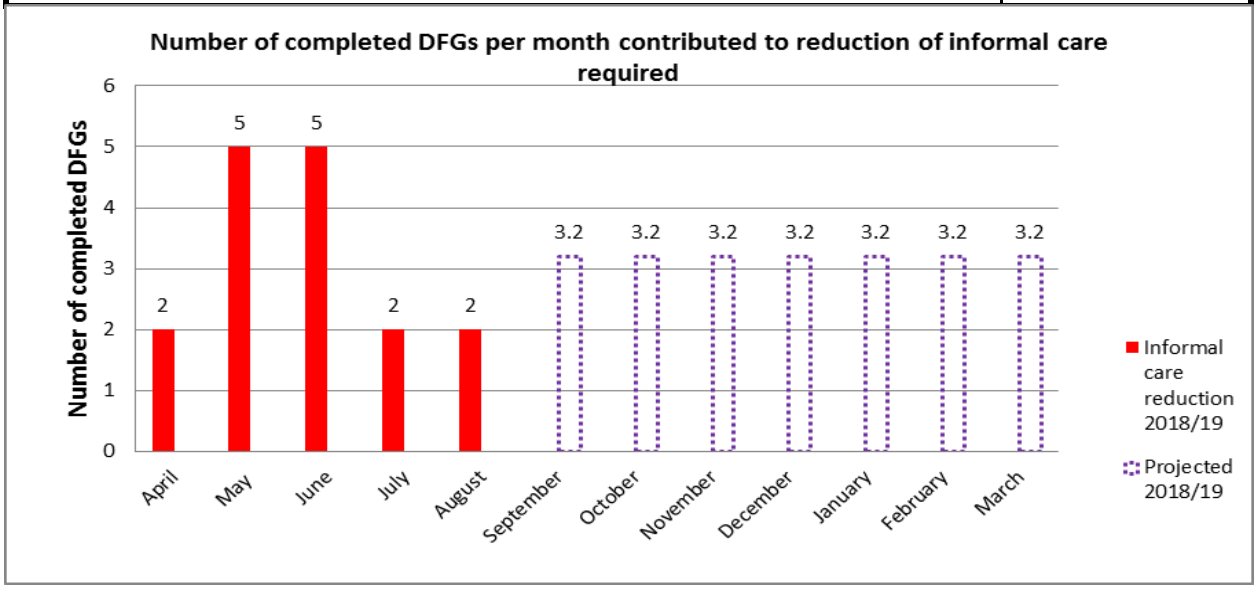


Number of completed DFGs per month contributed to improvement of carer wellbeing	
Number of completed DFGs contributed to improvement of carer wellbeing (per month)	2
Projected average monthly performance (based on performance to date)	3.2





Number of completed DFGs per month contributed to reduction of informal care required	
Number of completed DFGs contributed to reduction of informal care required (per month)	2
Projected average monthly performance (based on performance to date)	3.2



Case study - 1 per month	
Type of job completed	Wheelchair access, bathroom adaptation, other repairs
Time for adaption completion	68 weeks

Client x lives alone with a degenerative condition. Her requirements were to get wheelchair access in and out of her home and for her bathroom to be adapted so that she could safely use it (a Level Access Shower). During an assessment by a Technical Officer it became clear the home would also need a number of other works such as rewiring, installing additional sockets and repairs to the windows and roof.

We were able to use a Decent Homes grant to carry out these additional works which not only enabled the necessary adaptations to be installed but for the client to continue to live safely in her home. Due to the extensive nature of the works they were not carried out as quickly as other cases but the client is now able to continue living in her home for the foreseeable future.

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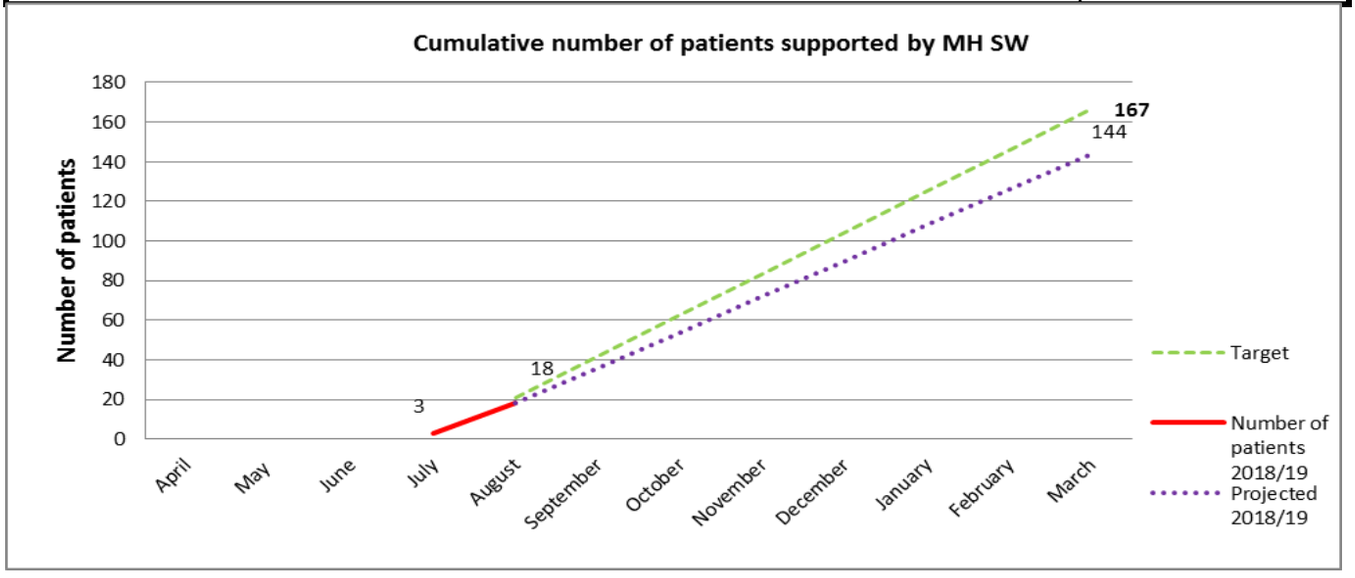
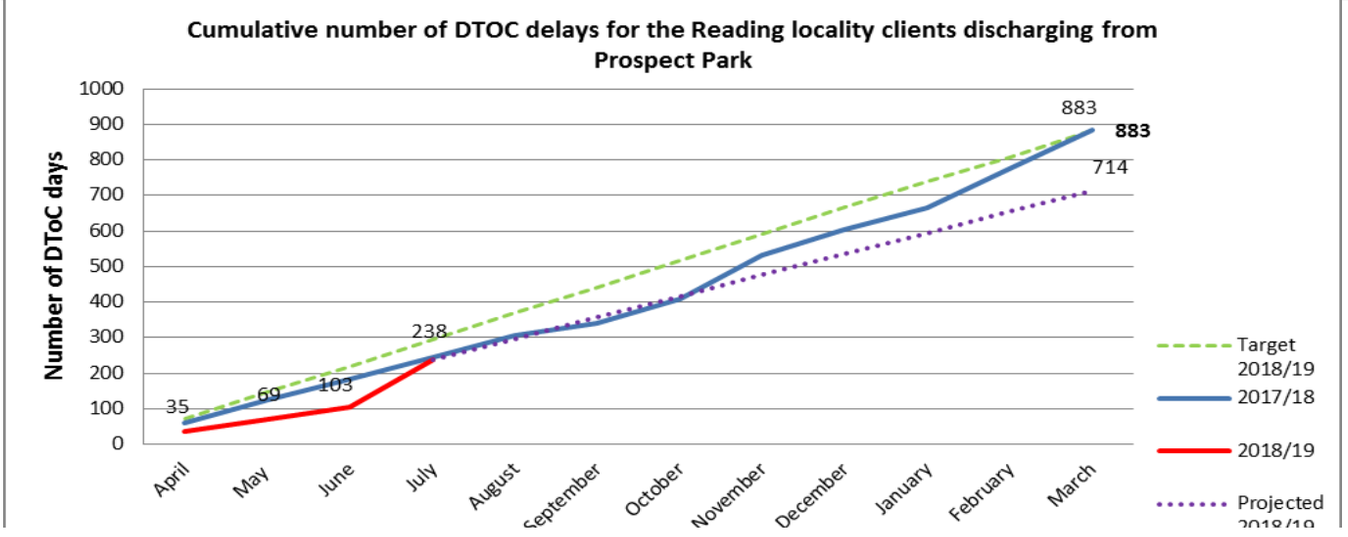
Local Target: Mental Health Social Worker

Local Targets:	Mental Health Social Worker in Prospect Park Hospital
Reporting Month:	Month 5 (August 2018)
Status:	Amber

Cumulative number of supported cases per month	
Target performance per year (not less than)	250
Actual performance this month	15
Projected average performance (based on performance to date)	216
Status	Amber
Status change since last month	→



Cumulative number of SC and Both attributed DTOC delays for the Reading locality clients discharging from Prospect Park	
Target performance per year (not more than)	883
Actual performance this month	135
Projected average performance (based on performance to date)	714
Status	Green
Status change since last month	↓



Number of readmissions within 90 days associated with clients who have been supported by the MH Social Worker role	
Target performance per year (not more than)	0
Actual performance this month	0
Projected average performance (based on performance to date)	0
Status	Green
Status change since last month	↑

No data until November 2018

Case study - 1 per month	
Main challenge	
Length of provided support	
No case study supplied	

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NHS North and West Reading Clinical Commissioning Group

Reading Borough Council Working better with you

NHS South Reading Clinical Commissioning Group

READING HEALTH AND WELLBEING BOARD

DATE OF MEETING:	**12 October 2018**	**AGENDA ITEM:**	**13**
REPORT TITLE:	**Health and Wellbeing Dashboard - October 2018**		
REPORT AUTHOR:	**Kim McCall**	**TEL:**	**0118 9373245**
JOB TITLE:	**Health and Wellbeing Intelligence Officer**	**E-MAIL:**	**kim.mccall@reading.gov.uk**
ORGANISATION:	**Reading Borough Council**		

1. PURPOSE OF REPORT AND EXECUTIVE SUMMARY

1.1 The Health and Wellbeing Dashboard is intended to keep Board members informed of local trends in priority areas identified in the Health and Wellbeing Strategy. The broad format has previously been agreed by the Board.

1.2 Appendix A - Health and Wellbeing Dashboard – October 2018

2. RECOMMENDED ACTION

2.1 That the Health and Wellbeing Board notes the following performance updates contained in the dashboard:

- **Health checks indicators updated with Q1 performance**
- **Alcohol treatment completion has been updated with Q1 performance**
- **Estimated dementia diagnosis rate (aged 65+) has been updated with monthly snapshots.**
- **% pupils with social, emotional and mental health needs (primary, secondary and all schools) with 2018 data**

2.3 That the Health and Wellbeing Board notes the following areas where performance is worse than set target.

<u>Priority 1</u>

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 is unlikely to 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 in 2018/19**.** 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

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 average (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 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

2.15iii - Successful treatment of alcohol treatment

At the end of 2017/18, the proportion of people receiving alcohol treatment who successfully complete treatment fell below the national average for the first time since 2015. Statistically, the rate is similar to the national average**.** Performance has improved and remained stable following the commissioning of a new, single treatment provider in October 2014. The treatment provider has reported a drop in performance in recent months and has been reviewing all open cases in order to improve the rate of successful completion.

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 national average.

Priority 4

Pupils with social, emotional, and mental health needs (primary school age)

The proportion of primary school children with social, emotional or mental health need has risen slightly between 2017 and 2018, in line with the national average and the average amongst local authority areas with similar levels of deprivation.

Priority 5

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. Performance is stable, but remains below target.

Priority 8

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.

That the Health and Wellbeing Board notes that updates are expected to be available for the January meeting of the Board in relation to the following indicators (all dates are provisional)

2.3
- **Dementia friends (Priority 5) – update to number trained until end of August 2018**
- **Dementia diagnosis rate – monthly updates expected for September – November**
- **Health checks indicators Q2 updates expected**
- **Alcohol treatment completion Q2 update expected**
- **Excess weight in adults**
- **Smoking status at time of delivery**
- **Adult social care users with as much social contact as they would like**
- **Adult carer with as much social contact as they would like**
- **Incidence of TB**
- **Age-standardised mortality rate from suicide and injury of undetermined intent.**

3. POLICY CONTEXT

3.1 The final version of Reading's Health and Wellbeing Strategy was approved by the Health and Wellbeing Board on 27th January 2017 and an action plan based on the eight strategic priorities has been developed and sets out in detail how the priorities will be met.

3.2 In July 2016, Reading's Health and Wellbeing Board agreed to introduce a regular Health and Wellbeing Dashboard report to ensure that members of the board are kept informed about the Partnership's performance in its priority areas, compared to the national average and other similar local authority areas.

4. THE PROPOSAL

4.1 Current Position: The current Health and Wellbeing Dashboard has been developed in consultation with Health and Wellbeing Strategy Priority/Action Plan Leads. The dashboard will be presented to the board on a quarterly basis. **Board m**embers are presented with the full dashboard at each meeting in order to facilitate a review of performance against selected indicators and targets. Information about which indicators have been updated since the previous report will be included within the dashboard and highlighted in the covering report.

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

5.1 This proposal supports Corporate Plan priorities by ensuring that Health and Wellbeing Board members are kept informed of performance and progress against key indicators, including those that support corporate strategies.

6. COMMUNITY & STAKEHOLDER ENGAGEMENT

6.1 A wide range of voluntary and public sector partners and members of the public were encouraged to participate in the development of the Health and Wellbeing Strategy and, as described above, a draft of the proposed Strategy was made available for consultation between 10th October and 11th December 2016. The indicators included in this report reflect those areas highlighted during the development of the strategy and included in the final version.

7. EQUALITY IMPACT ASSESSMENT

7.1 An Equality Impact Assessment is not required in relation to the specific proposal to present the dashboard in thus format. However, it is anticipated that this will be one of the tools which Board members can use to monitor the success of the Health and Wellbeing strategy as a vehicle for tackling inequalities.

8. LEGAL IMPLICATIONS

8.1 There are no legal implications.

9. FINANCIAL IMPLICATIONS

9.1 The proposal to note the report in Appendix A offers value for money by ensuring that Board members are better able to determine how effort and resources are most likely to be invested beneficially in advance of the full Health and Wellbeing Dashboard.

10. BACKGROUND PAPERS

10.1 Reading Borough Council (2017) *Reading's Health and Wellbeing Strategy*

APPENDIX A – Health and Wellbeing dashboard October 2018

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 2014-2019	Not Met	Worse
	2.22 iv Cumulative % of those offered a healthcheck who received a healthcheck 2014-2019	Not Met	No change
	2.22 v Cumulative % of those aged 40-74 who received a healthcheck 2014-2019	Not Met	Worse
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)	Not Met	Worse
	Pupils with social, emotional and mental health needs (secondary school age)	Met	Better
	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	2016-17	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	2017	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	2017	27.6	28.9	Met	Better	25.7	23.7
2.22iii Cumulative % of those aged 40-74 offered a healthcheck 2014-2019	Public Health Outcomes Framework	www.healthcheck.nhs.uk	Annual	High	2014-2019	50.0%	100%	Not Met	Worse	76.7%	Not available
2.22 iv Cumulative % of those offered a healthcheck who received a healthcheck 2014-2019	Public Health Outcomes Framework	www.healthcheck.nhs.uk	Annual	High	2013-2018 Q4	49%	50%	Not Met	No change	48.3%	Not available
2.22 v Cumulative % of those aged 40-74 who received a healthcheck 2014-2019	Public Health Outcomes Framework	www.healthcheck.nhs.uk	Annual	High	2013-2018 Q4	25%	50%	Not Met	Worse	37.0%	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/1l % 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/1l % 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	Q1 2018/19	36.4%	38.3%	Not Met	Worse	38.9%	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	2018	2.4%	2.3%	Not Met	Worse	2.2%	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	2018	3.2%	3.3%	Met	Better	2.3%	2.1%
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	2018	3.0%	3.0%	Met	No change	2.4%	2.2%

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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	Monthly	High	Aug-18	67.1	67.7	Not Met	No change	67.3	66.2
No. of Dementia friends	NA (Local only)	Local Report	Quarterly	High	Sep-18	6818	6000	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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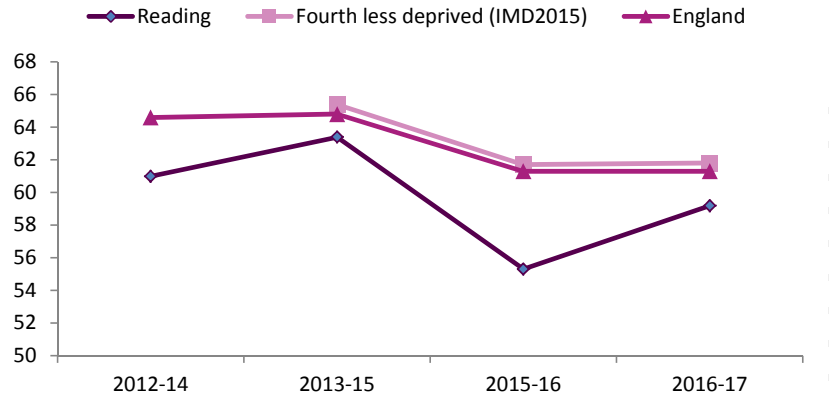
[Back to HWB Dashboard](#)	
Data source	Active Lives Survey (previously Active People Survey) Sport England
	* Note change in methodology in 2015-16
Denominator	Number of adults with valid height and weight recorded. Active lives Survey. Historical (before 2015-16) Number of adults with valid height 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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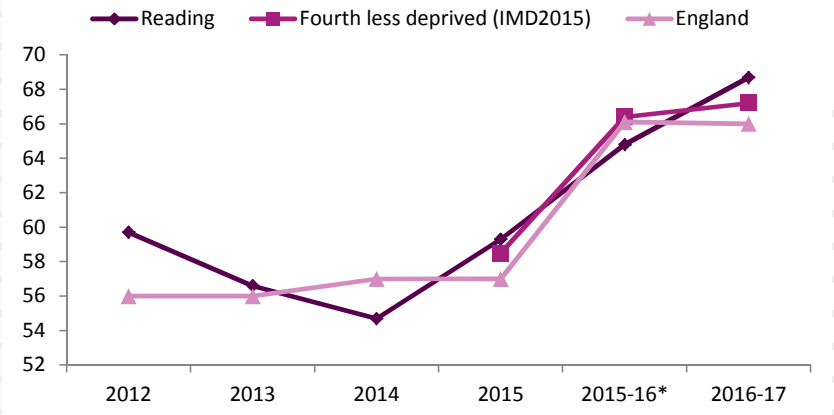
Data source	Until 2015 - Active People Survey, Sport England 2015-16 onwards - Active Lives, Sport England
	* Note change in methodology in 2015-16
Denominator	Weighted number of respondents aged 19 and older with valid responses to questions on physical activity
Numerator	Weighted number of respondents 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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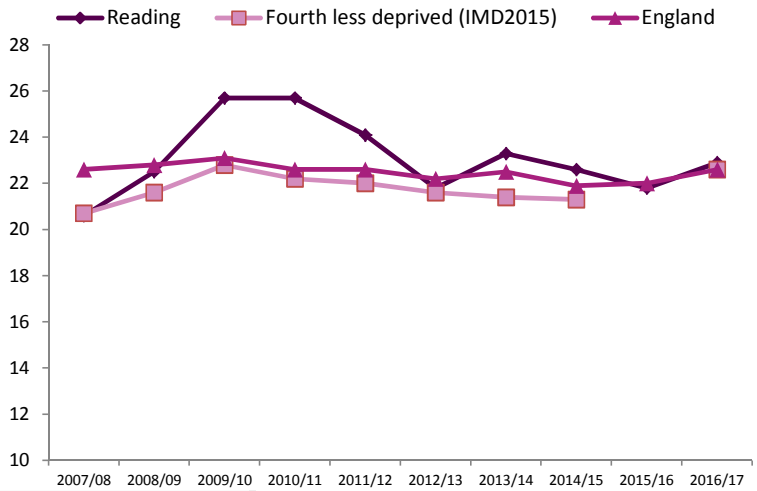
Data source	National Child Measurement Programme
Denominator	Number of children in Reception (aged 4-5 years) measured in the National Child Measurement Programme (NCMP) attending participating state maintained schools in England.
Numerator	Number of children in Reception (aged 4-5 years) classified 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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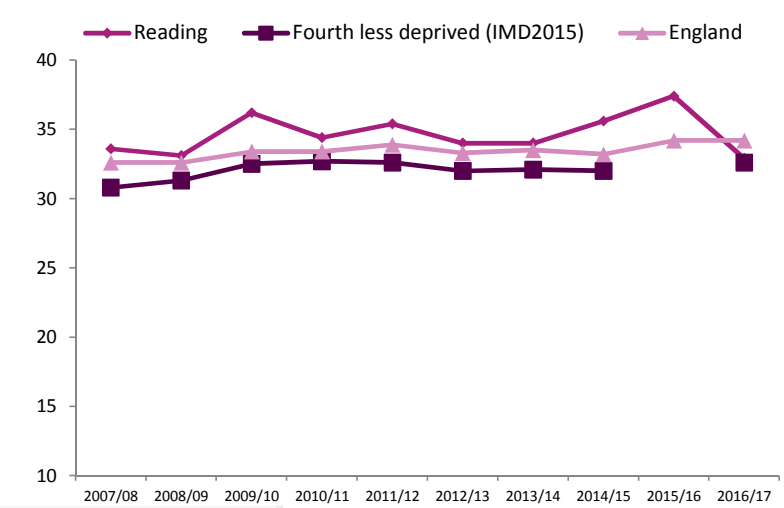
Data source	National Child Measurement Programme
Denominator	Number of children in Year 6 (aged 10-11 years) measured in the National Child Measurement Programme (NCMP) attending participating state maintained schools in England.
Numerator	Number of children in Year 6 (aged 10-11 years) classified as 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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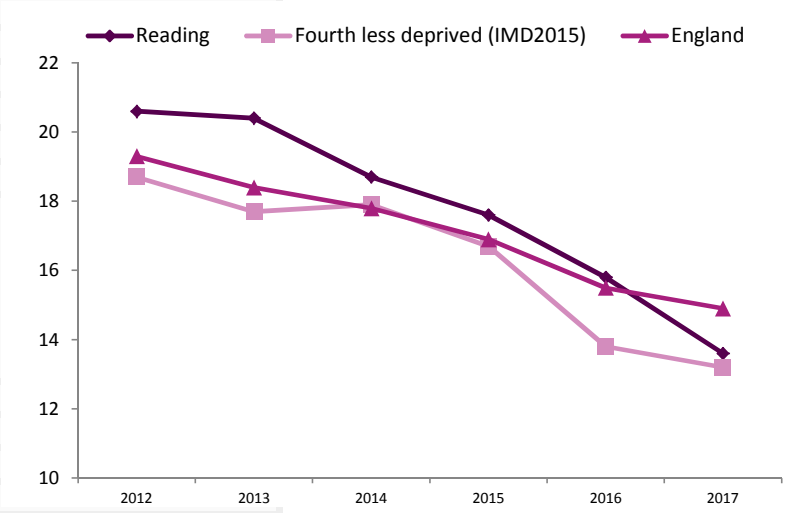
Data source	Annual Population Survey
Denominator	Total number of respondents (with valid recorded smoking status) aged 18+ from the Annual Population Survey. The number of respondents has been weighted in order to improve representativeness of the sample. The weights take into account survey design and 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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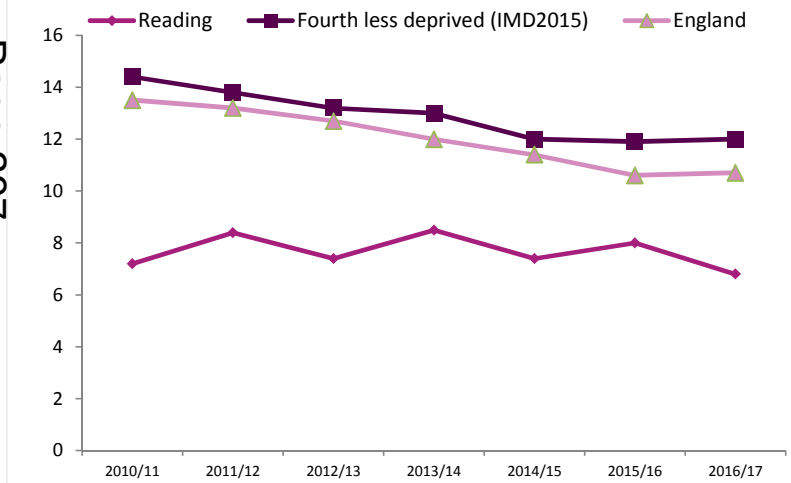
Data source	Calculated by KIT East from the Health and Social Care Information Centre's return on Smoking Status At Time of delivery (SSATOD)
Denominator	Number of maternities (estimated based on counts for CCGs)
Numerator	Number of women known to smoke at time of delivery (estimated based on counts 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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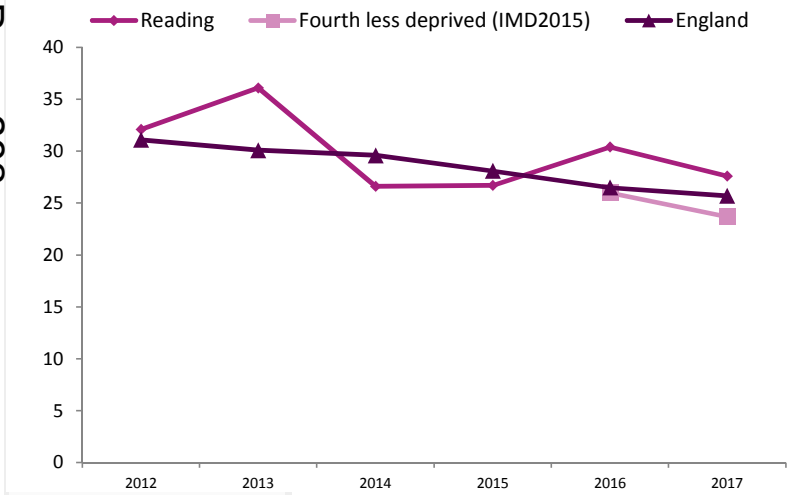
Period	Reading	Lower CI	Upper CI	Fourth less deprived (IMD2015)	England
2012	32.1	26.4	37.8	*NO DATA*	31.1
2013	36.1	30.1	42.1	*NO DATA*	30.1
2014	26.6	21.2	32	*NO DATA*	29.6
2015	26.7	20.6	32.7	*NO DATA*	28.1
2016	30.4	23	37.9	*26*	26.5
2017	27.6	19.4	35.8	*23.7*	25.7

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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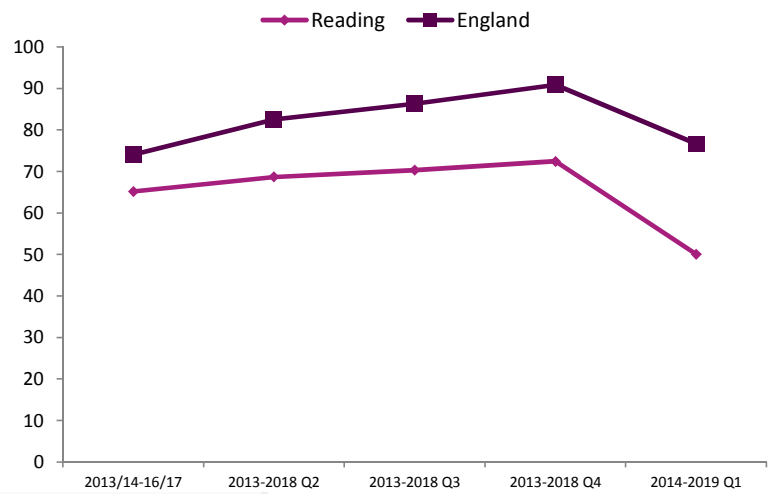
Data source	Public Health England - www.healthcheck.nhs.uk
Denominator	Number of people aged 40-74 eligible for an NHS Health Check in the five year period
Numerator	Number of people aged 40-74 eligible for an NHS Health Check who were offered an NHS Health Check in the five year period

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
2014-2019 Q1	50.08				76.67



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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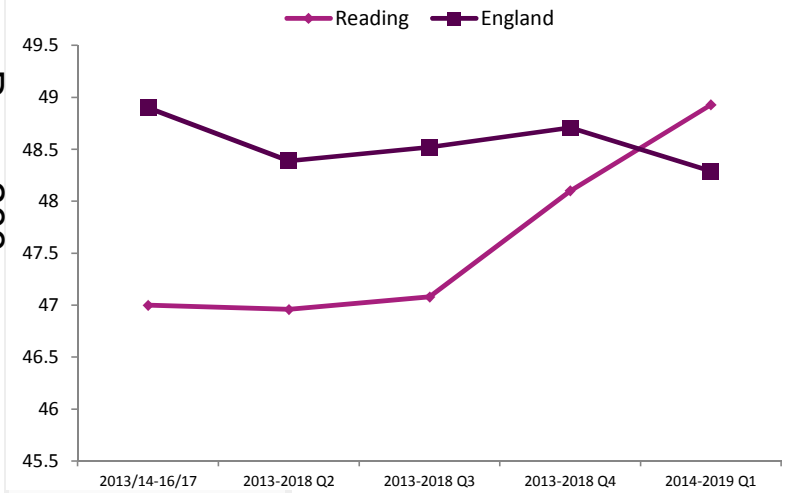
Data source	Public Health England - www.healthcheck.nhs.uk
Denominator	Number of people aged 40-74 offered an NHS Health Check in the five year period
Numerator	Number of people aged 40-74 eligible for an NHS Health Check received an NHS Health Check in the five year period

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
2014-2019 Q1	48.93				48.29



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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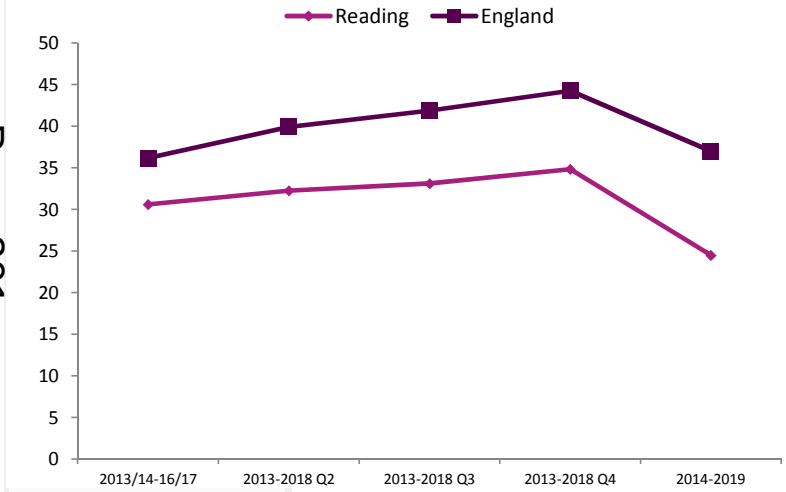
Data source	Public Health England - www.healthcheck.nhs.uk
Denominator	Number of people aged 40-74 eligible for an NHS Health Check in the five year period
Numerator	Number of people aged 40-74 eligible for an NHS Health Check who received an NHS Health Check in the five year period

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
2014-2019	24.5				37.02



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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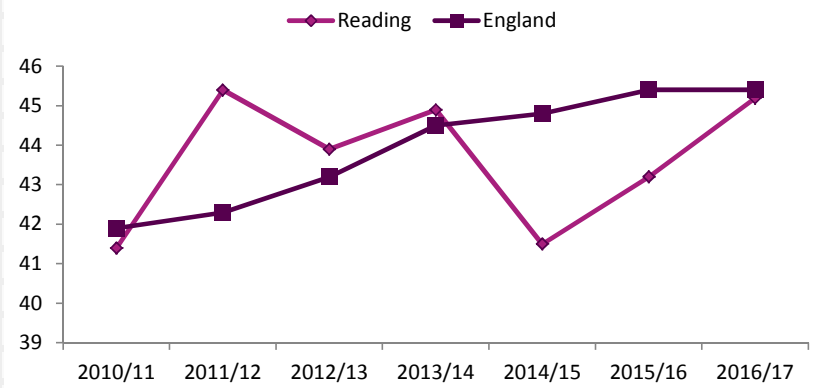
Data source	Adult Social Care Survey - England
	http://content.digital.nhs.uk/catalogue/PUB21630 - Annex Tables
Denominator	The number of people responding to the question "Thinking about how much contact you've had with people you like, which of the following statements best describes your social situation?"
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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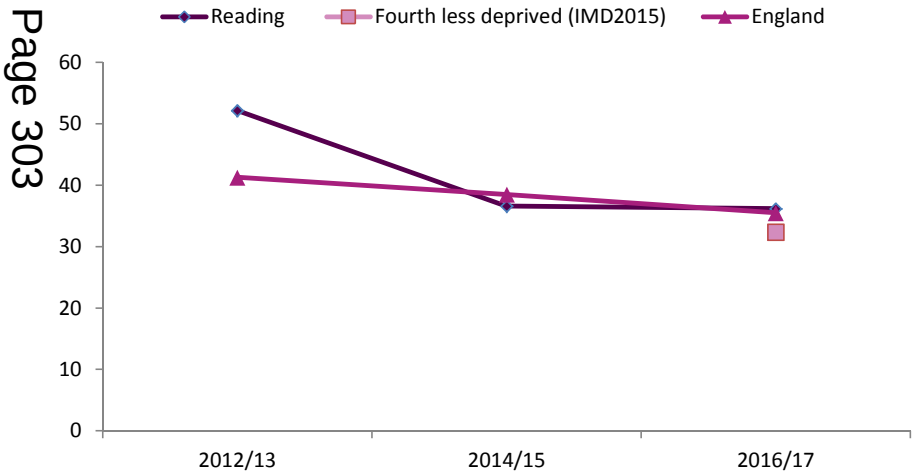
Data source	Carers Survey
Denominator	The number of people responding to the question "Thinking about how much contact you've had with people that you like, which of the following statements best describes your social situation?", with the answer "I have as much social contact as I want with people I 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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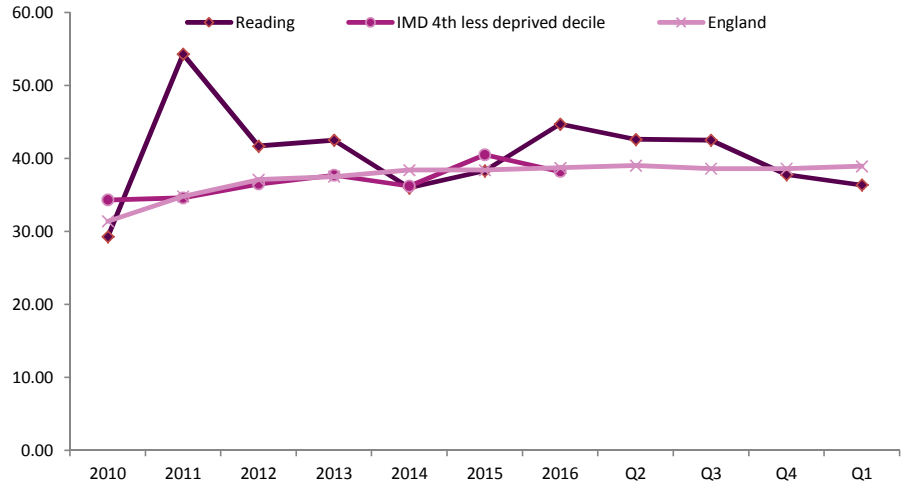
Data Source	National Drug Treatment Monitoring System
Denominator	Total number of adults in structured alcohol treatment in a one year period
Numerator	Adults that complete treatment for alcohol dependence who do not re-present to treatment within six months

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
Q1	36.36		38.92



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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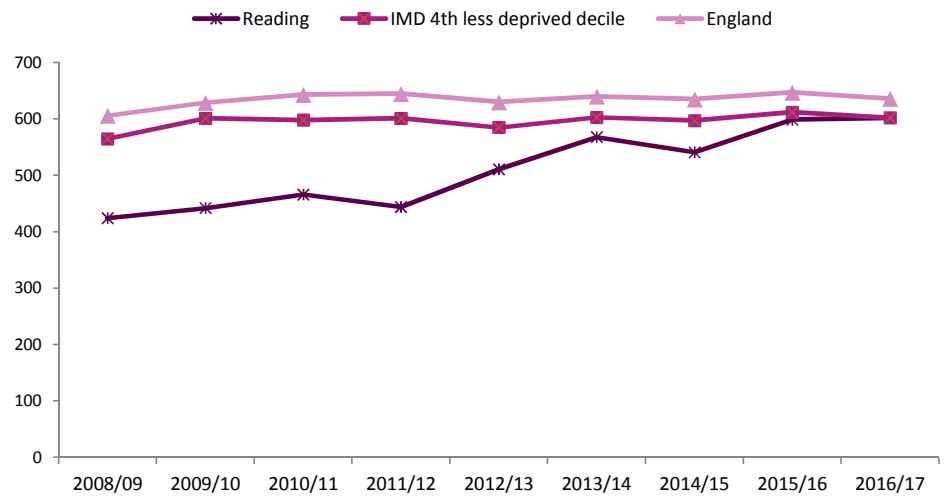
Data Source	Health and Social Care information Centre - Hospital Episode Statistics. Via Local Alcohol Profiles for England
Denominator	Mid-Year Population Estimates (ONS)
Numerator	Admissions to hospital where primary diagnosis is an alcohol-related condition or a seconday diagnosis is an alcohol-related 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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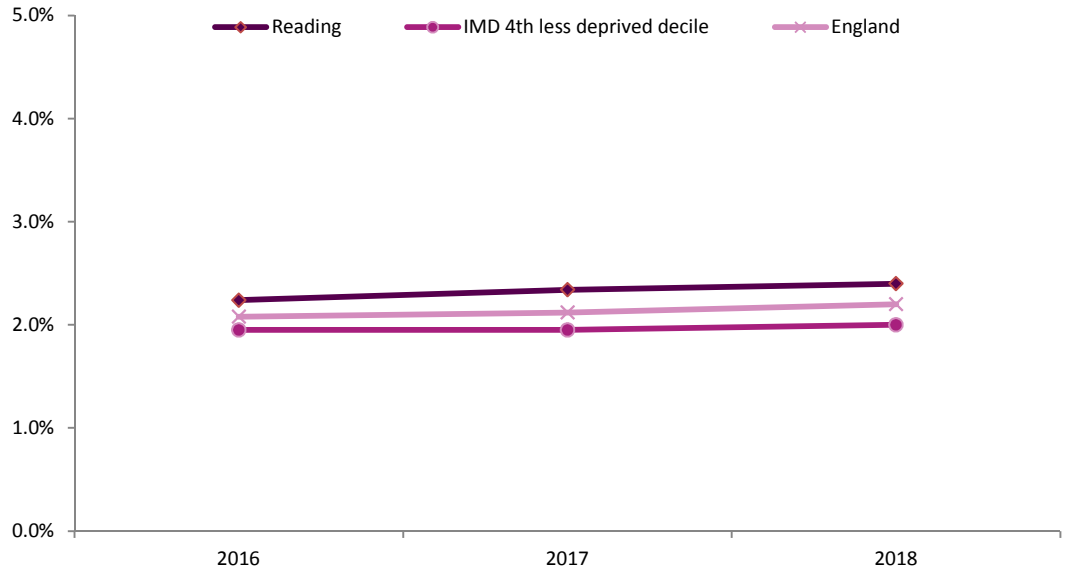
Data Source	DFE Special Needs Education Statistics
Denominator	Total pupils (LA tabulations) https://www.gov.uk/government/collections/statistics-special-educational-needs-sen
Numerator	Number of pupils with statements of SEN where primary need is social, emotional and mental health

Period	Reading	IMD 4th less deprived decile	England
2016	2.2%	2.0%	2.1%
2017	2.3%	2.0%	2.1%
2018	2.4%	2.0%	2.2%



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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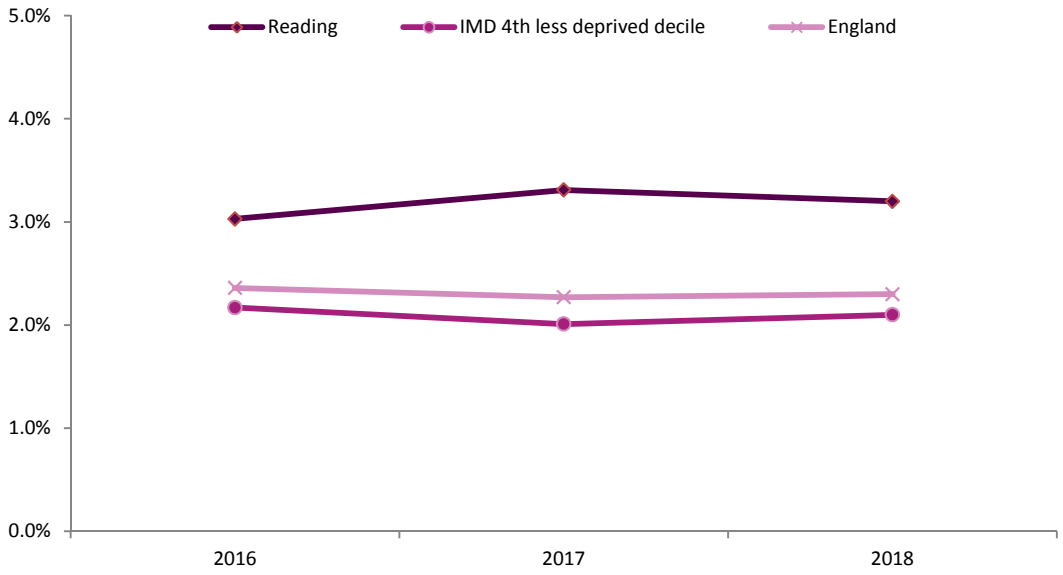
Data Source	DFE Special Needs Education Statistics
Denominator	Total pupils (LA tabulations) https://www.gov.uk/government/collections/statistics-special-educational-needs-sen
Numerator	Number of pupils with statements of SEN where primary need is social, emotional and mental health

Period	Reading	IMD 4th less deprived decile	England
2016	3.0%	2.2%	2.4%
2017	3.3%	2.0%	2.3%
2018	3.2%	2.1%	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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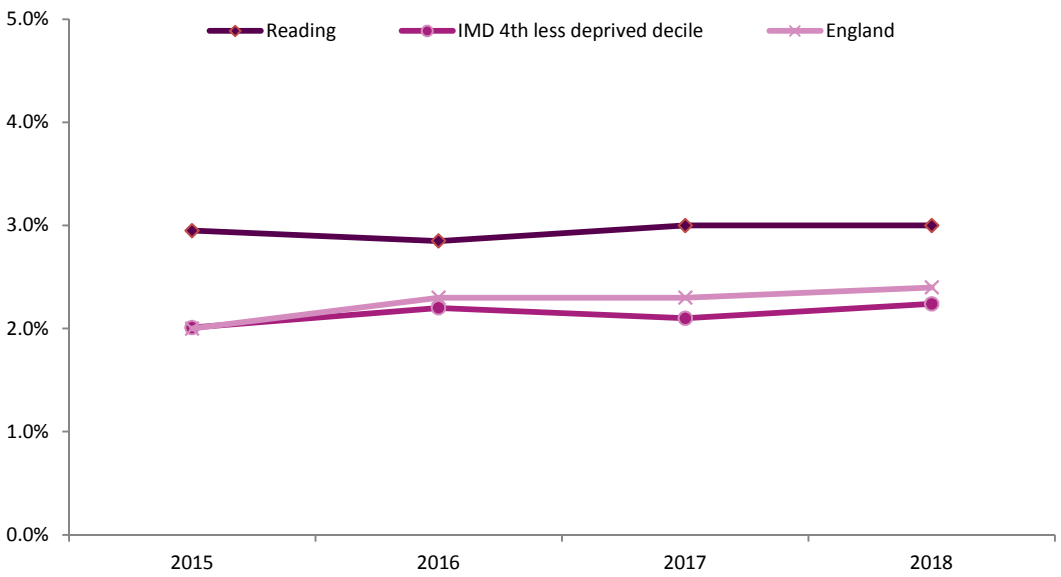
Data Source	DFE Special Needs Education Statistics
Denominator	Total pupils (LA tabulations)
Numerator	Number of pupils with statements of SEN where primary need is social, emotional and mental health https://www.gov.uk/government/collections/statistics-special-educational-needs-sen

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%
2018	3.0%	2.2%	2.4%



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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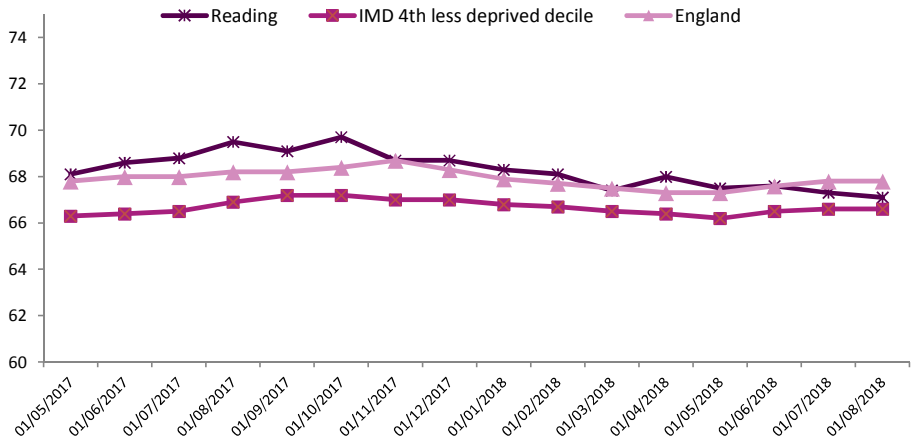
Data Source	NHS Digital
Denominator	Applying the reference rates to the registered population yields the number of people aged 65+ one would expect to have dementia within the subject population where:
Numerator	**Registered population** Patients aged 65+ registered for General Medical Services, counts 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
30/06/2018	67.6	66.5	67.6
31/07/2018	67.3	66.6	67.8
31/08/2018	67.1	66.6	67.8

Indicator number	**NA**
Outcomes Framework	**NA**
Indicator full name	**No. of Dementia Friends**

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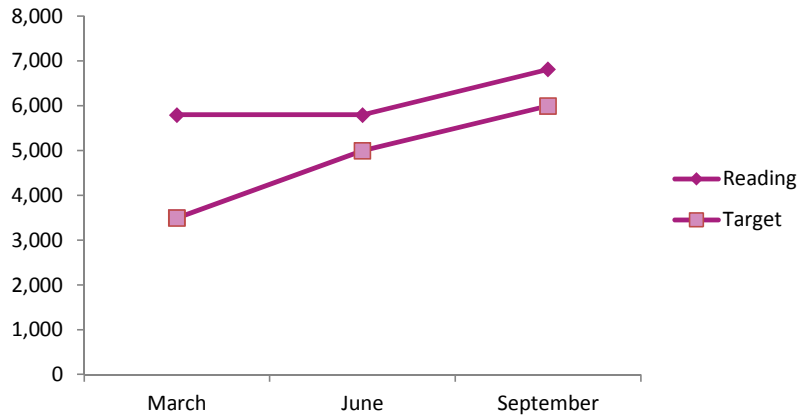
Period	Reading	Target
March	5,800	3,500
June	5800	5,000
September	6,818	6,000

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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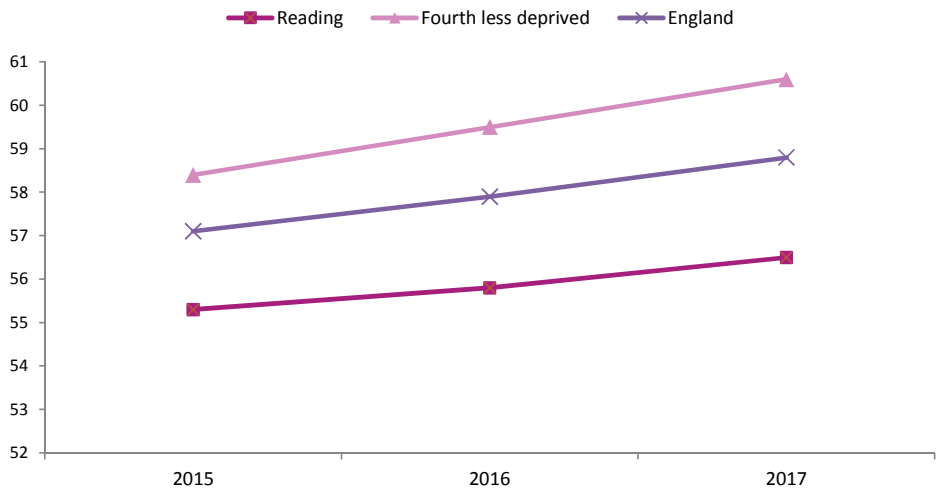
Period	Reading	Fourth less deprived	England
2015	55.3	58.4	57.1
2016	55.8	59.5	57.9
2017	56.5	*60.6*	58.8

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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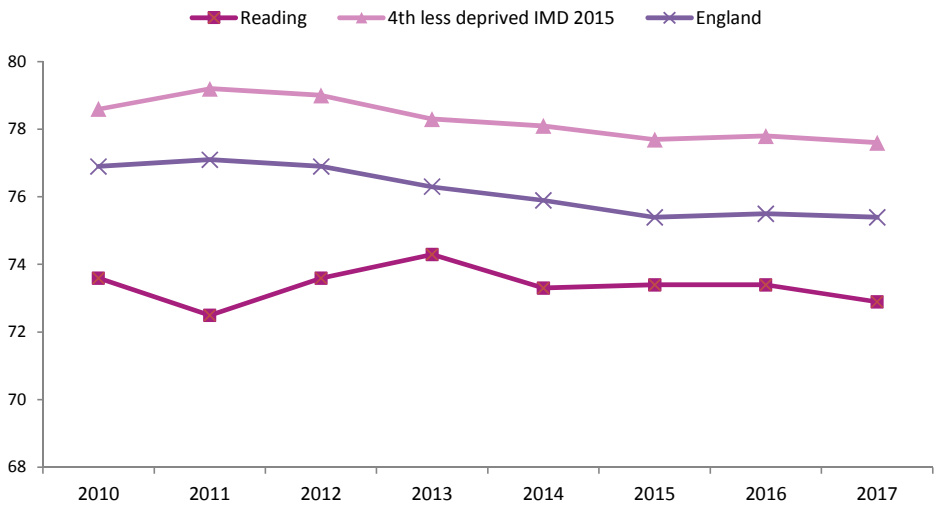
Period	Reading	4th less deprived IMD 2015	England
2010	73.6	78.6	76.9
2011	72.5	79.2	77.1
2012	73.6	79	76.9
2013	74.3	78.3	76.3
2014	73.3	78.1	75.9
2015	73.4	77.7	75.4
2016	73.4	77.8	75.5
2017	72.9	77.6	75.4

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



Indicator number	**3.05ii**
Outcomes Framework	**Public Health Outcomes Framework**
Indicator full name	**Incidence of TB (three year average)**

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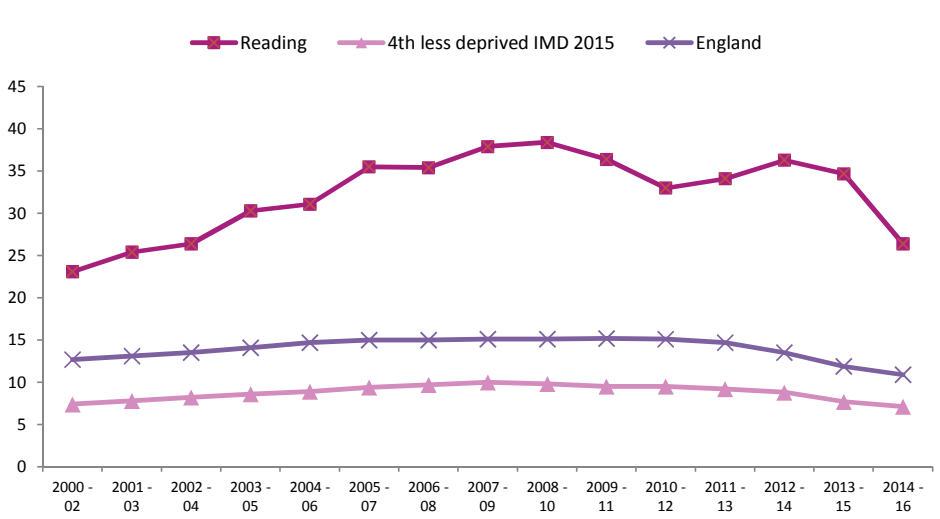
Data Source	Enhanced Tuberculosis Surveillance system (ETS) and Office for National Statistics (ONS)
Denominator	Sum of the Office for National Statistics (ONS) mid-year population estimates for each year of the three year time period
Numerator	Sum of the number of new TB cases notified to the Enhanced 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 Q2 performance
  Health checks indicators updated with Q1
  Alcohol treatment completion updated with Q1 performance
  Dementia diagnosis rate (updated with June, July and August performance)
  % pupils with social, emotional and mental health needs (primary, secondary and all schools)

- **Updates expected before January 2019 (dates are provisional)**

  No. of Dementia Friends (local indicator) (Priority 5) updated with Q3 performance
  Health checks indicators updated with Q2 (Expected ?)
  Alcohol treatment completion updated with Q2 performance (expected ?)
  Dementia Diagnosis rate - monthly

  2.12 Excess weight in adults

  2.03 Smoking status at the time of delivery
  1.18i/1l % of adult social care users with as much social contact as they would like

  1.18ii/1l % of adult carers with as much social contact as they would like

  3.05ii Incidence of TB (three year average)
  4.10 Age-standardised mortality rate from suicide and injury of undetermined intent

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.