Peter Sloman
CHIEF EXECUTIVE

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

To: All Members of the Health and Wellbeing Board

Our Ref:
Your Ref:

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

5 March 2020

Your contact is: Nicky Simpson - Committee Services

NOTICE OF MEETING - HEALTH AND WELLBEING BOARD 13 MARCH 2020

A meeting of the Health and Wellbeing Board will be held on **Friday, 13 March 2020 at 2.00 pm** in the **Council Chamber, Civic Offices, Bridge Street, Reading RG1 2LU**. The Agenda for the meeting is set out below.

AGENDA Page No

CIVIC OFFICES EMERGENCY EVACUATION: If an alarm sounds, leave by the nearest fire exit quickly and calmly and assemble on the corner of Bridge Street and Fobney Street. You will be advised when it is safe to re-enter the building.

A report summarising the work of the Reading Reducing Loneliness and Social Isolation (LSI) Steering Group - a multi-agency partnership established in 2017 to deliver on one of the priorities of the Health and Wellbeing Strategy 2017-20 – and seeking the Health and Wellbeing Board's endorsement of the current Action Plan and specific proposals regarding a Reading 'Safe Places' scheme.

6. FUTURE IN MIND UPDATE (LOCAL TRANSFORMATION PLAN FOR CHILDREN AND YOUNG PEOPLE'S MENTAL HEALTH AND WELLBEING) 121 - 204

A report providing an overview of the refreshed Future in Mind Local Transformation Plan (LTP) which was published in October 2019 in accordance with national Future In Mind requirements. The LTP provides an update on service development and improvement across the comprehensive Child and Adolescent Mental Health Service (CAMHS) system.

7. BERKSHIRE HEALTHCARE NHS FOUNDATION TRUST - MENTAL HEALTH STRATEGY 2016-21 PROGRESS UPDATE 205 - 218

A report providing an update on the progress of the Berkshire Healthcare NHS Foundation Trust's Mental Health Strategy 2016-21.

8. UPDATE ON JOINT STRATEGIC NEEDS ASSESSMENT MODEL 219 - 232

A report with an update on each of the three strands of the Joint Strategic Needs Assessment (JSNA) model, as agreed at Health and Wellbeing Board in October 2018.

9. CORONAVIRUS UPDATE Verbal Report

The Director of Public Health will give a verbal report at the meeting on the latest situation regarding the Coronavirus disease.

10. DEVELOPING A BERKSHIRE WEST JOINT HEALTH AND WELLBEING STRATEGY Verbal Report

The Consultant in Public Health will give a verbal update at the meeting on the latest progress in developing a Berkshire West Joint Health and Wellbeing Strategy.

11. INTEGRATION PROGRAMME UPDATE 233 - 238

A report giving an update on the Integration Programme – progress made within the Programme itself and performance against the national BCF targets for the financial year so far.

12. HEALTH AND WELLBEING DASHBOARD - MARCH 2020 239 - 274

A report presenting an update on the Health and Wellbeing Dashboard (Appendix A), which sets out local trends in a format previously agreed by the Board to provide the Board with an overview of performance and progress towards achieving local goals as set out in the 2017-20 Health and Wellbeing Strategy for Reading.

13. CARE QUALITY COMMISSION (CQC) READING LOCAL SYSTEM REVIEW - ACTION PLAN QUARTERLY UPDATE 275 - 296

A report providing an update on the Action Plan as a result of the Care Quality Commission (CQC)-led Local System Review that the Reading system across Health and Social Care was subject to during October 2018.

14. DATES OF FUTURE HEALTH & WELLBEING BOARD MEETINGS - PROPOSED

- 17 July 2020
- 9 October 2020
- 22 January 2021
- 19 March 2021

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Present:

Councillor Hoskin (Chair)	Lead Councillor for Health, Wellbeing & Sport, Reading Borough Council (RBC)
Mandeep Bains	Chief Executive, Healthwatch Reading (substituting for David Shepherd)
Councillor Brock	Leader of the Council, RBC
Andy Ciecierski	North & West Reading Locality Clinical Lead, Berkshire West CCG
Seona Douglas	Director of Adult Care & Health Services, RBC
Deborah Glassbrook	Director of Children's Services, Brighter Futures for Children (BFfC)
Tessa Lindfield	Strategic Director of Public Health for Berkshire
Rachel Spencer	Chief Executive, Reading Voluntary Action
Cathy Winfield	Chief Officer, Berkshire West CCG

Also in attendance:

Poppy Barnard	National Management Trainee & Time to Change Champion, RBC
Ramona Bridgman	Reading Families Forum
Gurmit Dhendsa	Trustee, Healthwatch Reading
Clare French	Joint Legal Team & Time to Change Champion, RBC
Sarah Hunneman	Neighbourhood Facilitator, Public Health & Wellbeing Team, RBC
Deb Hunter	Head of SEND & Principal Educational & Child Psychologist, BFfC
Gail Muirhead	Prevention Manager, Royal Berkshire Fire & Rescue Service (RBFRS)
David Munday	Consultant in Public Health, RBC
Janette Searle	Preventative Services Manager, RBC
Nicky Simpson	Committee Services, RBC
Kate Stockdale	Senior Drug & Alcohol Commissioning Manager, RBC
Lewis Willing	Integration Project Manager, RBC & Berkshire West CCG

Apologies:

Neil Carter	RBFRS
David Shepherd	Chair, Healthwatch Reading
Councillor Terry	Lead Councillor for Children, RBC

1. DECLARATIONS OF INTEREST

Andy Ciecierski declared an interest in Item 6 on the Reading Walk In Centre Update, as he was on the panel for the procurement exercise.

Cathy Winfield declared an interest in Item 7 on Future CCG Management Arrangements, as this item involved her post.

2. MINUTES

The Minutes of the meeting held on 11 October 2019 were confirmed as a correct record and signed by the Chair.

3. QUESTIONS IN ACCORDANCE WITH STANDING ORDER 36

The following question was asked by Francis Brown on behalf of Tom Lake in accordance with Standing Order 36:

a) Health Improvement Through Leisure:

"It is widely agreed that the determinants of health go far beyond the field of medicine and that work, housing, leisure and transport influence our health.

Some of these influencing factors are in the hands or in the purview of the local authority. In so far as this is true, should it not be this board at which these influences are considered and improvements sought? Do we just pay lip service to the wider determinants of health or are we trying to work with them?

The present Reading Borough draft budget contains 43 million pounds of capital spend on leisure improvement. What public health and NHS input has there been in the planning of the proposed facilities?

Will there be any joint NHS/borough facilities? Will there be opportunities for the borough, public health and the NHS to work together to further the improvement of health through leisure?"

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

"The Council is committed to tackling the wider determinants of health which, as is rightly pointed out, is about much more than just medicine.

The leisure procurement process to develop the specification and evaluate the bids was supported by an in-house team, which included Public Health, to ensure the contract delivers wider public health outcomes. In addition to the facilities specification, there is a detailed service specification, which sets out the type and level of service to be delivered by the provider

In addition, the provider will be required to contribute towards the achievement of the nine Authority Outcomes, the three most relevant to this topic are the Council's commitment to:

1. Improving health and wellbeing and reducing health inequalities.
2. Educating, protecting and providing opportunities for young people
3. Supporting and caring for vulnerable adults and older people

The provider is proposing to undertake the following activities that will contribute to health and wellbeing in Reading. The implementation of these activities will be supported by the RBC Public Health Team to ensure they meet the needs of the local Reading population. The proposed activities are:

- provide a room available weekly within each leisure centre to enable an accredited provider to deliver Public Health-commissioned interventions.

- increase participation for certain target groups including GP referral customers and clinical and high-risk referrals, pre-diabetes, rehabilitation management and the least physically active.
- deliver weight management courses for the local population.
- increase the current Exercise Referral Scheme (ERS) which supports a physical activity and behaviour change intervention for those with a Long Term Medical Condition.
- deliver cardiac and cancer rehabilitation and a falls prevention scheme.

Once the provider has commenced delivery of the service, they will report on its performance of the delivery of services in accordance with the agreed specification and against the performance standards. A report will be produced regularly providing qualitative and quantitative evidence of how the provider has performed to the Council's requirements. This mechanism will create opportunities for the borough, public health and the NHS to work together to further the improvement of health through leisure."

The following question was asked by Francis Brown in accordance with Standing Order 36:

b) The future arrangement for the NHS commissioning in your area

"The claim of this recent marketing document is that the proposed merger will lead to a more efficient organisational structure. This proposed structure will in turn be even more capable of reducing costs through transformed ways of working involving 14 local authorities and parts of the NHS. Further benefit will arise from new ways of working within different parts of the NHS.

The actual headcount savings, less redundancies, are likely to be tiny in the context of the transformational saving from better integrated methods.

Is the Reading Borough Council satisfied that the merger will really lead onto even better ways of working together? Or is there a risk that increasing the gap between the 14 local authorities and a super CCG is a step in the wrong direction?

Are you concerned that there is no financial information to support a radical and potentially damaging re-organisation?"

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

"Thank you for your question Mr Brown. In our formal response to the official NHS engagement on these plans myself and Councillor Ruth McEwan, as Chair of the committee responsible for Health Scrutiny, outlined our concerns about the proposed moves towards a larger NHS planning and administrative area and the potential merging of CCGs.

I shall arrange for you to have a copy but our concerns were summarised as this, "In principle we are opposed to moving towards the planning and commissioning of NHS to a larger geographical area. We believe this could lead to decision making becoming more distant from local communities, that planning is increasingly centralised and more closely controlled by NHS

England, and that local action to deliver integrated care and address health inequalities may be weakened."

That said we are aware that these moves are being driven by national government and NHS national headquarters and that, despite our local concerns, these changes may well happen regardless. Reading Borough Council therefore believes it is important to continue our strong record of working closely with local NHS organisations and the membership of this Health and Wellbeing Board is testament to that.

Partnership working with the NHS is currently happening in increasing measure through the local Berkshire West Integrated Care Partnership (ICP). Councillors and Officers from RBC are part of the formal structure of this ICP and are able to ensure that the voice and needs of the population of Reading are heard and understood within this.

With regard to the proposed changes to Clinical Commissioning Group (CCG) structures that you make reference to, RBC has engaged closely with the Berkshire West CCG and the wider Buckinghamshire, Oxfordshire and Berkshire West system (BOB), about these plans. This has been via this Health and Wellbeing Board, the RBC Adult Social Care, Children's Services and Education Committee and also through joint scrutiny meetings with colleagues from neighbouring Local Authorities within the BOB footprint. Indeed, we have an update on these proposed changes on the agenda of our meeting today. Councillors and Officers have also provided detailed responses to the CCG during the consultation phase at the end of last year to ensure the Reading perspective was fed into decision making.

Although there may be some considerable challenges to ensuring local Reading-specific issues are not lost within the proposed change to having one larger CCG, we are pleased to see that the local new Berks West ICP will remain in the new structure. The CCG is also committed to ensuring it maintains a local presence here in Reading, even if it formally becomes one regional organisation. As I have described, the ICP is the primary mechanism through which we connect with the NHS and we already commission some services at this ICP level which ensures economies of scale and joined up approaches to services exist, which benefits the population of Reading.

The rationale for the proposed change isn't specifically a reduction in head count but creating an infrastructure that will support strategic change across a bigger geography. There is no specific financial detail included because this continues to be worked on by BOB as it develops its Long Term Plan submission. With this is mind, RBC are committed to continue to work in partnership with the NHS and through local democratic structures such as this Health and Wellbeing Board, and will continue to use all the powers and influence at its disposal to push for the adequate funding of NHS services for the residents of Reading."

4. SPECIAL EDUCATIONAL NEEDS AND DISABILITY STRATEGY – ANNUAL UPDATE

Further to Minute 3 of the meeting held on 18 January 2019, Debs Hunter submitted a report on progress made in delivering the SEND (Special Educational Needs and Disability) Strategy since January 2019.

The report explained that work on SEND had continued and set out the following specific key achievements which had been secured:

- Continued close working with Reading Families Forum to ensure co-production of materials and service delivery
- Views of children and young people in Special United and in schools had informed coproduction of services and materials, such as the mental health work and development of the Education Health and Care Plans.
- A SEND free school with places for Reading children and young people with SEMH and ASC was in process.
- Two new primary resources for children with Social Communication Difficulties had been agreed and scoping exercises were under way re location – it was intended that there would be one in the west and one in the north.
- Preparing for Adulthood: an information guide for parents and carers – a joint co-produced publication for young people moving into adulthood
- The Therapeutic Thinking Schools approach was well embedded in schools
- The Mental Health Support Team trailblazer was established and was going live in January 2020
- The Graduated Response Guidance was being more consistently used by schools with the number of pupils at SEN Support increasing.
- A communication plan was also being developed which would support greater engagement with the strategy

The report had appended the following:

Appendix 1: SEND strategy on a page
Appendix 2: SEND strategy refresh from October 2019 – refreshed following a workshop with all key stakeholders and co-produced with Reading Families Forum and other key partners.
Appendix 3: Co-production and how we work together
Appendix 4: Equality Impact Assessment

The SEND strategy on a page set out the following five priorities, detailing what would be done and the outcomes required:

- Making SEND everybody's business
- Embedding co-production at every level
- Working together to identify and assess needs
- Working together to deliver support in the right place at the right time
- Resources would be allocated fairly, transparently and with evidence that they supported improving outcomes

Debs Hunter explained that the 'plan on a page' was being developed, in order to be able to take this to each of the teams and every school, for example, asking schools

to look at their own development plans and to see how they could ensure that they were aligned with the SEND strategy.

Ramona Bridgman from Reading Families Forum attended the meeting and addressed the Board, noting that, with the move to BFfC, it was hard to make sure that carers assessments were working for everyone and that there was still some work to be done to get this right for carers for children. There were also still some issues in getting meaningful pathways for adult social care for 18-25 year olds, with some young people waiting over a year to get a plan agreed and in place, so this needed improvement. Ramona also reported on a national campaign to ensure that disabled women had access to the same health checks as others and queried what Reading's policy was on this. For example, if someone was in a wheelchair and there was no hoist at their GP surgery, they might not have access to cervical smears.

David Munday and Seona Douglas said they would pick up these issues outside the meeting, with David noting that he had already met with Ramona Bridgman and Debs Hunter to see how Public Health could help with early identification and assessment of needs and saying that he would investigate the campaign on access to health checks for disabled women.

Deborah Glassbrook said that, if families were struggling to get assessments, they could escalate the problem to her as Director of Children's Services to ensure that families got the services they needed, and she would take this up outside the meeting.

Resolved -

(1) That the progress made on delivery of the SEND Strategy be noted and Ramona Bridgman be thanked for attending the meeting;

(2) That the members of the Health and Wellbeing Board continue to support the work of the SEND team and particularly the work with stakeholders to embed co-production in all services and all service delivery;

(3) That David Munday, Seona Douglas and Deborah Glassbrook pick up the specific issues raised by Ramona Bridgman outside the meeting.

5. TIME TO CHANGE: RBC EMPLOYER ACTION PLAN REFRESH

Janette Searle submitted a report outlining Reading Borough Council's progress to date in delivering on a 'Time to Change' Employer Pledge to end mental health discrimination, and setting out the ambitions of a refreshed Action Plan (attached at Appendix 1) which had been approved by the Council's Corporate Management Team in November 2019, within the adoption of a new Employee Wellbeing Action Plan.

The report explained that, in 2017, the Council had developed a proposal for how the authority could deliver on a Time to Change Employer Pledge, which had been approved by the national Time to Change team, and at the 6 October 2017 Health and Wellbeing Board, Councillor Hoskin had signed the Time to Change Employer Pledge on behalf of the Council (Minute 3 (4) refers).

The Council's Time to Change Action Plan was owned by a group of Champions who had been recruited from across the authority, supported through training, peer mentoring and access to Time to Change resources. There were over 60 Champions, representing each Directorate and most services, with meetings and Champion-led events taking place across the various Council sites and the report gave examples of the events held promoting staff mental wellbeing.

The report gave details of how the Action Plan had been refreshed in 2019 and had appended the refreshed Action Plan which listed activities, people responsible, timescales and performance measures.

Poppy Barnard, Clare French attended the meeting as Time to Change Champions, explaining their involvement and the activities in which they had taken part and Sarah Hunneman addressed the Board as the coordinator of the Champions, emphasising the value of the Champions in disseminating information and raising awareness. It was noted that the refreshed plan recognised the need to mainstream and normalise mental health conversations and so there was an increased emphasis on embedding mental health awareness within the organisation's day to day business.

Resolved – That the report be noted and the actions which the Council had committed to as a Time to Change employer, and how these supported and promoted wellbeing in the Borough, be noted.

6. READING WALK-IN CENTRE UPDATE

Cathy Winfield submitted a report which explained that the Alternative Provider Medical Services (APMS) contract for Reading Walk-in Centre would come to an end on 30 June 2020. The service was being re-procured and the CCG intended to have a new contract in place from 1 July 2020.

The report stated that the services provided at the Reading Walk-in Centre were currently provided by Virgin Care, whose contract ended on 30 June 2020. Following the review of the service specification by a multi-agency group including health, local authority and Healthwatch Reading representatives, the CCG was currently running a procurement exercise. The intention was to let a contract for the next four years, coinciding with the length of the current lease on the Broad Street Mall premises.

10,168 patients were currently registered with the Walk-in Centre. Under the new contract, the provider would be required to continue to care for these patients and to grow the registered list further. In addition, the service would continue to offer walk-in access 8am-8pm, seven days a week for patients registered with other practices. Prospective providers would be required to demonstrate how they would gear the service to meet the needs of specific population groups that currently accessed the centre, including homeless patients and children.

As currently, and in accordance with the Berkshire West Integrated Care Partnership's emerging Urgent Care Strategy, patients would be encouraged to routinely access their own GP practice to ensure continuity and full access to notes. Patients who frequently attended the walk-in element of the service might be asked to consider registering there as was currently the case. It was anticipated that access to primary care would change over the coming years with practices increasingly working together through their Primary Care Networks to improve same day care provision. As such, the contracting model anticipated that walk-in activity would decline over the life of

the contract and encouraged the provider to work with Primary Care Networks to optimise access to primary care for Reading patients. In future patients who attended Emergency Departments with minor illness might also be re-directed to this service.

Resolved – That the report be noted.

(Andy Ciecierski declared an interest in this item, as he was on the panel for the procurement exercise).

7. FUTURE CCG MANAGEMENT ARRANGEMENTS

Cathy Winfield submitted a report which had been considered by the Berkshire West CCG Governing Body on 14 January 2020 on future CCG management arrangements. The report had appended:

- Appendix 1: Table of mitigating actions in response to themes identified from engagement report
- Appendix 2: Summary of local engagement activities during the engagement period
- Appendix 3: Proposed Job Description for single Accountable Officer role

The report explained that the NHS Long-Term Plan stated that "Every ICS will need streamlined commissioning arrangements to enable a single set of commissioning decisions at system level… This will typically involve a single CCG for each ICS area. CCGs will become leaner, more strategic organisations that support providers to partner with local government and other community organisations on population health, service redesign and Long-Term Plan implementation".

As a result of this policy statement, the CCGs within the BOB (Buckinghamshire, Oxfordshire and Berkshire West) ICS (Integrated Care System) had established an 'Architecture Oversight Group" comprising the CCG Chairs and Chief Officers, ICS Leaders and lay members from each Place, to co-ordinate the work in this area and design a proposal which reflected the areas of mutual agreement between the parties. In October to December 2019, the three CCGs had carried out a period of engagement with stakeholders on a document setting out the proposal "The future arrangements for NHS commissioning in your area".

The engagement exercise had sought the views of stakeholders on the following three proposals:

a. The appointment of a single Accountable Officer and Shared Management Team for the three CCGs
b. The design principles for the creation of stronger Integrated Care Partnerships for each of the three places
c. The creation of a single commissioning organisation across the BOB geography (ie a merger of the three existing CCGs)

The report gave information on the outputs of the engagement exercise and detailed quantitative and thematic analysis and explained how the proposal design had been changed as a result of the responses. It recommended to the CCG Board that it agreed to commence the process for appointing a shared Accountable Officer for the

three CCGs in the BOB area and stated that decisions on the design of ICPs and the potential CCG merger were not yet required. The report set out recommended design principles as a basis from which a proposal for a single management team could be produced and recommended proposed mandatory roles and functions to be incorporated in any future management team structure.

Cathy Winfield reported that the CCG Governing Body had agreed all three recommendations. She noted that the proposals maintained the emphasis on place-based working, with a Managing Director for each of the three places, with a seat on the Board, and with retention of certain management responsibilities and functions at that place level. She said she was still expecting the majority of commissioning and service redesign decisions to be made locally in Berkshire West, which was the most advanced of the ICPs across BOB, and the most embedded.

In response to concerns expressed about possible future moves towards a single control total for the ICS and the potential impact on being able to keep appropriate focus on health inequalities, Cathy Winfield confirmed that Berkshire West CCG would remain a statutory body with its own separate budget.

Resolved – That the report and situation be noted.

(Cathy Winfield declared an interest in this item, as it involved her post.)

8. SUPPORTING OUR FUTURE: ADULT SOCIAL CARE STRATEGY 2019 - 2022

Seona Douglas submitted a report presenting the Adult Social Care Strategy for the period 2019-2022, as revised and refined following a two month public consultation, and as approved by the Adult Social Care, Children's Services and Education Committee on 21 October 2019. A copy of the Strategy was appended to the report.

The report explained that the Strategy focused on reducing the need for long term health and social care services by putting in place more self-enabling support. This meant developing a whole system approach which encouraged people to take responsibility for their own health and wellbeing, so that healthier choices were accessible to everyone, and people got the support they needed to stay active and felt they were part of a community. Family and unpaid carers were a vital part of this.

Putting the Strategy in place would provide the Council with a framework for placing prevention and early intervention at the core of care and support in the Borough. This had started with Public Health's role in analysing the local population and its health needs, and putting in place support, a strong focus would then be needed on individual and community assets to improve outcomes and manage demand on the formal care system. When people needed Adult Social Care, on a short or long term basis, that support needed to be empowering, re-abling and good value as part of a sustainable care system.

'Supporting Our Future' had identified five priority outcomes for the local care system, as follows:

- An approach which drove wellness and independence;
- Clear information and advice about local services, which facilitated access and self-care;

- A supportive and sustainable local market, offering choice and value;
- A skilled workforce which empowered and enabled people;
- A sustainable system which offered good value.

Resolved – That the 'Supporting Our Future' Reading Borough Council Adult Social Care Strategy 2019-2022 be noted.

9. READING DRUG AND ALCOHOL COMMISSIONING STRATEGY FOR YOUNG PEOPLE AND ADULTS 2018 – 2022 AND ACTION PLAN - UPDATE

David Munday submitted a report giving an update on the Reading Drug and Alcohol Commissioning Strategy and Action Plan for Young People and Adults from 2018 to 2022. The report had appended:

- Appendix 1 - Reading Drug and Alcohol Commissioning Strategy for Young People and Adults 2018-2022
- Appendix 2 - Reading Drug and Alcohol Strategy Action Plan 2018-2022.

The report explained that the Strategy had been written in line with the Government Drug Strategy 2017, the Governments' Alcohol Strategy 2012 and Reading Health and Wellbeing Strategy 2017-2020 and had been agreed by Policy Committee on 24 September 2018.

The Public Health Team had carried out a procurement exercise from October 2018 to March 2019 to re-procure a new drug and alcohol treatment service and the new Drug and Alcohol Behaviour Change, Treatment Recovery System contract had been awarded to Change, Grow, Live (CGL), and had commenced on 1 October 2019.

The Action Plan had been developed with partners and had three priority areas, of Prevention, Treatment, and Enforcement and Regulation. It had been approved by the Adult Social Care, Children's Services and Education Committee on 21 October 2019, but was being used as a 'live' document and would be regularly updated.

Kate Stockdale addressed the Board giving a summary of activity by CGL since the start of their contract. She said that things had gone well, with new referrals even in the first few weeks, CGL undertaking outreach work in joint operations with Thames Valley Police, providing routes into treatment for hard to reach groups, and that there were further operations planned. CGL were also developing partnerships with local hospitals, GPs and community pharmacies.

David Munday reported that there were more potential opportunities to reduce drug-related harm and partners were looking at developing innovative ways to reduce harm and death related to drug use and increase referrals into treatment services in Reading. He said that he would bring a report to a future meeting of the Board.

Resolved –

(1) That the report and the Drug and Alcohol Action Plan 2018-2022 be noted;

(2) That a report on the development of plans for reducing drug-related harm be brought to a future meeting of the Board.

10. BERKSHIRE WEST LOCAL SAFEGUARDING CHILDREN BOARD (LSCB) ANNUAL REPORT 2018/19

Deborah Glassbrook submitted a report presenting the Berkshire West Local Safeguarding Children Board (LSCB) Annual Report for 2018/19 on the work of and achievements of the LSCB for the 2018/2019 financial year, which was appended to the report. The report also described the new partnership arrangements that had replaced the LSCB from April 2019.

The report explained that, until March 2019, the LSCB had been the key statutory partnership whose role was to oversee how the relevant organisations co-operated to safeguard and promote the welfare of children in Reading and to ensure the effectiveness of the arrangements, as outlined in statutory guidance Working Together to Safeguard Children 2015 and 2018.

The LSCB was required to publish an Annual Report on the effectiveness of child safeguarding and promoting welfare of children in Reading. The report had to be presented to the Health and Wellbeing Board in line with statutory guidance.

The report explained that the Annual Report contained information on activities and achievements that demonstrated the partnership working and scrutiny in the LSCB and the impact this had on practice, and listed the achievements and ongoing challenges for the LSCB and partners against the following priorities identified for the 2018/19 year:

- Domestic Abuse
- Exploitation
- Implementation of the new multi-agency safeguarding arrangements
- Locality based priorities

The report stated that, in May 2018, the three separate LSCBs in Berkshire West (Reading, Wokingham and West Berkshire) had begun a trial year operating as a single Board, as part of the transition to new partnership arrangements. In July 2018, a revised Working Together to Safeguard Children had been published, which had removed the statutory requirement to have an LSCB, but required statutory partners to ensure appropriate local safeguarding arrangements were in place. Berkshire West had published its arrangements in March 2019 and they had been implemented in June 2019. However, there remained a requirement for a final LSCB annual report, which was attached for information. This was a Berkshire West report, but information in relation to Reading was specified within it.

The annual report also provided more details of how the new multi-agency partnership, the Berkshire West Safeguarding Children Partnership (BWSCP), would be different to the LSCB and it had appended a structure chart for the new arrangements. The BWSCP would continue to produce an annual report, which would be shared.

Resolved – That the annual report of the Berkshire West Local Safeguarding Children Board 2018/19 and the revised safeguarding children partnership arrangements be noted.

11. INTEGRATION PROGRAMME UPDATE

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

The report stated that, of the four national BCF targets, performance against one (limiting the number of new residential placements) was strong, with 49 placements made in eight months and a projected 74 placements for the financial year (against a target of 116 for the financial year). It stated that partners had not met the target for reducing the number of non-elective admissions (NELs) but the performance was close to the target and work against this goal remained a focus for the Berkshire West-wide BCF schemes and the Reading Integration Board work plan.

The target for reducing the number of delayed transfers of care (DTOC) had been met for half of the financial year, with improvement in performance in four of the six months of the financial year for DTOC attributed to both health and adult social care and improvement in five of six months attributed to health.

Progress against the target for increasing the effectiveness of reablement services remained in line with the decreased performance previously reported, but this was due to revised guidance around the methods of measuring their impact and did not reflect a drop in actual performance. Further activities were planned to align the reablement offer with emerging national best practice.

The report gave further details of BCF performance and gave details of items progressed since September 2019 and the next steps planned for January to March 2020.

Resolved - That the report and progress be noted.

12. BETTER CARE FUND PLANNING RETURN 2019/20

Lewis Willing submitted a report seeking retrospective approval for the Better Care Fund (BCF) Funding planning template, which had been completed for the financial year 2019/2020 and submitted in September 2019 in line with required timescales. The report included a table that provided a summary of how the Better Care Fund budget would be spent in 2019/20 and a more comprehensive breakdown of the budget for 2019/20 and the services that it supported was set out in Appendix 1.

The report explained that the return covered details of the plans to utilise the Better Care Fund and how Adult Social Care and Health services planned to use these funds in an integrated way to maximise system impact (pending NHS England agreement). It was reported at the meeting that NHS England had now agreed the Reading Better Care Fund for 2019/20.

The funds had to be used to support the locality to meet the four Better Care Fund targets and the use of the funds had to be jointly agreed. The four targets were:

- Reducing the number of placements made in residential and nursing homes
- Reducing the number of delayed transfers of care (DTOC)
- Reducing the number of people that returned to hospital within 90 days of their discharge

- Reducing non-elective admissions to hospital (NEL)

The report explained that the timing of the return and the Better Care Fund quarterly returns did not align with Health and Wellbeing Board meetings and this was compounded by short timescales to collect and draft the complex responses that were required by NHS England.

The report therefore requested retrospective approval for the BCF submission that had been submitted by the required deadline and reported that the sign off of all future Better Care Fund returns had been delegated by the Adult Social Care, Children's Services and Education Committee to the Executive Director of Social Care and Health and the Clinical Commissioning Group Director of Operations for Reading, in consultation with the Lead Councillor for Health, Wellbeing and Sport and the Lead Councillor for Adult Social Care (Minute 27 refers).

Mandeep Bains noted that, while she accepted that there was probably service user feedback being gathered on the BCF projects, there was no information about this feedback provided at the Reading Integration Board or the Health and Wellbeing Board and it would be useful to see evidence of how these services and improvements were being experienced by users, when considering programmes of work. It was suggested that Lewis Willing should ask the Chair of the Reading Integration Board (RIB) to take on a piece of work for the RIB to look at information on the service user feedback being gathered in the various BCF work programmes and report on this to the Health and Wellbeing Board.

Resolved –

(1) That the report be noted;

(2) That retrospective approval be given for the Better Care Fund submission (a summary of which was set out in Appendix 1), which had been submitted in September 2019 in order to comply with national deadlines outside of the Board meeting cycle;

(3) That it be noted that the Executive Director of Social Care and Health (Reading Borough Council) and the Director of Operations (Clinical Commissioning Group) had been given delegated authority to sign off Better Care Fund returns in future, in consultation with the Lead Councillor for Health, Wellbeing and Sport and Lead Councillor for Adult Social Care;

(4) That Lewis Willing investigate the pulling together of information on the service user feedback being gathered on BCF work programmes, to be looked at by the RIB and for the RIB to report on this to the Health and Wellbeing Board.

13. HEALTH AND WELLBEING DASHBOARD & ACTION PLAN – JANUARY 2020

Janette Searle submitted a report giving an update on delivery against the Health and Wellbeing Action Plan (Appendix A) and on the Health and Wellbeing Dashboard (Appendix B), which set out local trends. The report therefore gave an overview of performance and progress towards achieving local goals as set out in the 2017-20 Health and Wellbeing Strategy.

The report summarised the performance against the eight priority areas in the Action Plan and paragraph 2.2 of the report set out details of updates to the data and performance indicators which had been included in the Health and Wellbeing dashboard since the last report.

Resolved - That the report be noted.

14. CARE QUALITY COMMISSION (CQC) REVIEW OF READING HEALTH AND SOCIAL CARE SYSTEM – ACTION PLAN QUARTERLY UPDATE

Lewis Willing submitted a report giving a quarterly update on the Action Plan developed following the Care Quality Commission (CQC) Review of the Reading Health and Social Care System that had been carried out by the CQC in 2018. The report had appended the updated Action Plan, which gave details of progress made on each area for improvement.

Resolved – That the report be noted.

15. DATE OF NEXT MEETING

Resolved – That the next meeting be held at 2.00pm on Friday 13 March 2020.

(The meeting started at 2.00pm and closed at 4.13pm)

TO:	**HEALTH & WELLBEING BOARD**		
DATE:	**13 MARCH 2020**		
TITLE:	**REDUCING LONELINESS & SOCIAL ISOLATION: UPDATE FROM THE READING STEERING GROUP**		
LEAD COUNCILLOR:	**COUNCILLOR HOSKIN**	**PORTFOLIO:**	**HEALTH**
SERVICE:	**ALL**	**WARDS:**	**BOROUGHWIDE**
LEAD OFFICER:	**JANETTE SEARLE**	**TEL:**	**0118 937 3753**
JOB TITLE:	**PREVENTATIVE SERVICES MANAGER, RBC**	**E-MAIL:**	**Janette.Searle@reading.gov.uk**

1. PURPOSE OF REPORT AND EXECUTIVE SUMMARY

1.1 This report summarises the work of the Reading Reducing Loneliness and Social Isolation (LSI) Steering Group - a multi-agency partnership established in 2017 to deliver on one of the priorities of the Health and Wellbeing Strategy 2017-20 – and seeks the Health and Wellbeing Board's endorsement of the current Action Plan and specific proposals regarding a Reading 'Safe Places' scheme.

1.2 The Steering Group's work has included support for research to develop local understanding of loneliness and social isolation as an all-age issue. The report includes the findings set out *Tackling loneliness and social isolation in Reading, England* published by the University of Reading in 2019, together with the Steering Group's response.

1.3 National indicators available to monitor progress in this area remain limited to a small subset of the population, although this is about to change. The report includes examples of work carried out by some Steering Group members to monitor the wellbeing impact of different local services aimed at reducing social isolation.

1.4 Although loneliness and social isolation are now more widely recognised as significant health and wellbeing issues, there is still a stigma around loneliness and some myths perpetuate around who is affected or at risk. As well as the need for greater general awareness and acceptance, there is also a need for targeted action to meet the needs of more vulnerable people or those at greater risk. Because so many factors can impact on loneliness and social isolation risk, there is a need for more joined up thinking at a policy level, e.g. to address infrastructure issues such as transport.

2. RECOMMENDED ACTION

2.1 That the Health and Wellbeing Board:

(a) notes the findings and recommendations contained in the University of Reading report *Tackling Loneliness and Social Isolation in Reading, England* (attached at Appendix 1 and summarised at Appendix 2);
(b) endorses the Reading Loneliness and Social Isolation Steering Group's Action Plan (Appendix 3), and specifically the proposal to develop a Reading Safe Places scheme; and
(c) notes the impact of the three *Narrowing the Gap* service areas summarised at Appendix 4 – social prescribing, peer support for elderly or frail adults, and peer support for adults living with mental health challenges.

3. POLICY CONTEXT

3.1 The need to reduce loneliness and social isolation increasingly features as a health protection issue in national policy, with specific measures included in both the Public Health Outcomes Framework and the Adult Social Care Outcomes Frameworks. Both loneliness and social isolation (linked but not identical conditions) are now understood to be serious conditions which can adversely affect an individual's mental and physical health.

3.2 'Social isolation' describes an inadequate level of meaningful human interaction, and is something which lends itself to objective measurement, although the optimum level of social contact varies from individual to individual. In some ways, 'loneliness' should be easier to identify for individuals themselves as it refers to a negative emotional state. With so much stigma still surrounding loneliness, however, people who are lonely may attribute their negative feelings or health impacts to other causes.

3.3 A 2017 review of published research[1] identified a number of specific impacts of loneliness and social isolation, indicating that individuals who are socially isolated are:
- 1.8 times more likely to visit their GP practice
- 1.6 times more likely to visit hospital emergency departments
- 1.3 times more likely to be admitted to hospital on an emergency basis
- 3.5 times more likely to enter residential care
- 3.4 times more likely to suffer from depression
- 1.9 times more likely to develop dementia in the following 15 years

[1] Griffiths, H. (2017*). Social Isolation and Loneliness in the UK: With a focus on the use of technology to tackle these conditions*, IOTUK. Available at: https://iotuk.org.uk/wp-content/uploads/2017/04/Social-Isolation-and-Loneliness-Landscape-UK.pdf [accessed 18.02.2020]

- 2 to 3 times more likely to be physically inactive which in turn is associated with a higher risk of other health problems, such as diabetes and cardiovascular disease.

3.4 In October 2017 this Board resolved to adopt the Prevention Concordat for Better Mental Health as a set of guiding principles. This concordat promotes an increased focus on prevention and the wider determinants of health in seeking to promote mental wellbeing. The associated toolkit includes an evaluation of a signposting service aimed at reducing social isolation and loneliness amongst older people. This demonstrated a Return on Investment of £1.26 from every £1 invested in the service, which was considered to be a very conservative estimate as it focused on mental health improvements and did not take account of additional health benefits, such as improved physical health, as well as potential benefits for the protection of cognitive health.

3.5 The Government published its first loneliness strategy in 2018. The rationale for taking action was summarised in these words.

"Feeling lonely frequently is linked to early deaths. Its health impact is thought to be on a par with other public health priorities like obesity or smoking. Research shows that loneliness is associated with a greater risk of inactivity, smoking and risk-taking behaviour; increased risk of coronary heart disease and stroke; an increased risk of depression, low self-esteem, reported sleep problems and increased stress response; and with cognitive decline and an increased risk of Alzheimer's Disease." [2]

3.6 The national loneliness strategy sets out the vision for the UK to be a country where everyone can have strong social relationships, where families, friends and communities support each other, especially at vulnerable points where people are at greater risk of loneliness. There are three overarching goals:
1) To play a part in improving the evidence base so we better understand what causes loneliness, its impacts and what works to tackle it;
2) To embed loneliness as a consideration across government policy and how government can ensure social relationships are considered across wider policy-making; and
3) To build a national conversation on loneliness, to raise awareness of its impacts and to help tackle stigma.

3.7 There is a complex interplay between factors which increase the risk of loneliness and social isolation. Addressing the issue involves support which helps to build individual resilience as well as addressing situational and societal factors. The Campaign to End Loneliness proposes a framework[3] to recognise the range of factors which need to be understood and the interplay between them.

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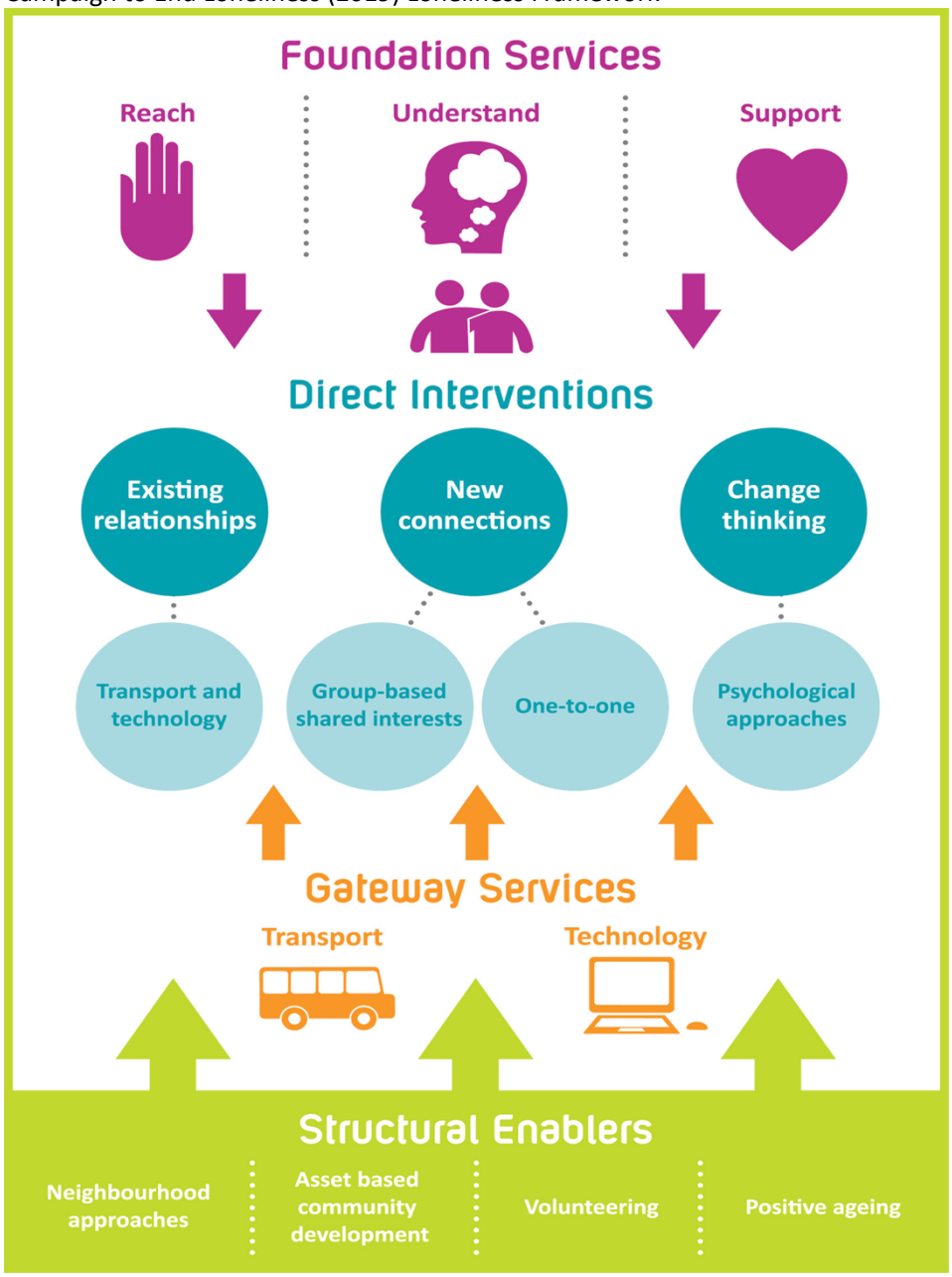
[2] *A Connected Society: a Strategy for Tackling Loneliness* – HM Government (2018)

[3] Campaign to End Loneliness (2019) *Guidance for Local Authorities and Commissioners.* [Online] Available at: https://campaigntoendloneliness.org/guidance/ [Accessed 18.02.2020]

Campaign to End Loneliness (2019) Loneliness Framework



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

3.9 Reading now has a Loneliness and Social Isolation Steering Group, which is a cross sector partnership of individuals committed to developing understanding, raising awareness, and to promoting services, opportunities, community assets and an evidence-based approach. The Steering Group recognises loneliness and social isolation as both causes and a consequences of ill-health, with many

points of connection across Reading's current Health and Wellbeing Strategy, as well as being a priority in its own right.

4. DEVELOPING UNDERSTANDING

4.1 The LSI Steering Group oversaw the development of a local loneliness and isolation needs analysis to help target interventions in line with strategic commitments. The majority of national research on loneliness and social isolation focuses on older people, and in developing a local evidence base, there has been a concerted effort to redress this as well as improve understanding of the particular issues for Reading residents.

4.2 Building on Reading Voluntary Action's social activity survey[4] carried out in 2017, Reading Borough Council's (2018) Needs Analysis concluded that individuals may be at greater risk of loneliness or social isolation in Reading if they:

- are single (have no current spouse or life partner);
- have recently experienced a significant change to their life, particularly a bereavement;
- are impeded by practical barriers including physical mobility or another limiting health condition or physical or learning disability, geographical or transport barriers, or lack of funds, time, energy and confidence; or
- lack social and economic resources.

Local survey information also suggests that a recent move to the area (meeting the criteria for a significant change) may be a particular risk in Reading.

4.3 In 2019, the Public Health (Shared Services) Team for Berkshire reviewed evidence sources to inform the current picture of loneliness and social isolation risk in each of the Berkshire local authority areas. This was based on the 2016-17 Community Life survey, which identified the following groups:
widowed older homeowners living alone with long term health conditions (predominantly living in the outer wards of Reading to the North and West)
unmarried middle agers with long term health conditions (dispersed across Reading but with the highest concentration in Kentwood ward)
young renters with little trust and sense of belonging to their area (predominantly to the East of Reading).
This indicates that loneliness and social isolation is a borough-wide problem, but different approaches may be needed in different areas to reflect the make up of the most at-risk groups.

4.4 Through its Participation Lab, the University of Reading was commissioned to provide qualitative insights into the dynamics of loneliness and social isolation in Reading, and to identify best practices which may prevent and tackle the issue. This was progressed through 21 interviews with diverse range of service providers, and 6 focus groups with 65 participants: service users, peer support volunteers & community members.

4.5 The research set out to explore the interactions between societal, situational and personal factors through posing the following key questions:

[4] Reading Voluntary Action (2017) – *Loneliness and Social Isolation in Reading*

- Which factors may lead to loneliness?
- Which barriers prevent people from developing social connections?
- Why are particular groups vulnerable to loneliness and social isolation?
- How does loneliness and social isolation affect people's health and wellbeing?
- Which services, practices and approaches are most helpful in preventing or reducing loneliness and social isolation in Reading?
- How can best practice to prevent or reduce loneliness and social isolation in Reading be strengthened and developed in the future?

4.6 This led to the following recommendations, on the basis of which the Reading Steering Group has now restructured its Action Plan.

1. **Raising awareness** about loneliness and social isolation (LSI) and its links to health and wellbeing, among statutory and voluntary and community sector service providers, employers, schools, members of the public
2. Greater provision of **specialist support services** for groups at risk of LSI, encompassing tailored one-to-one support, as well as group activities, with increased opening hours, particularly at weekends
3. Fostering more **collaborative working, 'joined-up' thinking and signposting** between organisations, Reading Borough Council and primary healthcare providers
4. Increasing the **affordability and social accessibility of transport,** including through concessionary fares, building people's confidence, supporting and raising awareness about alternative transport services for people with complex needs and carers, such as ReadiBus and neighbourhood volunteer transport initiatives
5. Developing and supporting **peer support initiatives and befriending and volunteering schemes**
6. Fostering **good neighbourliness, supportive faith communities and community development**
7. Providing more **accessible information, communication and promotion of activities and services** in appropriate formats.

5. CURRENT POSITION & PROPOSALS

5.1 The Reading LSI Steering Group Action Plan is attached at Appendix 3. It brings together a wide range of initiatives reflecting the breadth of the population affected by the issue and of the approaches needed to achieve a sustained impact. A full communications plan is in development.

5.2 Access to volunteering or employment is recognised as a protective factor against loneliness, with actions being taken by The Oracle, Get Berkshire Active, Reading Refugee Support Group, SupportU, the Salvation Army, Communicare, Reading Community Learning Centre, Berkshire West Your Way and the Council. The local authority and Reading Voluntary Action are involved in various activities to promote peer support and befriending schemes, including commissioning activity, community development and the ongoing promotion of the Ready Friends toolkit (see http://rva.org.uk/ready-friends/toolkit/). Various approaches are being pursued to raise awareness of community support, including targeted actions to reach those at greatest risk of missing out.

5.3 The Action Plan has recently been updated to add the development of a Reading 'Safe Places' scheme, aimed at adding to local support for people at particular risk of experiencing loneliness or social isolation. The Safe Places National Network was created to break down barriers vulnerable people face every day. The Preparing for Adulthood Team at RBC became interested in this as a way of supporting young people with learning disabilities to become more independent as they enter adulthood. However, the scheme can support any vulnerable adult, and the national Safe Places team encourages a broader remit. The Dementia Friendly Reading Group (formerly the Dementia Action Alliance) is keen to support the initiative, as are Reading Buses, Autism Berkshire and Age UK.

5.4 By becoming a member of Safe Places, Reading will be able to access a range of resources to help teach people about keeping safe and how to locate a Safe Place while out and about. The aim is to encourage vulnerable adults to engage with their community. Resources include an interactive Safe Places web site and free-to-use Safe Places smart phone apps, as well as Safe Places stickers which premises can display. For premises to be included in the scheme, staff need to have undergone a short (20 mins) training session, and there needs to be a minimum of two members of staff on duty at times the premises are advertised as being available as a Safe Place.

5.6 Safe Places can be viewed on a map and listed at the touch of a button. The App is free to use and available to download at the App store and Google Play. It includes a reactive 'Get me to my nearest Safe Place Now' function. This means that if no Safe Place is located within a 15-minute walk, the App will automatically offer to call the non-emergency 101 number for the user. The IOS Apps can be Voice Activated to improve accessibility for those with visual impairments or who may struggle to use a smart phone in the traditional way. (Android Voice Activation is in development.)

5.7 RBC's Public Health and Wellbeing team will co-ordinate the rollout of local training, and the aim is to include face to face and video options, both involving people with lived experience of the vulnerabilities which the scheme is deigned to recognise. The LSI Steering Group will oversee the Reading scheme, with individual members supporting the scheme as most appropriate to their circumstances, e.g. offering venues or support in developing and delivering local training. Health and Wellbeing Board members are invited to support the local scheme by help with:

- Offering possible Safe Place premises
- recruiting people with lived experiences
- delivering training
- making resources accessible, including videos
- promoting the scheme and getting people to sign up
- Use of partner logos

5.8 Another recent development is a specific group to address gaps in support with transport. This includes public and voluntary sector partners, and allows people to give more focus to an issue which has come up regularly both within the Steering Group and at the Befriending Forum. The issues go beyond support to get on and off a bus. Some people never or rarely go out because of

a lack of confidence in using transport. Not being able to access transport means people miss out on social activities, but also other opportunities to connect with others at difficult times – like being able to visit friends or family in hospital or at end of life. The kind of people likely to need such support are elderly people who have not used a bus for a long time and can no longer drive; people who feel vulnerable in public spaces; and people with mental health challenges or learning disabilities that limit their confidence.

5.9 The Group plans to pilot plans with two cohorts – Southcote residents in need of assistance to access transport for whatever reason, and young people with a learning disability transitioning from school or college into employment or training. In Southcote, this will start with encouraging people to use off peak transport to and from the hospital via the town centre. The scheme will be run by volunteers who will support people to gain confidence by travelling with them, but recognising that some people will need permanent support. The young people with a learning disability in the other cohort will already have received travel training in special schools. The support of the proposed scheme will be to use volunteers to supplement this by travelling with them and providing longer term practice in travelling independently than can be provided by the schools. The support provided in both schemes will cover a range of confidence issues, such as physical anxieties about physical competence and safety and concerns about handling money, for example.

6. MEASURING SUCCESS

6.1 The results from the national mandatory 2018/19 Adult Social Care user survey were published in November 2019 and tell us that a higher proportion of respondents to the survey than previously have reported that they have as much social contact as they would like (47.1% compared to 41.4% the previous year). Furthermore, a larger proportion of respondents in Reading reported as much social contact as they would like compared with elsewhere in England (45.9%). Responses to the Survey of Adult Carers in England (SACE) are sought only every two years. The proportion of Reading carers reporting enough social contact in the 2016/17 survey was 32%, while the national average is only slightly higher at 32.5%.

6.2 Currently, national indicators which facilitate tracking progress in reducing loneliness and social isolation only refer to people known to Adult Social Care, although the Reading LSI Steering Group's remit is much wider. The Office for National Statistics (ONS) has undertaken a programme of scoping work and consultation leading to the recommendation that four questions to capture different aspects of loneliness are added to the Public Health Outcomes Framework. The first three questions are from the University of California, Los Angeles (UCLA) three-item loneliness scale. The last is a direct question about how often the respondent feels lonely, currently used in the Community Life Survey.

For adults aged 16 years and over, the questions are as follows.

Question	Response options
1. How often do you feel that you lack companionship?	Hardly ever or never, Some of the time, Often
2. How often do you feel left out?	Hardly ever or never, Some of the time, Often Hardly ever or never, Some of the time, Often
3. How often do you feel isolated from others?	Hardly ever or never, Some of the time, Often
4. How often do you feel lonely?	Often/always, Some of the time, Occasionally, Hardly ever, Never

An adapted version of the measures is recommended for use with children and young people aged 10 to 15 years.

Question	Response options
1. How often do you feel that you have no one to talk to?	Hardly ever or never, Some of the time, Often
2. How often do you feel left out?	Hardly ever or never, Some of the time, Often
3. How often do you feel alone?	Hardly ever or never, Some of the time, Often
4. How often do you feel lonely?	Often/always, Some of the time, Occasionally, Hardly ever, Never

6.3 This means that future it should be possible to track the effectiveness of local measures to address loneliness and social isolation much more systematically across the whole population as well as benchmarking performance against other areas. In the meantime, however, individual services are monitoring their impact on individual wellbeing using various tools. It is important in the context of service delivery to ensure that questions posed do not inadvertently undermine efforts to reach people. Enquiries which add to the stigma around loneliness, for example, are regarded by local providers as less helpful than those which emphasise individual wellbeing or pose positive questions around social connection.

6.4 The Council's *Narrowing the Gap II* commissioning framework includes services to help overcome the barriers to social connection experienced by adults with a learning disability, a physical disability, a hearing impairment, a visual impairment, autism, multiple sclerosis, experience of mental health difficulties, or who are in older age and/or frail. Further services support unpaid carers, and the framework also includes a social prescribing service. Examples of the wellbeing impacts captured by some of these services are summarised at Appendix 4.

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

7.1 Reducing loneliness and social isolation is one of the priorities of the current Reading Health and Wellbeing Strategy, and the Reading LSI Steering Group was established to develop and deliver on an Action Plan in support. Its work also contributes to the achievement of other priorities linked to emotional wellbeing, positive self-esteem and social inclusion i.e.

- Supporting people to make healthy lifestyle choices,
- Promoting positive mental health and wellbeing in children and young people
- Reducing deaths by suicide
- Reducing the amount of alcohol people drink to safe levels
- Making Reading a place here people can live well with dementia

7.2 The Steering Group addresses the underpinning principles of the 2017-20 Health and Wellbeing strategy by including carers as a key interest group, making it a collective priority to raise awareness of services and opportunities, and considering the safeguarding implications of any approach considered.

8. COMMUNITY & STAKEHOLDER ENGAGEMENT

8.1 The Reading Loneliness and Social Isolation Steering Group was formed on the back of an open workshop attended by 50 local residents and organisational representatives. The Steering Group brings together those who have agreed to play a role in delivering on the Loneliness and Social Isolation Action Plan and to represent particular interest groups, and currently has 42 active members, some job-sharing a representation role.

8.2 *Tackling loneliness and social isolation in Reading England* was developed through 21 interviews with diverse range of service providers, and 6 focus groups with 65 participants: service users, peer support volunteers & community members.

8.3 A public consultation running from November 2018 to January invited Reading residents and other stakeholders to comment on the services offered or commissioned by the Council which contribute to health and wellbeing outcomes. Reducing loneliness and social isolation was named as a key issue in 18 of the 260 written responses. A wide range of health benefits and health risks associated with levels of social connection were referred to in the public feedback. Areas suggested for the Council to address included support for smaller community groups, access to transport, and helping to raise awareness of community services through multiple channels.

9. LEGAL IMPLICATIONS

9.1 There are no direct legal implications arising from this report. The Loneliness and Social Isolation Steering Group supports the delivery of the Reading Health and Wellbeing Strategy 2017-20, and so the discharge of the duties placed on the local authority and clinical commissioning group under The Health and Social Care Act (2012), and on the Council under the Care Act (2014).

10. EQUALITY IMPACT ASSESSMENT

10.1 An Equality Impact Assessment is not required in relation to the specific proposals presented to the Board through this report. However, the Health and Wellbeing Strategy and Action Plan are vehicles for addressing health inequalities, and accordingly delivery is expected to have a differential impact across groups, including those with protected characteristics. This differential impact should be positive, and so delivery of the Action Plan supports the discharge of Health and Wellbeing Board members' Equality Act duties.

11. FINANCIAL IMPLICATIONS

11.1 There are no new financial implications arising from this report. The LSI Steering Group's Action Plan is being delivered within members' existing resources and includes contributions in kind from statutory, third sector and commercial partners.

12. APPENDICES

Appendix 1 Evans & Bridger (2019) - *Tackling Loneliness and Social Isolation in Reading, England* - University of Reading

Appendix 2 summary presentation: *Tackling Loneliness and Social Isolation in Reading, England*

Appendix 3 Reading Loneliness and Social Isolation Action Plan – updated February 2020

Appendix 4 Measuring the wellbeing impact: summary of Narrowing the Gap II monitoring (services 3.2, 13.1 and 14.1) – February 2020

13. BACKGROUND PAPERS

Reading Health and Wellbeing Strategy 2017-20

Loneliness and Social Isolation in Reading – Reading Voluntary Action – July 2017

Loneliness and Social Isolation in Reading: Needs Analysis – Reading Borough Council – March 2018

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Participation Lab
Co-producing knowledge for social change

University of Reading

TACKLING LONELINESS AND SOCIAL ISOLATION IN READING, ENGLAND

Olivia Bridger and Ruth Evans

Research findings of the Loneliness and Social Isolation in Reading research project funded by the Health and Wellbeing Team, Reading Borough Council and the Participation Lab, University of Reading.

PARTICIPATION LAB RESEARCH REPORT
OCTOBER 2019

Reading Borough Council
Working better with you

Acknowledgements

We wish to thank all the organisations and individuals who participated in the interviews and focus groups and to the Loneliness and Social Isolation Steering Group for their patience. This research would not have been possible without their cooperation, enthusiasm and knowledge. They include: Alliance for Cohesion and Racial Equality (ACRE), Cruse Bereavement Care, University of Reading Chaplaincy, Reading Mencap, Compass Recovery College, Sport in Mind, Launchpad, Reading Voluntary Action, Reading Community Learning Centre, Reading Refugee Support Group, The Globe Lunch Club, Total Communications, Sue Ryder Duchess of Kent Hospice, Reading Association for the Blind, IRiS, Enrych, Talking Therapies, Autism Berkshire, Readibus, Reading Borough Council (RBC) Young Carers, RBC Dementia Care, Whitley Researchers, Berkshire Carers Hub, Reading Deaf Centre over 50's club.

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About the authors

Olivia Bridger is an undergraduate student in Human and Physical Geography, Department of Geography and Environmental Science, University of Reading, UK.

Ruth Evans is an Associate Professor in Human Geography and Participation Lab Leader, Participation Lab, University of Reading, UK.

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For further information, contact

Ruth Evans
Participation Lab
University of Reading
Whiteknights, PO Box 227
Reading RG6 6AB
United Kingdom

r.evans@reading.ac.uk.
https://research.reading.ac.uk/participation-lab
www.reading.ac.uk/ges/aboutus/r-evans.asp

Participation Lab Reports

Participation Lab Reports are intended to present our research results to as wide an audience as possible and may contain preliminary research findings or highlight results of relevance to policy and practice.

CONTENTS

EXECUTIVE SUMMARY

Introduction

Tackling loneliness has become a key priority for local and central government in England in recent years, with the publication of the Government's Strategy for Tackling Loneliness launched in October 2018, following the appointment of a Minister for Loneliness earlier in the year. Following the establishment of the Reading Loneliness and Social Isolation Multi-Agency Steering Group in 2017, the Health and Wellbeing Team and Steering Group identified a need for more in-depth understanding of the dynamics of loneliness and social isolation in Reading and best practices which may help to prevent and tackle it. The Participation Lab was commissioned to undertake this qualitative study, building on the quantitative survey of Reading residents previously conducted by Reading Voluntary Action (2017) and the Needs Analysis (2018) prepared for the Steering Group.

Research aims

The overarching aim of the study was to provide an in-depth understanding of the dynamics of loneliness and social isolation in Reading and to identify best practices which may prevent and tackle it.

The key research questions guiding the study were:

1. Which factors may lead to loneliness and social isolation? Which barriers prevent people from developing social connections and networks?
2. Why are particular groups vulnerable to loneliness and social isolation?
3. How does loneliness and social isolation affect people's health and wellbeing?
4. Which services, practices and approaches are most helpful in preventing or reducing loneliness and social isolation in Reading?
5. How can best practices to prevent or reduce loneliness and social isolation in Reading be strengthened and developed in the future?

Research methods

This research used a qualitative methodology to explore in depth the perspectives of practitioners and the lived experiences of different groups of service users, volunteers and community members. Semi-structured interviews were conducted with a total of 24 practitioners/service providers from 21 different voluntary and community organisations and statutory providers in Reading. Six focus groups were conducted with a total of 65 participants who were service users, peer support volunteers and members of the community in Reading, comprising groups of Deaf and hearing impaired people, older carers, peer support volunteers with experience of mental illness, people at risk of homelessness, mothers, and refugees and asylum-seekers.

Key findings

The research found a complex interaction between societal, situational and personal risk factors and barriers that prevent people from developing good social connections and networks in Reading, confirming national and international research evidence on the dynamics of loneliness and social isolation. It revealed how, for example, cuts in public services or barriers to statutory service provision may further marginalise people who are already vulnerable to loneliness due to their particular circumstances, such as mental health challenges, disability, ageing and loss of mobility, caring responsibilities, living alone or other significant changes, disruptions or transitions over the lifecourse.

The research identified a number of best practices in alleviating and preventing loneliness and social isolation among statutory and third sector organisations working with vulnerable groups and community members in Reading. These include:

- Specialist support and safe spaces;
- Focused group activities;
- Making services and activities socially, financially and physically accessible;
- Advocacy and assistance 'taking first steps';
- Peer support, befriending and volunteering;
- Signposting to 'someone to talk to';
- Support from healthcare professionals;
- Raising awareness about loneliness, isolation, social anxiety and mental health;
- Befriending, good neighbourliness and faith communities.

Recommendations for action

Best practices for reducing LSI need to be specifically targeted to meet the diverse needs of the people most at risk of loneliness and social isolation according to socio-economic, geographical, gender, age and ethnicity differentials, in addition to situational and personal factors, including immigration status, homelessness, drug and alcohol addiction, mental health, disability, loss of mobility and long term illness, caring responsibilities, living alone, lifecourse transitions and so on.

To ensure that best practices in alleviating and preventing loneliness and social isolation are strengthened, enhanced and developed in the future, this project has identified the following recommendations for action:

- **Raising awareness about loneliness and social isolation (LSI) and its links to health and wellbeing among statutory and voluntary and community sector service providers, employers, schools, members of the public**
- **Greater provision of specialist support services for groups at risk of LSI, encompassing tailored one-to-one support, as well as group activities, with increased opening hours, particularly at weekends**
- **Fostering more collaborative working 'joined-up' thinking and signposting between organisations, Reading Borough Council and primary healthcare providers**
- **Increasing the affordability and social accessibility of transport, including through concessionary fares, building people's confidence, supporting and raising awareness about alternative transport services for people with complex needs and carers, such as ReadiBus and neighbourhood volunteer transport initiatives**
- **Developing and supporting peer support initiatives and befriending and volunteering schemes**
- **Fostering good neighbourliness, supportive faith communities and community development**
- **Providing more accessible information, communication and promotion of activities and services in appropriate formats.**

Finally, despite distinctions between the concepts of 'loneliness' and 'social isolation' being widely recognised in the literature, in this research, we often found the two concepts being used interchangeably among practitioners and service users. The government strategy published in 2018 focuses on loneliness, rather than loneliness and social isolation, with accompanying guidance about how to measure loneliness and resources to tackle it. Reading Borough Council's multi-agency steering group may wish to consider having a clearer focus on alleviating and/or preventing 'loneliness', specifically, as the work develops in future.

1. INTRODUCTION

Tackling loneliness has become a key priority for local and central government in England in recent years, with the publication of the Government's Strategy for Tackling Loneliness launched in October 2018, following the appointment of a Minister for Loneliness earlier in the year. The policy focus on loneliness was largely spearheaded by the work of the late Jo Cox, Member of Parliament, and the Commission for Loneliness established after her death that sought to continue the work she started. As the Government Strategy document recognises, loneliness is not new, but there is an increasing body of evidence pointing to the negative effects of loneliness on people's social wellbeing, in addition to their physical and mental health (Department for Digital, Culture, Media and Sport, 2018).

This policy emphasis on loneliness and social isolation, in combination with substantial research considering its relationship with health and wellbeing, led to the identification of 'Reducing loneliness and social isolation' as one of Reading Borough Council's (RBC) eight priorities for Health and Wellbeing for 2017–2020. As part of the plan to address this issue, Reading's Health and Wellbeing Strategy outlined the need to focus on actions that would:

> *Improve our understanding of who in our community is most at risk from loneliness and develop a co-ordinated all-age approach to reach those most in need of support to connect or re-connect with their community; and*
>
> *Improve the quality of people's community connections as well as the wider services which help these relationships to flourish – such as access to transport and digital inclusion (RBC, 2017).*

Following the establishment of the Reading Loneliness and Social Isolation Steering Group, a multi-agency steering group formed in 2017, the Health and Wellbeing Team and Steering Group identified a need for more in-depth understanding of the dynamics of loneliness and social isolation in Reading and best practices which may help to prevent and tackle it. The Participation Lab was commissioned to undertake this qualitative study, building on the quantitative survey of Reading residents previously conducted by Reading Voluntary Action (RVA, 2017) and the Needs Analysis prepared by and for the Steering Group.

1.1 Aims and objectives

This report seeks to provide qualitative insights into a diverse range of people's experiences of loneliness and social support groups in Reading; to explore how existing third sector organisations and services working with a diverse range of clients aim to prevent and tackle loneliness and build social connections; and to identify best practices and priorities in preventing and tackling loneliness and social isolation in Reading. This report is intended to be used by local partners to develop strategies and plans, and to inform the development, delivery and funding of services that prevent and/or reduce loneliness and social isolation in Reading.

The overarching aim of the study was to provide an in-depth understanding of the dynamics of loneliness and social isolation in Reading and to identify best practices which may prevent and tackle it. The objectives of the Undergraduate Research Opportunities Programme (UROP) placement[1] were:

- To review and synthesise existing literature.

1 The fieldwork, analysis and part of the report writing was undertaken by Olivia Bridger, as part of a Participation Lab Undergraduate Research Opportunities Programme (UROP) project, University of Reading, supervised by Ruth Evans and Sally Lloyd-Evans, Participation Lab Leaders. Ruth Evans also analysed the data and co-wrote the report.

ii To use qualitative methods to investigate the views of local stakeholders and practitioners working in health and social care and the third sector in Reading, and to explore the experiences of particular groups of people who may be vulnerable to loneliness and social isolation.

iii To analyse the qualitative data.

iv To present the findings in an open access report.

The key research questions which the study sought to address were:

i Which factors may lead to loneliness and social isolation? Which barriers prevent people from developing social connections and networks?

ii Why are particular groups vulnerable to loneliness and social isolation?

iii How does loneliness and social isolation affect people's health and wellbeing?

iv Which services, practices and approaches are most helpful in preventing or reducing loneliness and social isolation in Reading?

v How can best practices to prevent or reduce loneliness and social isolation in Reading be strengthened and developed in the future?

2. WHAT IS MEANT BY LONELINESS AND SOCIAL ISOLATION?

This section gives an overview of the key themes and concepts used in the research and policy literature on loneliness and social isolation. While academic work in psychology has tended to focus on loneliness from the perspective of an individual's emotional state, sociological and social policy literature has focused more on social isolation and drawn attention to structural as well as relational and individual dimensions. There is a rapidly growing policy literature on loneliness and social isolation, with numerous reports published by third sector organisations, some of which focus on 'vulnerable' groups considered to be particularly at risk of loneliness, such as those experiencing mental illness, dementia, carers and so on. Few studies however have examined policies and practices that may help to tackle loneliness and social isolation. We identify existing definitions and concepts that are most relevant to our research questions.

2.1 Defining and measuring loneliness and social isolation

Although it is well documented and widely understood that the terms loneliness and social isolation differ, it is important to briefly define these two terms, and to consider the implications of these distinctions in meaning in the context of reducing loneliness and social isolation in Reading.

Although neither term has a universally accepted definition, loneliness is broadly considered to be a subjective, negative emotional state, whereby the social relationships an individual has are not consistent with the social relationships they desire (Asher & Paquette, 2003). Social isolation, however, is considered to be an objective, physical state whereby an individual has very limited social interactions and connections (Heinrich & Gullone, 2006). These distinctions in meaning underline the point that loneliness and social isolation are not synonymous, although the two concepts are related and are often considered together. An individual may feel lonely when surrounded by people they know. Equally, in some circumstances, an individual may have very few social interactions and be socially isolated, yet not feel lonely.

Social isolation is therefore considered to be quantifiable and more easily measured, as it more directly concerned with the number (opposed to quality) of an individual's encounters. Social isolation is however usually considered a risk factor for loneliness.

Loneliness is generally considered to be a 'gnawing emotional state', and a psychological consequence of social isolation. Weiss' (1973) early work on loneliness categorises two dimensions of loneliness; emotional loneliness, and social loneliness. Emotional loneliness refers to a lack of close, intimate relationships with another person and is associated primarily with issues of attachment. Social loneliness is concerned with a lack of a network of social relations and individuals with whom they share a common interest, and is in many ways more closely linked to the notion of social isolation. Young (1982) suggests that three types of loneliness exist:

i Transient loneliness: a very brief or short term experience encountered by most people in their everyday lives.

ii Situational loneliness: a medium to longer term experience encountered by individuals who have previously had satisfying relationships that have been affected by life events.

iii Chronic loneliness: an enduring experience of loneliness, whereby an individual has been without a fulfilling social relationship for over two years.

Academic studies specifically focused on loneliness from the 1970s onwards have largely been conducted by psychologists, although studies of people's social networks and connections which are informed by a sociological and social policy perspective have

increased significantly in recent years. The psychological literature generally regards loneliness as a personal and individualised experience, which means that unlike social isolation, it is difficult to quantify. Nonetheless, there are two key measurement scales, developed by psychologists, which have been used to measure loneliness.

The UCLA scale was published in 1978 and has been updated three times since its publication, most recently revised in 1996 (Russell, et al., 2010). The UCLA 3-item scale works by asking respondents how frequently they experience the following statements, with responses of 'hardly ever', 'some of the time' or 'often':

- How often do you feel that you lack companionship?
- How often do you feel left out?
- How often do you feel isolated from others?

Similarly, the De Jong Gierveld 6-item loneliness scale, based on the work of Weiss, presents the following statements:

- I experience a general sense of emptiness.
- There are plenty of people I can rely on when I have problems.
- There are many people I trust completely.
- I miss having people around me.
- There are enough people I feel close to.
- I often feel rejected.

Respondents are asked to respond with 'Yes', they feel this, 'No', they don't or 'More or less' (Campaign to End Loneliness, 2015).

At the request of supporting organisations, the Campaign to End Loneliness developed its own loneliness measurement tool (Campaign to End Loneliness, 2015). The tool builds on the UCLA and De Jong Girveld scales and presents the following statements:

- I am content with my friendships and relationships.
- I have enough people I feel comfortable asking for help at any time.
- My relationships are as satisfying as I would want them to be.

Respondents are then asked whether they 'strongly agree', 'disagree', 'neutral', 'agree', 'strongly agree' or 'don't know'.

The more positive statements used in the Campaign to End Loneliness scale focus more on people's social connections and relationships than the earlier scales. They appear to be informed more by a resilience perspective that focuses on strengths rather than adopting a solely individualised, psychological deficit model of loneliness.

As part of the government's Loneliness Strategy, the Office for National Statistics (ONS) (2018a) undertook a programme of scoping work and consultation with experts on existing approaches to loneliness measurement. They suggest that the 'gold standard' is to use both direct and indirect measures of loneliness in national surveys where possible and identified recommended measures of loneliness for adults and children (ONS, 2018a), as seen in Tables 1 and 2.

Table 1:
Recommended measures of loneliness for adults (Office for National Statistics, 2018a, p.4)

Measures	Items	Response categories
The three-item UCLA Loneliness scale	1. How often do you feel that you lack companionship? 2. How often do you feel left out? 3. How often do you feel isolated from others?	Hardly ever or never, Some of the time, Often Hardly ever or never, Some of the time, Often Hardly ever or never, Some of the time, Often
The direct measure of loneliness	How often do you feel lonely?	Often/always, Some of the time, Occasionally, Hardly ever, Never

The ONS (2018a, p.5) note that there is more robust and extensive data on loneliness in older people, but much less for other age groups including children and young people: "Much less is known about why younger people become lonely and how this compares with factors associated with loneliness in older people. An adapted version of the measures is recommended for use with children and young people aged 10 to 15 years, with the wording changed to a more 'plain English' version, as shown in Table 2.

Table 2:
Recommended measures of loneliness for children (Office for National Statistics, 2018a, p.5)

Measures	Items	Response categories
The three-item UCLA Loneliness scale for children	1. How often do you feel that you have no one to talk to? 2. How often do you feel left out? 3. How often do you feel alone?	Hardly ever or never, Some of the time, Often Hardly ever or never, Some of the time, Often Hardly ever or never, Some of the time, Often
The direct measure of loneliness	How often do you feel lonely?	Often/always, Some of the time, Occasionally, Hardly ever, Never

All of these measurement tools are primarily focused on an individual's subjective experience, however, and are not very helpful in understanding the relational or wider structural factors that may influence why someone feels lonely or becomes socially isolated. Relational factors may include for example, relationship breakdown, divorce, bereavement, conflict with family members, neighbours or friends, interpersonal violence, isolation, stigmatisation and harassment of particular groups and so on. Structural factors may include financial pressures, unemployment, limited access to healthcare, community

resources and support, limited or inaccessible transport infrastructure, inaccessible public venues and facilities for disabled people, children, older people, hostile public and media environment towards refugees and other migrants and other groups, austerity and cuts to public services and so on.

For the purpose of this report, we adopt the definitions of loneliness and isolation used by Victor, Mansfield, Kay and colleagues (2018, p.8) in their review of the effectiveness of interventions to address loneliness. Social isolation is defined as "having few and infrequent social ties", which is an objective quantifiable construct. This contrasts with loneliness, which is the "outcome of an individual's evaluation of their social relationships as not meeting their expectations". Thus loneliness and isolation are distinct but related concepts and "are not linguistically, empirically or conceptually interchangeable". Despite this, the multi-agency steering group in Reading has a focus on loneliness and social isolation and so the dual term 'loneliness and social isolation' or LSI is used in this research.

2.2 Understanding the factors that influence loneliness and social isolation

The Office for National Statistics (ONS) (2018b) report produced from the 2016–17 CAL survey considered 34 characteristics and circumstances to assess who is most likely to experience loneliness. Of the 34 considered in its analysis, the following 13 characteristics were found to have an impact on loneliness: age; sex; marital status; respondent and partner's (if applicable) gross income; disability status (self-reported); general health (self-reported); number of adults in the household; caring responsibilities; whether chat to neighbours more than to just say hello; feeling as though you belong to a neighbourhood; satisfaction with local area as a place to live; the number of years lived in local neighbourhood; how often meet up in person with family members or friends.

The ONS (2018b) report identified biographical profiles of those who may be the loneliest:

- widowed older homeowners living alone with long-term health conditions.
- unmarried, middle-agers with long-term health conditions.
- younger renters with little trust and sense of belonging to their area.

Additionally, the multi-agency Campaign to end Loneliness (CEL, 2019a) considers there to be two broad categories of risk factors, that is 'personal' and those pertaining to 'wider society'. The 'personal' risk factors include: Poor health; Sensory loss; Loss of mobility; Lower income; Bereavement; Retirement; Becoming a carer; Other changes (for example, giving up driving). The factors relating to 'wider society' include: Lack of public transport; Physical environment (no public toilets or benches); Housing; Fear of crime; High population turnover; Demographics; Technological changes.

The risk factors identified in the national policy reports discussed above are broadly aligned to those outlined in RBC's (2018) Loneliness and Social Isolation Needs Analysis, which identified the following themes as risk factors: Age; Living alone; Life events; Income; Transport; Health.

Due to the implications LSI has on health and wellbeing there is a significant body of research that attempts to unpack the risk factors and causes of LSI. However, academic work on this is limited, with the majority of research being undertaken by local and central government, and NGOs. One of the most substantive piece of social science academic research that considers risk factors for LSI is Victor and colleagues' (2005) report, which identified 5 sets of risk factors: 1. Socio-demographic; 2. Material Circumstances; 3. Health Resources; 4. Social Resources; 5. Life Events. This study however, only considers the experience of loneliness amongst older people, therefore, although potentially cross cutting, the findings of this study cannot be used to consider loneliness across the lifecourse.

A key point raised by Victor and others (2005) is that within existing literature, there is limited consideration of protective factors, characteristics, and circumstances that prevent individuals from becoming lonely. Victor and others (2005) argue that this oversight is detrimental to efforts made to reduce loneliness, and that supporting individuals so that they do not become lonely or isolated is more effective than tackling loneliness once it has taken hold. This suggests that a resilience perspective may be helpful in understanding the protective mechanisms that enable people to thrive and achieve positive outcomes despite experiencing difficult circumstances.

Within the sociological and social policy literature, the concept of social capital has been widely used to examine people's social connections and networks, levels of trust and so on which act as resources within communities. As Lovell (2009, p.781) observes, social capital has been proposed as a "cure-all for society" as researchers emphasise positive relationships between social capital and variables such as health, socio-economic status and confidence in government. Robert Putnam (2000), one of the best known proponents of social capital, refers to social capital as connections among individuals and the social networks and norms of reciprocity and trustworthiness that arise from them (Franklin, 2003). A distinction is often drawn between 'bonding' (within group) social capital, which tends to be selective, excluding those who differ from an individual or group; and 'bridging' (between group) social capital, which crosses social divisions to encourage societal inclusiveness (Lovell, 2009).

In the context of loneliness and isolation, the focus would therefore be on how people may be unable to develop beneficial social networks, reciprocity and relationships of trust within their group (bonding social capital) and/or between groups (bridging social capital) within communities. In a study in western Finland, Nyqvist and others (2016) found that frequent loneliness (defined as experienced often or sometimes) was higher among younger people (39.5%) compared to older people (27.3%) and that low levels of trust were linked to loneliness across four age groups. They conclude that low social capital, especially in terms of low trust, may be a risk factor for loneliness.

The concept of social capital has, however, been widely critiqued by social scientists. There is a lack of consensus on how to define and measure 'social capital', and related notions, such as 'social networks' (Clark, 2009; Lovell, 2009). Commentators have argued that the concept "barely touches the complex reality and the diversity of people's lives" (Franklin, 2003, p.351). A broader, more liberal approach might focus on a range of social processes, recognising how individuals in contemporary societies adapt to, and live with, the insecurities that come with social change (Beck and Beck-Gernsheim, 2002). The community development literature, with its established themes of community capacity building and empowerment, may be more appropriate in practical work to tackle loneliness, marginalisation and the isolation of particular groups and individuals at the grassroots level (Lovell, 2009).

From a psychological perspective, Heinrich and Gullone (2005) draw on Jones' (1982) 'cycle of loneliness' and concluded that lonely people consider more things to be of a threat than non-lonely people, with links to paranoia and negative social behaviours. Jones (1982) argues that the behaviour patterns of those who are lonely can be detrimental to social communications, making forming relationships difficult and perpetuating the cycle of loneliness and isolation. However, as more recent research has demonstrated, the negative effects of loneliness are not due to unusual features or behaviours of those who are lonely, but rather the effect that loneliness has on normal people (Cacioppo & Cacioppo, 2018). This suggests that loneliness is a normal part of life. Furthermore, recent reports and media broadcasts have pointed out that loneliness is not necessarily always negative; there can be positive benefits associated with loneliness. This suggests that a resilience approach that emphasises strengths may also be helpful when considering loneliness and social isolation.

Recent neurological research has begun to consider how loneliness may be more than a risk factor for physical and mental ill health, and could itself be considered a heritable trait due to differing brain structures (Kanai and others, 2012). Cacioppo and others (2014) hypothesised that some people are genetically more susceptible to loneliness, and that loneliness can be considered to be a trait that arises due to the expression of a specific gene. It is however important to note neurological and biological studies are only just starting to examine these potential risk factors. Such studies often conflict with the broad consensus of policymakers and social scientists that loneliness and isolation need to be considered as linked to personal, relational and societal factors rather than regarding these as simply biologically determined (Cacioppo and Boomsma, 2013).

2.3 The effects of loneliness and social isolation on health and wellbeing

The effects that loneliness and social isolation may have on health and wellbeing are extensive and well documented in the medical and psychological literature. Numerous studies identify a causal relationship between heightened levels of loneliness and social isolation, and poorer mental and physical health and wellbeing.

Holt-Lunstad and others' 2010 study suggest loneliness is as detrimental to health as smoking 15 cigarettes per day (Holt-Lunstad and others, 2010), and their 2015 study suggests loneliness increases mortality by up to 26% (Holt-Lunstad and others, 2015). Additionally, loneliness is considered a risk factor for cardiovascular disease (Valtorta and others, 2016) and high blood pressure (Hawkley and others, 2010). The onset of disability (Lund and others, 2010), frailty (Gale & Cooper, 2018) and clinical dementia (Holwerda and others, 2014) occurs quickest for the loneliest individuals, and the loneliest are more likely to use emergency services unnecessarily (Geller and others, 1999).

In addition to the effects on physical health, loneliness has significant implications for mental wellbeing. Heightened levels of loneliness are linked to depression across age groups (Bhagchandani, 2017) (Cacioppo and others, 2006), and specifically in the elderly cognitive decline (James, and others, 2011), and completed suicide (O'Connell and others, 2004). Equally, loneliness in young people is linked to poor emotional development (Besevegis & Galanaki, 2010) and lower academic achievement (Margalit, 2010).

Good social networks have long been identified as a key determinant of health (Whitehead & Dahlgren, 1991), and the findings of these, and many other studies clearly demonstrate that an absence of good social networks is more than undesirable. Loneliness and social isolation are now regarded a public health issue, which warrant research that identifies risk factors for its progression and best practices which reduce its occurrence.

Although understanding causal mechanisms or how loneliness and social isolation progress over a period of time are not within the scope of this study, this research seeks to understand which factors may contribute to feelings of loneliness and social isolation, with reference to particular vulnerable groups in Reading.

2.4 Vulnerabilities of particular groups to loneliness and social isolation

As numerous policy reports across a range of social groups have argued, loneliness occurs across the lifecourse and affects different people in different ways, depending on their particular circumstances, characteristics and barriers to social inclusion. Carers who support people who are older disabled or seriously ill have been identified as particularly vulnerable to loneliness and isolation. Carers UK's (n.d.) State of Caring 2017 survey, for example, found that 81% of carers felt lonely or socially isolated as a result of their caring role, with this figure rising to nearly 86% for carers providing 50 hours a week. Almost half

of carers surveyed (48%) said not having time to spend on social activities had made them feel lonely or isolated, and almost half (49%) identified the difficulty of not being able to get out of the house much, as causes of their loneliness and social isolation. Over half (54%) of carers reported that regular breaks from their caring role would help to make them feel less lonely, and 52% identified a need for more understanding from society. A third (30%) of those in work and care said that more understanding at work would help while a third (31%) said support with paying for social activities would help.

Disability charity Sense's (n.d) report for the Jo Cox Commission on Loneliness suggests that disabled people are more likely to be chronically lonely. Having one or more impairment increases the risk of loneliness and social isolation, with over half of disabled people (53%) reporting that they feel lonely, while the figure rises to 77% for young disabled people. Furthermore, almost a quarter of disabled people (23%) say they feel lonely on a typical day. The report discusses the particular dynamics of loneliness for people with a wide range of impairments and identifies the causes of loneliness for disabled people in terms of practical barriers to establishing social connections such as physical activity transport premises or issues related to the nature of conditions themselves. Stigma and poor public attitudes were also directly related to feelings of isolation among disabled people, a finding that Olivia Bridger (2019) also explored in her research with physically disabled people in Reading. The following areas are identified as crucial in reducing LSI among disabled people:

- **increasing awareness** through improving social attitudes and increasing professional awareness and support
- **improving access to services** by enabling independence through access to social care and provide access to services that respond to loneliness
- **tackling poor accessibility** by ensuring physical access to communities, providing accessible transport and addressing the digital divide
- **addressing financial barriers** by providing fair and adequate financial support and the increasing access to employment and work experience.

A Mental Health Foundation survey in 2010 found that 42% of adults in the UK have felt depressed because they felt alone, demonstrating that loneliness is closely related to people's mental health. The figures were higher among women (47%, compared to 36% men) and higher among those aged 18 to 34 (45%, compared to 31% of those over 55). If Sense (n.d) also recognise the two-way relationship between mental health and loneliness: LSI can have a significant impact on a person's mental health, and mental health problems often lead to feelings of isolation. In particular, mental health problems can lead to low self-esteem and poor self-image. For people who experience conditions such as phobias, social contact or leaving the house may be especially difficult. Some people find the medication they take for their condition can affect the way they see themselves or the way they communicate, leading to people worrying about others judging them. People with mental health conditions are less likely to be in work which reduces the availability of support networks people have access to. The Sense (n.d) report also suggests 9 out of 10 people with mental health problems experience social stigma and discrimination impacts on their level of social connectedness.

In terms of children's and young people's vulnerability to loneliness, an ONS (2018c) report found that 11.3% of children aged 10–15 said that they were "often" lonely, while 9.8% of young people aged 16–24 said that they were "often" lonely. Children in lower socio-economic groups and those who had difficult social relationships with family and friends were more vulnerable to loneliness. For example, children who reported "low" satisfaction with their relationships with family and friends were also more likely to say they were "often" lonely (34.8% and 41.1%, respectively), while 27.5% of children who received free school meals said they were "often" lonely, compared with only 5.5% of those who did not (ONS,

2018c). Action for Children's (n.d.) report on the impact of loneliness in children and young people and families identifies those most at risk, including children who experience neglect, children in care, disabled children, young parents and parents with mental health problems. The report recommends:

- central and local government recognise that loneliness is a problem that affects children and young people and families and measures to address loneliness must not be restricted to provision for the older generation
- central and local government support to extend the provision of services that reduce isolation for children and young people and families, particularly for those most at risk. Examples cited include the continued funding of young carers support services, services for disabled children, children's centres and young parents support groups
- further research to measure loneliness and its impact on children and young people and families
- organisations providing social support services to children and young people and families to develop an understanding of loneliness and evaluate the impact of their services in reducing loneliness.

While much less attention has been paid to loneliness among Black, Asian and Minority Ethnic groups, research suggests a real problem of 'hidden loneliness' among BME older people (Khan, n.d.). Acting Director of Runnymead, Khan's essay in the report on Loneliness and Diversity suggests the causes of this are related to the fact that the vast majority of the current UK BME population aged over 65 were born overseas and their experiences of ageing – and of loneliness – are affected by their migration history. They do not necessarily share this history with other members of their household and family, who are much more likely to have been born and raised in the UK. Older BME people are also much more likely to live in poverty, as with minority ethnic groups generally, this is explained both by their lower wages and their higher likelihood of unemployment, meaning they are less able to save for retirement. Khan identifies that language issues may also be important factors, since older BME people may be more likely to have poor English and research suggests that those experiencing dementia often lose whatever second-language ability they had.

Khan (n.d.) identifies several areas that need to be strengthened including: language provision, including translation services and better support for English for Speakers of Other Language programmes; care provision, where services are not always suitably developed to meet the needs of older minority ethnic groups, in terms of language needs, but also wider cultural needs and preferences; and activities that bring people together, such as lunch clubs or exercise groups for older people, with programmes tailored to people from particular ethnic backgrounds and events supporting mixed interactions. The accessibility of services aimed towards the general population is also highlighted to ensure that they are sensitive to the needs of older BME people and are affordable.

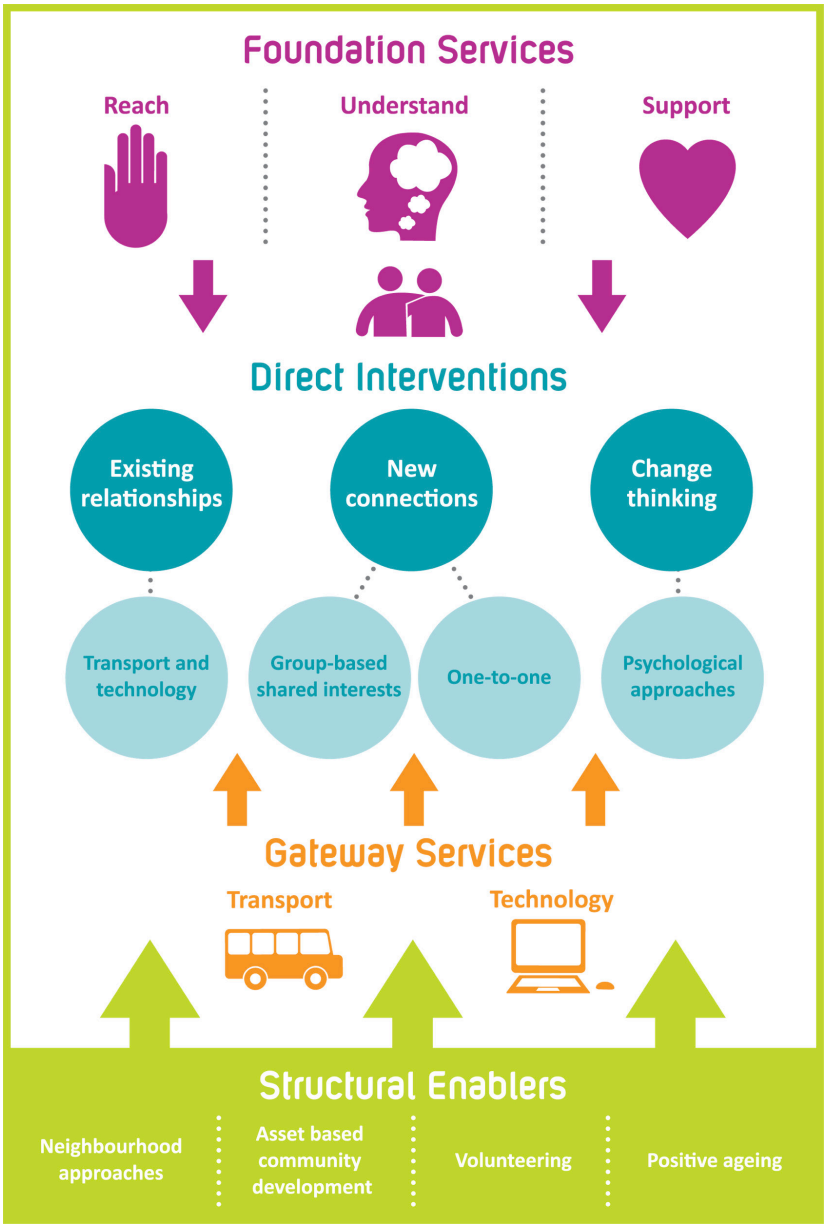
Reading Borough Council's (2018) Needs Analysis concluded that individuals may be at greater risk of loneliness or social isolation in Reading if they: are single (have no current spouse or life partner); have recently experienced a significant change to their life, particularly a bereavement; are impeded by practical barriers including physical mobility or another limiting health condition or physical or learning disability, geographical or transport barriers, or lack of funds, time, energy and confidence; and lack social and economic resources. Local survey information also suggests that a recent move to the area (meeting the criteria for a significant change) may be a particular risk in Reading.

2.5 Best practices to prevent and reduce loneliness and social isolation

The UK Government's Strategy for Loneliness (Department for Digital, Culture, Media and Sport, 2018, p.67) has three overarching goals: "to catalyse a national conversation on loneliness; to build the evidence base on loneliness; and to drive a lasting shift in government so that relationships and loneliness are considered as a matter of course in policy-making". It identifies preliminary measurement areas for each of the goals.

The following Loneliness Framework (CEL, 2019b) is the strategic approach used by the Campaign to End Loneliness which sets out the interventions needed to tackle loneliness, and their strategic implementation.

Figure 1. **Campaign to End Loneliness' (2019) Loneliness Framework**



1. **Foundation services**
   Focus on reaching, understanding, and supporting.
2. **Direct Interventions**
   Directly improve the quantity/quality of an individual's interactions. Focuses on three areas: Supporting and maintaining existing relationships, which is supported by transport and technology; supporting new connections, through group-based shared interests (identified as best when they focus on specific groups or when additional benefits are tagged on) or one to one approaches; and changing thinking through psychological approaches (such as mindfulness and Cognitive Behavioural Therapy).
3. **Gateway services**
   Technology and transport provisions improve an individual's ability to connect to services and the community's ability to provide them.
4. **Structural enablers** underpin the above three levels, since they create the right conditions and arrangements to reduce loneliness and emphasise how services are delivered. These range from neighbourhood approaches, asset-based community development, volunteering and positive ageing.

The Jo Cox Commission on Loneliness, made the following calls to action in 2017:

1. National Leadership, with a UK wide strategy, a lead minster and a family relationships test for new policy;
2. Measureable Progress, with a national indicator; and
3. Catalysing Action to stimulate solutions innovatively.

A point reiterated in the 2017 report is that action across all parts of the community is required and that everyone has their part to play to tackle loneliness and social isolation. The work of RVA, and Reading's Champions to End Loneliness are promising in this respect.

Victor and colleagues' (2018) review highlights the limited evidence from published literature about the effectiveness of interventions to address loneliness at all stages of the lifecourse, with the majority of published literature focusing on the 55 years and older age group. Nevertheless, their review of available literature suggests that programmes tailored to the circumstances and needs of individuals, specific groups or type of loneliness experience would be more likely to result in reductions in loneliness. They identify a number of mediating factors which are central to the development of successful loneliness interventions including: the development of companionship, supporting meaningful relationships and tailoring interventions to the needs of those for whom interventions are designed. In particular, the authors comment on the complexities of befriending (offering supportive reliable relationships usually in person and by volunteers), emphasising the need for appropriate promotion of interventions emphasising the development of meaningful relationships, rather than as 'loneliness' interventions, which may be both unappealing and stigmatising.

In terms of policy, Victor and colleagues (2018, p.6) call for a focus on person-centred and tailored loneliness interventions, which are designed for the specific needs of a targeted population defined in terms of sociodemographic, vulnerability or types of loneliness. They suggest the need to develop programmes to alleviate loneliness across the life course and with due attention to diverse population groups, social contexts and change over the life course. They also highlight the importance of promoting programs to alleviate loneliness which pay attention to the avoidance of stigma or the reinforcement of marginalisation and isolation. Programs are needed which emphasise meaningful relationships and improved social connections for those who are lonely or at risk of loneliness.

Victor and colleagues (2018, p.6) also raise broader points about the need for conceptual clarity in loneliness work; for policy support to develop social impact models of the processes and mechanisms by which loneliness interventions work; and for policy support for better evaluations and primary research in this field, including measures of costs.

2.6 Summary

This section has reviewed the academic and policy literature on the factors which appear to increase the risk of loneliness and social isolation, the vulnerabilities of particular social groups in the UK, the relationship between LSI and health and wellbeing, and policies and practices to address LSI. The complex and intersecting nature of many of the societal, situational and personal factors that lead to loneliness and social isolation suggests a need for a diverse range of services, community infrastructure and support that is tailored to the needs of people experiencing loneliness in Reading and to reduce isolation and prevent loneliness at an early stage, as we explore in Section 6. The next section gives an overview of the research methods used in this study.

3. RESEARCH METHODS

3.1 Introduction

This section gives an overview of the research methods used in this study. Given the quantitative data gathered in the Reading Voluntary Action (2017) survey, this research sought to use a qualitative methodology to explore in more depth the perspectives of practitioners and the lived experiences of different groups of service users, volunteers and community members.

3.2 Research methods

Semi-structured interviews were conducted with a total of 24 practitioners/service providers from 21 different voluntary and community organisations and statutory providers in Reading (a small number of interviews were with two practitioners). Six focus groups were conducted with a total of 65 participants who were service users, peer support volunteers and members of the community in Reading, comprising groups of Deaf and hearing impaired people, older carers, peer support volunteers with experience of mental illness, people at risk of homelessness, mothers and refugees and asylum-seekers.

Table 3:
Research methods used with different groups and numbers of participants in focus groups and interviews

Characteristics of group	Number of focus groups	Number of focus group participants	Number of practitioner interviews	Number of practitioner interviewees
Black, Asian & Minority Ethnicities			3	3
Refugees and asylum-seekers	1	25	1	1
Bereavement			1	1
Homelessness	1	5	1	1
Drug/Alcohol addiction & recovery			1	1
Mental health	1	3	3	3
Physical impairment			2	2
Sensory impairment	1	20	2	2
Learning disability and Autism			2	4
Dementia and life-limiting illness			2	2
Adult carers	1	7		
Young carers			1	1
Parents/mothers	1	5		
University students			1	1
Other third sector organisations			1	2
Total:	**6**	**65**	**21**	**24**

Table 3 above shows the diverse range of social groups who participated in focus groups or with whom practitioners worked. The selection of these groups for the sample was

informed by the literature review and existing contacts suggested by Reading Borough Council's Health and Wellbeing Team and the researchers. The purposive sample does not seek to be representative, but does provide depth of insight into a diverse range of perspectives and experiences of different social groups at risk of loneliness and social isolation in Reading.

As shown in Table 3, the number of focus group participants ranged from 3 peer support volunteers with experience of mental illness, to 20 Deaf and hearing impaired people and 25 refugees and asylum-seekers. However, in these larger focus groups, many participants observed rather than spoke themselves. A British Sign language interpreter was used in the focus group with Deaf people.

All interviews and most of the focus group audio recordings were transcribed in full. In the two large focus groups where the audio-recording was difficult to transcribe, 'notes and quotes' were written up by the researcher.

Thematic analysis of the interview and focus group transcription was undertaken using a sifting and sorting approach to identify the key themes. A summary document was produced for each interview and focus group to capture the key points, including examples and potential quotations to be used in the report.

Ethical approval for the project was obtained from the University of Reading Research Ethics Committee prior to the fieldwork and participants' views have been anonymized throughout this report.

3.3 Conclusion

This section has given an overview of the qualitative research methods used with participants in Reading. The following sections 4, 5 and 6 discuss and identify the key findings emerging from the data gathered for this project.

4. DYNAMICS OF LONELINESS AND SOCIAL ISOLATION IN READING

4.1 Introduction

This section discusses the dynamics of loneliness and social isolation in Reading, based on the experiences of community members, service users and volunteers from marginalised groups who received support from statutory and/or third sector organisations, in addition to the professional experiences of practitioners working with those who may be vulnerable to LSI in Reading. It focuses on the first research questions guiding the study: Which factors may lead to loneliness and social isolation? Which barriers prevent people from developing social connections and networks?

The analysis is structured according to understandings of the factors leading to LSI discussed in the research literature (see Section 2), focusing on societal factors, situational factors and personal factors.

4.2 Which factors may lead to loneliness and social isolation? Which barriers prevent people from developing social connections?

As expected, the research confirmed that the risk factors for LSI, and barriers which prevent people developing meaningful social connections, are complex and multifaceted. In an attempt to simplify what is a very complex topic, the factors mentioned and discussed during interviews and focus groups have been analysed according to the following spatial scales: societal, situational and personal. It is, however, important to note that these factors are interlinked and should not be viewed in isolation.

4.2.1 Societal factors

Societal factors encompass societal attitudes, changes or wider issues that were perceived to increase an individual's risk of loneliness or restrict their ability to develop meaningful social connections. Table 4 summarises the factors identified and the numbers of interviews or focus groups where these issues were mentioned, with an indication of which social group of focus group participants raised the issue given in brackets.

Table 4:
Perceptions of societal factors mentioned by practitioners and community members that may increase the risk of loneliness and social isolation

Risk factor for LSI	Number of interviews with practitioners where mentioned (n=21 interviews)	Focus groups where mentioned (n=6 focus groups)
Stigmatisation of particular groups	9	2 (homelessness; mental health)
Access to transport	4	2 (refugees; carers)
Cuts to public services & infrastructure	2	3 (homelessness; parents; carers)
Barriers in accessing statutory services	3	2 (homelessness; parents)
Internet and technological changes	3	2 (carers; parents)
Unsupportive workplace	1	2 (homelessness; parents)
Exclusion from job market	3	2 (refugees; homelessness)

Stigmatisation of particular 'vulnerable groups'

Lack of understanding and stigmatisation of particular 'vulnerable groups' was perceived by many practitioners and service users as a key issue which could result in significant loneliness and isolation. The effects of national policy and attitudes toward refugees, asylum seekers and other migrants was said to be key factors in these groups' isolation. For example, the 2016 Immigration Act was regarded as having *"really reinforced the hostile environment for asylum seekers"* (practitioner working with refugees). Equally, negative media coverage and public prejudice were perceived to be a key factor for loneliness because asylum seekers and refugees are:

> *a part of the population that are lambasted on the front of the Daily Mail every chance they get. Every crime that's committed in the area someone will blame on all the asylum seekers over here. They're very much pilloried by the state and by a lot of the press. So they're going to feel isolated and slightly paranoid.*

A hostile environment was also in evidence more broadly against Black, Asian and Minority Ethnic (BAME) groups, such as *"being asked to show your passport when you go to get medical service or when you call the police out"* (practitioner working with BAME groups). This led to minority ethnic groups who had previously been quite well integrated in Reading becoming "*more segregated and inward looking"* due to feeling more unsafe. As this practitioner commented:

> *[there are] women who now feel like they don't want to walk their children to school in the morning because they're at fear.. [of] a lot of verbal racism and hate crimes.[...] really low level but continuous bias and discrimination....[results in many BAME people becoming] more socially isolated and starting to only mix then more with their own communities".*

Negative public perceptions and racist, Islamophobic attitudes have major consequences for a sense of belonging, security and isolation of particular minority ethnic communities. Nonetheless a practitioner working with refugees and asylum seekers felt that Reading is a welcoming place, based on their positive experiences of working with a group of footballers who are refugees and asylum seekers within the mainstream local football league.

A lack of understanding and stigma was identified as affecting many vulnerable groups, not just migrants and BAME communities, such as people with learning disabilities, autism, mental illness and drug and alcohol addiction. One practitioner commented on the lack of understanding of autism behaviours: *"Everybody else will tut-tut because they're behaving differently".*

Participants at risk of homelessness and those with mental health conditions highlighted the significant stigma surrounding mental health and fear associated with particular behaviours deemed problematic, such as hearing voices or experiencing anxiety in public spaces, which could lead to a loss of social relationships.

Women related their experiences of anxiety in public spaces:

Female participant: *I used to be terrified of people, particularly groups of people, and, yes, one of the hardest things I ever did when trying to get better was to go and sit in Broad Street. I wasn't alone, I had someone I trusted [...] I was an absolute ball of terror, [...] it was horrific....*

Female participant: *Then you're blamed for it. Generally, society would point you out, "Oh, she's a weirdo, look at her. Oh, she's behaving very oddly. We'd best stay clear of her."*

Participants found themselves being blamed by others (and also sometimes blaming themselves) for "isolating themselves" rather than a loss of social connections being seen as part of their mental illness.

A related research project conducted by Olivia Bridger (2019) explored the role that attitudinal barriers towards disability may play in contributing to feelings of LSI among physically disabled people in Reading. It concludes that attitudinal barriers to disability consolidate the exclusion of disabled people and inhibit their ability to develop and maintain meaningful social relationships that are essential for wellbeing and the prevention of loneliness. Attitudinal barriers impacted on some disabled people's self-confidence and mood to the point where they did not want to go out and engage in activities in the community.

Access to transport

The government's Loneliness Strategy identifies the importance of accessible and inclusive transport that "supports people's social connections and helps people be connected to their community" (Department for Digital, Culture, Media and Sport, 2018, p.36). RVA's (2017) survey in Reading identified transport as the third most important barrier that prevents people being more socially active (reported by 29% of respondents). Groups identified as most affected by transport issues included those in unstable/ temporary accommodation (50%), those who were 85 and older (48%), those who were unemployed (42%), those who lived alone (33%) and full time parents (32%).

In this research, refugees and asylum seekers highlighted the cost of transport as a barrier to their mobility and social participation, which could lead to being isolated and feeling lonely at home. They expressed a need for cheaper bus services, since they had to prioritise food and meeting their children's needs with the little income support they received. The travel expenses they received when attending refugee support group sessions were highly appreciated and enabled them to access English language classes and social activities, especially for children.

In the focus group with carers of older people with a range of long term conditions, many highlighted how helpful Readibus transport services were for older people with mobility impairments, particularly those living alone. However, there was a perception by one man caring for his wife with dementia that the service would not meet their needs because his wife was no longer able to be independent in town and remember where to meet to be picked up at a specific place. This perception is at odds with the service ReadiBus provides, which enables carers to travel on the bus with people with dementia and other impairments who need to be accompanied by a carer.

Cuts to public services and infrastructure

The impacts of austerity and cuts to public services, seen at both the national and local levels, were widely commented upon across the interviews and focus groups. A Syrian male refugee emphasised the crucial importance of national policy and provision of English language learning for migrants: *"Role of government is key. Five hours a week is not enough to learn English"*.

Spending cuts to local councils and voluntary and community services such as support groups were regarded as a key risk factor that increased people's loneliness and social isolation. For example, due to financial constraints, a practitioner working with blind and partially sighted people explained they *"recently had to restrict* [attendance]*....the only way we can get these people in is to limit people* [attending] *to once a week"*.

Mothers commented on cuts to support groups and services that might help new mothers experiencing post-natal depression: "*I know we've got a lot of cuts that have taken place in Reading, support groups and whatever, but if we just tried to support each other more of*

sticking the boot in…"; "Or even if your doctor signposted it and gave you a number". They also highlighted the reduction in community centres in recent years: *"you used to have proper community centres, didn't you? But, again, cutbacks, they've taken a lot of them away"*.

Practitioners commented on how financial constraints had led to very limited knowledge about the specific needs of people with learning disabilities among social workers and a lack of awareness or joined up thinking about specialist support services that they could signpost people on to:

> *"They [Social workers] don't know anything about learning disability, they don't know the families, they don't know the person, and they don't know that there's Reading Mencap and Autism Berkshire out there, and CommuniCare, they just don't know what's out there. So, there is a huge lack of connectedness which, to me, has been caused by money"*.

Carers of older people with disability or long term health conditions were particularly concerned about cuts to respite day care services:

Male participant: *I think an awful lot of things have been cut back.*

Female participant: *That's why it's always worrying about day care because that isn't mandatory. They can cut any service whether it's children or adults.*

Older carers also commented on cuts to Age UK's exercise classes, such as Zumba and Tai Chi, which they used to volunteer for.

Participants at risk of homelessness expressed concern about the sustainability of third sector support services they were currently receiving and emphasised the importance of consistency of support provided in a regular routine over time. As one woman commented: *"I'm a bit worried about the changes that are coming here, because my support worker is not going to be here anymore. It's scary that it's changing because you get into routine and you don't really know what to expect"*. Others also echoed these concerns in the light of negative experiences of NHS mental health services:

> *We're scared about when our time here comes to an end, what we'll be doing. It's a worry when it stops, because it's so good. It's the first thing that's really stuck with me. Most of the NHS and stuff, I've found they just write you off and they don't really give you the support. You just feel really hopeless and negative there (female participant at risk of homelessness).*

Similarly, local decisions around infrastructure and leisure facilities were regarded as being just as detrimental as national policy measures in terms of contributing to social isolation. For example, the removal of the St Mary's Butts pedestrian crossing was mentioned by two practitioners, because this decision reduced the mobility of visually impaired people and "*how they navigate the town*". Equally, the significant reduction in public swimming facilities and other sports and leisure activities in the town and cuts to concessionary rates for accessing activities in recent years was mentioned in several interviews.

One practitioner highlighted the apparent contradiction in cuts to local services and the council's efforts to tackle loneliness and social isolation: "*The council… is rightly targeting tackling loneliness and isolation, but at the same time its doing other stuff that is the opposite to that, which you can't help because of budget restraints*". There was a recognition among many practitioners that reducing services to vulnerable groups was counter-productive, in terms of the long term impact on people's loneliness and social isolation. As one practitioner working with BAME groups commented: *"If we, as a society, do not look after our most vulnerable…. and we cut all of those services, then we are creating for ourselves a chronic problem of isolation and loneliness"*.

Barriers to accessing statutory services

Several practitioners and service users pointed to barriers in accessing statutory services. For example, practitioners supporting people with learning disabilities commented on the difficulties service users faced in accessing doctor's appointments with a support worker:

> *the doctor will only offer you an appointment at a certain time, on a certain day, and their support worker doesn't work then, so they're just going without appointments at the doctors or they're going to appointments not being able to say what's wrong with them and not being able to give a history, so the doctor can't diagnose them and they go untreated.*

Indeed, healthcare services were regarded by many practitioners and service users as inflexible and unresponsive to people's diverse needs.

Mothers commented on the situation of a new mother they knew who had committed suicide and emphasised the need for NHS doctors to spend more time listening to new mothers experiencing postnatal depression rather than "*just dismissing it*":

> *It's also the fact that if you do go to the doctors – I know they're hard-pushed for time or whatever, but just to sit and listen to someone. If they're a new mum and they're really down in the dumps, don't just dismiss it and say, 'You'll be alright, it's just the baby blues'. Find out why they're feeling so down and see if you can help.*

They felt doctors should play a key role in signposting mothers onto services which may help to reduce isolation.

Black and Minority Ethnic women were recognised as experiencing particular barriers in accessing healthcare. One practitioner supporting BAME communities commented that FGM is not understood by the services that should be there to provide care for women:

> *We just have one uniform system and if that doesn't work, then you kind of just slipped through the net. I feel that a lot of BAME women, a lot of most vulnerable women in our society, slip through that net very easily. That leads to their isolation and loneliness, which then leads to depression and anxiety which then compounds the issue to be even more isolated and lonely.*

Refugees also highlighted the language barriers they faced and inadequate provision of interpreters which meant that statutory services were inaccessible. For example, "*Many things make someone feel numb. [...] There is no trust with this refugee group, no interpreter to help access services. How can I been happy if I am strange here, and if no one helps me?"* (male participant).

A practitioner supporting drug and alcohol users also commented on the stigma many of their clients faced when trying to access statutory service provision:

> *I think wider services do need to look at how they work with us. Sometimes they're seen as trouble to be gotten rid of, rather than part of the community to be worked with.....We do get reports sometimes from our service users that they feel that they're judged and stigmatised. So, therefore, they will disengage, and out of choice, because they don't want to be in those environments.*

Participants at risk of homelessness who had mental health conditions also highlighted their negative experiences of seeking NHS support: *"In the NHS, I've been made to feel like a burden a lot. They minimise your problems, don't they? [...] I just feel like I'm a pain all the time, because I can't cope with things that lots of other people can do. I feel like I need more support than I maybe should at my age"* (female participant).

Some participants suggested that the thresholds for obtaining support could mean that people with Asperger's Syndrome were unable to access the support they needed.

Practitioners also highlighted a widespread lack of understanding about autism among statutory providers.

Some participants at risk of homelessness explained that they fell between different mental health services and were deemed too complex for a short-term Cognitive Behavioural Therapy (CBT) intervention, with no service wanting to provide support:

> *I think there's a massive breakdown between services because I, a couple of weeks ago, was assessed for... I was offered CBT in the NHS, then that service got in contact with me and said I was too complex for them, they wouldn't meet my needs. [...] Another service got in contact with me and they were like, "Well, we're not really sure what we can offer you." They were just, like, fobbing me off. I was told I was going to get something, really excited, and then they said I was too complex. Then the other service said they didn't know what to offer. I'm really not that complex. It just makes you feel like they've decided that you're not going to get better. So, it's, like, breakdown of service. You get one team that might be good, then you're just being passed to another person. I just wish there was, I don't know, more consistency.*

Carers of older people with a disability or long term health conditions highlighted difficulties in finding good respite care homes and the cost of respite care, which were major barriers that increased carers' isolation and loneliness. They also pointed to the difficulty of meeting thresholds for care support for older people with a disability or long-term health condition and lack of transparency about the assessment criteria: *"The council assesses you. They took a year to offer my husband a place because they kept saying, 'We don't think he fits the criteria'. I said, 'Tell me what the criteria are'. They never did."* Carers also expressed considerable frustration about the lack of availability of respite care at weekends and limited hours of council-run respite services during the week:

> *My wife goes to the care home one day a week which is really good, but they don't run Saturdays or Sundays. So if I want to do something at the weekends then there's nothing. [The hours are] 9:30 to 4:30. It's not even 9:00 to 5:00 [...] What's worse about the care home is that really it's 9:45 to 4:15. You get there at 9:30 the place is empty (male participant).*

The internet and technological changes

The pervasive role of the internet and other technological changes in recent years were regarded by some practitioners, service users and community members as an important factor that could either increase or reduce people's isolation.

Participants who were peer support volunteers for people with mental health conditions highlighted the importance of online support networks, particularly for people experiencing agoraphobia:

> *I have an online support network, online group. We actually play a game, World of Warcraft. So, I have a group of friends that I've made through there. So, they're from all over the world, and we get together at least three times a week for a couple of hours in the evening and do stuff together. Yes, that was my first experience, really, of any kind of proper support network, and it was really good. Considering I didn't leave the house, it had to be online...(female participant)*

Another female participant also highlighted the importance of socialising with friends online for people with mental health conditions:

> *My friends are all online as well, because I don't know anyone in Reading. So, that's why this is a little awkward for me, because loneliness is a really serious issue for me.[...] So, speaking to people online, that's mainly how I socialise. They're all over the country and all over the world, but I used to be, before I became unwell, a very sociable person.*

A male participant however felt that increasing reliance on online, rather than face-to-face interactions could lead to people becoming *"lonelier and lonelier": "although it's good, technology has moved us farther away from each other"*.

Some parents, carers of people with long-term conditions and people with mental health conditions perceived there to be much less contact with neighbours today than in previous decades. Mobile phones were perceived by parents to be causing less social interaction in public spaces, which inhibited communication between generations. There was a perception that if people did speak to anyone they did not know in public, they would be thought of as "*a nutter", "a bit weird"* or *"they're frightened to interact with anybody in case someone sees it the wrong way"*. Similarly a male older carer observed that women used mobile phones as a *"protective device"* when going for a walk in public. He highlighted the fact that, *"everyone will talk to you if you have a dog"*, but going for a walk alone could be stigmatised.

Unsupportive work environments

Participants at risk of homelessness who were unemployed thought that work could be a good way to make social connections and reduce isolation if the environment was supportive:

> *I see it like working would be amazing because then that would alleviate a lot of the isolation, but I'm guessing it depends what kind of company you work for and how supportive the environment is. Probably some people do feel really lonely at work, but if you're in a good environment then they wouldn't (female participant).*

People with mental health and/or neurological conditions who had experienced long-term sickness absence, however, talked about the stress they faced in returning to work and the impacts of a lack of understanding from line-managers and colleagues in unsupportive work environments. Some participants who had asked for adjustments to their workload due to their disability felt their line-managers responded by putting more pressure on them and blaming them for not coping. Such experiences could lead to long-term unemployment and accompanying risks of homelessness and a downward spiral of mental illness.

Exclusion from the job market

Refugees and asylum seekers regarded unemployment and not having the right to work as leading directly to social isolation and loneliness. As one older woman commented, *"If you can't work you don't meet anyone, and aren't leaving the house, so you feel lonely. Voluntary or other work would be good"*. Refugees and asylum seekers also pointed to the crucial importance of learning English in order to obtain work and thereby reduce the loneliness they experienced. For example, one male refugee commented: *"If I don't learn English I will be lonely…if my language [is] not good I can't get a good job, so I stay at home"*.

Practitioners supporting people with drug and alcohol addiction also pointed out how some service users were excluded from the job market because they were on certain medications and were not permitted to do certain jobs as a result.

4.2.2 Situational factors

Situational factors refer to social relations, circumstances or life events that were perceived to influence an individual's risk of loneliness and ability to develop meaningful social connections. This includes financial pressures, language barriers, mental health, disability and caring responsibilities.

The table below shows the key factors mentioned in interviews and focus groups.

Table 5:
Perceptions of situational factors mentioned by practitioners and community members that may increase the risk of loneliness and social isolation

Risk factor for LSI	Number of practitioner interviews where mentioned (n=21)	Focus groups where mentioned (n=6)
Limited support networks	9	3 (refugees; homelessness; mental health)
Financial pressures	8	2 (refugees; parents)
Language & communication	6	3 (refugees; deaf people; homelessness)
Mental illness	7	2 (homelessness; refugees)
Physical disability, ageing & loss of mobility	6	2 (carers; parents)
Significant life event or change	5	2 (homelessness; parents)
Negative coping strategies	4	1 (mental health)
Caring responsibilities	2	2 (parents; carers)
Living alone	0	3 (carers; homelessness; mental health)

Limited support networks

Perhaps unsurprisingly, many practitioners regarded limited support networks as increasing the risk of loneliness and social isolation among the groups they worked with. This could result from family members being spread further apart than in previous generations or people being newcomers to the area due to being a student or starting a new job or because they were newly arrived refugees and asylum seekers. Focus group participants who were refugees and asylum seekers highlighted their limited support networks and the fact that recently arrived refugees who did not know the area often stayed at home and became isolated.

A practitioner from an integrated treatment service supporting drug and alcohol users explained that when their clients try to change their drug and alcohol use, they often have to change their support group, their family group, their friendship group, which could be difficult. This could lead to isolation, fear and restrictions on their mobility in the neighbourhood:

> *A lot of our clients when they start to look at steps towards reducing and stopping their drug and alcohol use, they will stay indoors because they don't want to be out and be bumping into dealers or bumping into previous associates. So, then you start to isolate yourself.*

Participants at risk of homelessness and those with mental health conditions also highlighted the difficulties caused by being isolated from family members. They commented on how hearing about others' holiday plans could be particularly difficult when they were estranged from family members and were alone, for example, at Christmas:

> *…for Christmas I went training, but I went training because I didn't have anyone to spend it with. When people say, you know, talk about loneliness, that's a hard thing to do when you spend a month listening to people planning their Christmas breaks (male participant).*

Groups of carers and parents commented on the importance of good neighbours in reducing social isolation, giving examples of how they or their neighbours 'looked in' on older people and sought conversations with parents, carers and people living alone. Some participants with experience of mental illness said that they did not want to talk to their neighbours, as they felt they were being judged by them, while others just felt that society was becoming lonelier and *"no-one knows who lives next to them"* anymore. As one participant with experience of mental illness commented:

> *I live on the same road that I've lived on since I was two years old. I couldn't tell you the name of more than three people on it, and that's simply because I knew their kids when we went to school together. I have no contact with them.*

Financial pressures

Many practitioners pointed out how financial constraints limited the leisure and social activities people were able to do, leading to further isolation.

Refugees and asylum seekers highlighted the cost of transport as a barrier to accessing services. Furthermore, not being able to get a job due to limited English language learning opportunities led to significant financial pressures on refugee families and barriers to achieving their aspirations for the future.

The group of parents pointed to the low incomes that many parents had to cope with, resulting in long working hours and little time to care for their children or to have time for themselves to socialise or participate in the community. As one mother commented: *"I used to work 60 hours a week. I had two jobs. I never saw my boys grow up […] I wouldn't get home sometimes until 1 o'clock or 2 o'clock in the morning. Up again to take them to school the following morning at 7 o'clock again. Six days, seven days a week."* Such pressures could lead to isolation, loneliness and potentially mental illness. Job precarity could also lead to unemployment, with all the accompanying risks for individuals' and families' health and wellbeing.

Language and communication

Deaf and hearing impaired focus group participants highlighted the communication barriers deaf people may face, including not being able to use the phone, some deaf people not having learned to read or write English and problems if carers of deaf people did not use sign language. As one participant explained, lack of understanding and communication could lead to loneliness and mental health problems: *"Feeling lonely and depressed is not uncommon. People coming to visit helps. But a lot of people don't understand, many elderly people have carers who don't sign which contributes to isolation and loneliness."*

Furthermore, accessing mainstream (hearing group) activities on their own without peer support could be particularly challenging for deaf people. For example one participant attended a craft group which was hearing, but with another deaf person since,*"going to a hearing group by yourself is difficult"*.

In another focus group, one participant with epilepsy explained how having more seizures could make it hard for her to explain to service providers and members of the public about her needs.

Refugees and asylum seekers highlighted how isolation resulted from inadequate provision of English language learning and insufficient opportunities to improve their English by interacting with first language speakers of English. While this impacted on their access to

statutory services in the short to medium term, it also had major long-term consequences such as unemployment, which led to people staying at home and having reduced social contact.

Mental illness

Participants with experience of mental illness raised several points about how loneliness and social isolation were often key part of their experiences of mental illness, since it often triggered a loss of social networks and sometimes unemployment. One woman explained:

> *Mine [mental health story] literally kicked off when I lost all the friends that I had and then lost my job. So, I went from filling every single hour with people, living with someone, to losing it all, being completely isolated. To the extent that I couldn't open my front door when my mum called around. It was my birthday, she wanted to give me a birthday present, and I couldn't open the front door to her, because that outside, I did not want to do it, but I was so isolated (female participant).*

A female participant at risk of homelessness highlighted how isolation could worsen mental health, leading to self-harm or suicidal thoughts:

> *...at the worst extreme, if you're completely isolated, personally speaking, it can lead to a lot of very negative thoughts about either self-harm or suicide and stuff like that. Even though you don't act on them, because you feel like you have a responsibility to the people in your life who would be upset, feeling isolated is probably one of the biggest things that can make you feel like, "Well, what's the point of me being here?"*

Another female participant highlighted the particular issues faced by those with social anxiety such as finding large groups of people difficult in public spaces and facing challenges taking public transport which could lead to isolation. Other participants discussed the stigma and difficulties they faced in dealing with people's expectations and responses to their behaviour, such as hearing voices. Some talked about difficult relationships at work and stress they experienced in the workplace which impacted on their mental health and made them not want to go into work, leading to sick leave and reduced social contact.

Participants at risk of homelessness also pointed out how their mental health could mean they need to distance themselves from family members because of what they are going through, which could be painful and misunderstood. This could lead to further isolation and loneliness. Indeed several participants experiencing mental health difficulties highlighted the fact that they could be blamed by others or even blame themselves for "*deliberately cutting themselves off*", when people did not understand that it was their illness that led to the loss of social networks.

One woman at risk of homelessness highlighted the fact that people may feel lonely even when they share intimacy and feel close to a partner, family member or friends:

> *You can even feel alone when you're with your friends, and when you're with your family you can feel alone. "It's alright, [...] you've got me." Yes, but still you feel lonely. [...] Even two people that feel lonely together, sometimes they can't explain their loneliness to each other. They just feel lonely.*

A male participant with a mental health condition graphically illustrated how prolonged social isolation led to considerable anxiety about meeting new people, which may be avoided at all costs:

> *I think I spend so much time alone that now I kind of live in my own little world [...] if you said that, "Would you like to go to this party of 50 people or would you like to go into that field, pour petrol over yourself and have a merry dance with a load of firelighters?" I'd say, "Bring the petrol. Make sure it's the good stuff." It's true though, isn't it?*

Physical disability, ageing & loss of mobility

Parents felt that older people who become ill or lose their mobility, such as no longer being able to drive, were particularly vulnerable to isolation:

> *If you're of the older generation, like myself, if I didn't drive I'd be totally stuck. So, it's when you get to a certain age. Older people, they lose their peers and then they tend to withdraw. [...] They lose their confidence and their peers. So, they tend to back away from situations and that's how they become isolated.*

Practitioners supporting people with life-limiting illness also emphasised that it was the loss of mobility which led to LSI among their service users: *"Once they stop being able to get out of the house independently, that means they become isolated and then they become lonely"*.

Carers of older people also pointed to the isolation and loneliness that may result from ageing and loss of mobility, particularly for those without care support or who lived alone. Support from ReadiBus was seen as particularly important in enabling people to get out of the house and attend day centres or other social activities. They also highlighted how ageing and health problems could mean they had to stop doing activities they enjoyed, such as going for regular walks, which was detrimental for their wellbeing and led to reduced social contact with their neighbours.

Significant life event or change

Many life events, challenges or troubling changes in the lifecourse were perceived to increase the risk of loneliness and social isolation, including bereavement, becoming a new mother, abusive relationships, mental illness, drug and alcohol addition, homelessness. A mental health practitioner suggested that loss of social networks often occurred "*at crucial lifetime change points [...] if [people are] not very good at keeping a network"*.

A practitioner working with people who have experienced bereavement pointed to how personal coping mechanisms in wanting to deal with the experience alone could lead to isolation:

> *...sometimes people don't want anybody, they can't cope with everybody saying, "I'm so sorry," and all that sort of thing. They just want everybody to go away and they want to be on their own, and the trouble is that then that puts people off coming over to help or to talk to them or whatever, so they become isolated because of that.*

Parents also felt that a bereavement, particularly the death of a partner, could lead to reduced social participation and isolation: *"If they've lost one of their partners, like a husband or wife, that stops them from doing things that the used to do together so now they're on their own"*.

Becoming a new mother was another life event associated with major changes in women's lives, which could lead to isolation and loneliness. As one mother commented: *"From working full-time to then, 'I've got this baby and I've got all day until my husband comes home from work. What am I going to do with myself?' There's only so much housework"*.

Negative coping strategies

Participants with mental health conditions highlighted the fact that they could be driven to negative coping strategies such as alcohol addiction due to their mental illness. Recovering from alcohol addiction could lead to reduced face-to-face social contact, due to not being able to socialise in pub and bar environments. As one male participant explained:

> *I used to drink to wash away the voices [...] Then you go home on a Saturday night and you're playing internet chess because you can't go to a pub because, you know, and all that [...] but actually sitting in a pub with your chums is probably better than sitting around playing games of speed chess [online], obviously you've got no-one else to speak to.*

Practitioners working with young people with autism, with young carers and with students, in addition to those working with people with mental health challenges, drug and alcohol addiction and people at risk of homelessness regarded negative coping strategies that these groups engaged in as potentially leading to isolation and loneliness. Such coping strategies included poor diet, binge eating, drug and alcohol misuse, self-injury and suicidal thoughts.

Caring responsibilities

Focus group participants who were carers for family members with a disability or long-term health condition highlighted the challenges they faced in spending time with friends and socialising when they had caring responsibilities. This was particularly evident when people cared for a spouse or relative with dementia who may want to leave after a short period of time spent visiting friends.

Unpaid care work was also tiring which made it harder to socialise and maintain friendships. Participants highlighted the fact that engaging in social activities and maintaining friendships and social contact at weekends may be particularly difficult for carers, when few day care services were available. Carers also talked about a lack of understanding of carers' lives that they may encounter when meeting friends without such life experiences. As one female carer commented:

> *I find a lot of the friends I used to have, I don't see now. With some, I feel uncomfortable really because they don't really understand. I tend to get upset sometimes, but interestingly enough I don't get upset when I do my one thing that is really a 'me' time and that is, I have a French class I go to.*

The group of parents commented more broadly on the time pressures of balancing work and family life, which left little time for participation in the community and did not help to foster good neighbourliness which would help to reduce isolation.

Family wellbeing is recognised in the government strategy as crucial for preventing loneliness (Department for Digital, Culture, Media and Sport, 2018, p.57): "Research shows that parental loneliness is a predictor of their children's loneliness during school years. Over 40% of mums under 30 are lonely often or always". Parents in Reading also pointed out how new mums could be very isolated and struggled to attend playgroups, health appointments that took place early in the morning, due to *"getting the baby fed and clean and everything else and everyone else sorted out…"*. Parents with disabled children highlighted the additional caring demands placed on them, such as spending time at hospital seeing consultants, attending physiotherapy, hydrotherapy and other medical appointments, which meant that they missed out on opportunities to meet other parents at toddler groups, the school pickup and so on. This could lead to significant isolation.

Living alone

Carers pointed to the importance of day care services, not only for carers, but also in terms of reducing isolation and loneliness for older people with a disability or long-term health condition who lived alone. As a female carer commented, *"they never close for more than two days at bank holidays because a lot of the people who attend are on their own and they see no one. You see, now you're into loneliness";* a male carer added, *"Some people it's their outing […] They've eaten a proper meal"*.

Participants providing peer support to people with mental health conditions commented on how loneliness may be particularly difficult when people have started to make connections and feel supported but then go home to an empty place:

Male participant: *I kind of think sometimes we do these courses, and as much as that's somewhere I can feel comfortable, [...] just somewhere you can connect with people [...], and then I get this terrible feeling I'm sending them home alone. You know, and sometimes they open up, and then they're going to sit home alone and think, "I'm alone."*

Female participant: *You can see it sometimes, they, and we, will just leave our loneliness at the door, and then we pick it up again.*

Similarly, participants at risk of homelessness commented on how loneliness may be keenly felt after meeting friends and returning home alone, as one woman said: *"I like to see my friends, I have friends, but when I go home... Like [friend's name] said before she got upset, bless her, when you go home, you feel alone"*.

As discussed further in Section 6.2, these examples highlight the importance of creating safe spaces where people with mental health conditions are able to make positive social connections.

4.2.3 Personal factors

Personal factors refer to factors concerned with feelings or emotions that were perceived to influence an individual's risk of loneliness and their ability to develop meaningful social connections. It is important to note that these factors often stem from wider social issues, situational factors and structural barriers, such as mental illness and homelessness.

Table 4:
Perceptions of personal factors mentioned by practitioners and community members that may increase the risk of loneliness and social isolation

Risk factor for LSI	Number of practitioner interviews where mentioned (n=21)	Focus groups where mentioned (n=6)
Low confidence/ self esteem	10	2 (homelessness; mental health)
Mental health challenges	6	2 (homelessness; mental health)
Fear and anxiety	4	3 (homelessness; mental health; parents)

RVA's (2017) survey identified a lack of confidence as a major barrier which prevented people becoming more socially active, reported by 37% of respondents in Reading.

In this research, practitioners supporting people with life-limiting illness emphasised the importance of providing one-to-one support, such as through befriending schemes, before people lose confidence and become so low in mood so that they are not able to engage with activities in the community. Practitioners supporting people with learning disabilities also highlighted the anxiety that many service users experienced which hindered their participation. As one practitioner explained, time was needed to reduce anxiety and build confidence: *"enabling their level of anxiety to come down enough so that they can participate takes an enormous amount of time"*.

Participants at risk of homelessness and those with mental health conditions identified not feeling understood, in terms of their mental health, as causing loneliness and social isolation. They highlighted how difficult it was to meet others on a one-to-one basis due to low self-esteem linked to their mental illness. Some also felt that friends were too busy to spend time with them and they highlighted how negative thoughts about themselves could

spiral, if a friend, for example, cancelled meeting up. This could lead to feelings that they were a burden on others.

Practitioners supporting people with mental health problems highlighted the difficulties faced by people with limited social skills which meant they were afraid of being made fun of in group settings. They also noted that isolation compounded depression and led to further isolation:

> *If you're isolated, then you find it more difficult to speak to people so you become more depressed. One of the characteristics or symptoms of depression is to withdraw, so that you stop answering your phone, you don't go to any social occasion.... so you end up being isolated.*

Participants with mental health conditions highlighted social anxieties of being around other people and the difficulties of dealing with people's expectations and negative judgements about those who are more introverted. Several practitioners highlighted how fear and anxiety about socialising could be a major barrier to participation among the groups they worked with. A practitioner working with people with mental health challenges commented on how people sought to protect themselves by withdrawing: *"To protect yourself you back away because that feels the safest place to be. Then all those relationships break down. Then the relationships probably that you have are actually only with health professionals".*

A practitioner working with deaf people example also explained: *"They're frightened to get out of their house. They just stay in their house; they're housebound really."* A practitioner supporting older people from BAME groups suggested that fear, suspicion and a mistrust of authority could result in a lack of take-up of services, such as day centres, designed for the 'majority' (non-BAME) population*: "there's just a fear of an authority figure or officials, and even people who will risk coming through our doors, there's that fear"*. The interviewee added:

> *It isn't that anybody says to them, "Oh you can't come here," but they just don't go [to mainstream day centres]. And that adds to the loneliness because they are feeling that, "There is nothing for us," and 'for us' implies, "I want to see only black faces around, I want to hear a West Indian accent or an African accent."*

A practitioner supporting people with autism and their families highlighted the difficulty of motivating young people with autism to join groups and socialise with their peers: *"With the teenagers, we frequently find they just hibernate in their bedrooms... They need to be motivated sometimes to socialise, and then they enjoy it when they do."* Similarly, a member of the University chaplaincy commented that students with mental health problems or disabilities such as autism *"are going to find social stuff a little trickier"*. He added that there was an acceptance that leaving home (an experience encountered by most students at the university) is disruptive, but there was increased risk of isolation and loneliness if students' social skills *"for dealing with normal disruption have some somehow been inhibited"*. Among students, as has been found in research with other young people in Reading (McClane, 2018), it was usually people who *"didn't fit in the group"* who were most vulnerable to isolation. According to young people, based on the findings of McClane's (2018) RVA report on youth isolation and loneliness in Reading, loneliness often stemmed from strained relationships with family and friends, lack of confidence and mental health difficulties or disability.

Participants who had experienced mental illness commented on how anxiety and isolation could lead to situations where they felt threatened and were unable to communicate about their needs. This could lead to an overwhelming fear of engaging with the world and a desire to protect themselves by not engaging in social relationships.

4.3 Conclusion

This section has explored perceptions of practitioners, community members and service users about risk factors which may lead to loneliness and social isolation. The analysis of societal, situational and personal factors demonstrates the complexity and multifaceted nature of vulnerabilities to LSI. Recognition of the specific needs of particular groups and individuals is crucial in order to target services and support effectively towards those most at risk, as is explored in Section 6. The next section sums up some of the vulnerabilities of particular groups and draws out the impacts on health and wellbeing.

5. VULNERABILITIES AND HEALTH IMPACTS OF LONELINESS AND SOCIAL ISOLATION

5.1 Introduction

Having explored the dynamics of loneliness and social isolation in the Reading from a range of perspectives in Section 4, Section 5 focuses on the second and third research questions guiding the study: Why are particular groups vulnerable to loneliness and social isolation? How does loneliness and social isolation affect people's health and wellbeing? It summarises key factors that influence why particular groups are vulnerable to LSI and explores the relationship between LSI and health and wellbeing, based on analysis of the focus group discussions with service users and volunteers and of interviews with practitioners.

5.2 Why are particular groups vulnerable to loneliness and social isolation?

As evidenced in Section 4, loneliness and social isolation were perceived as both causes and consequences of mental ill health. Chronic or life-limiting health conditions, disability and caring responsibilities were also identified as major factors that could make people vulnerable to loneliness and social isolation. People experiencing ill health, disability or those caring for them, however, were not the only groups regarded as vulnerable to loneliness and social isolation. People experiencing a range of situational circumstances related to their immigration status, ethnicity and/or religion, unemployment, homelessness, drug and alcohol addiction, bereavement, or their age (young or older) and whether they lived alone, could all represent risk factors for LSI or could exacerbate existing circumstances of social isolation and/or feelings of loneliness in Reading.

Focus group participants with mental health conditions raised several points about how mental illness could lead to the loss of social networks. One participant highlighted the particular issues faced by those with social anxiety such as finding large group of people difficult in public spaces and challenges taking public transport which could lead to isolation. Other participants discussed the stigma and difficulties they face in dealing with people's expectations and responses to their behaviour which was regarded as problematic. Some talked about difficult relationships at work and stress they experienced in the workplace which impacted on their mental health and made them not want to go into work, leading to sick leave and reduced social contacts.

Participants at risk of homelessness also pointed how their mental health could mean they need to distance themselves from family members or friends because of what they are going through, which could lead to further isolation and loneliness. Indeed several participants experiencing mental health difficulties highlighted the fact that their illness led to the loss of social networks.

Focus group participants who were carers of people with a disability or long-term health conditions highlighted the challenges they face in spending time with friends and socialising when they had caring responsibilities, particularly for someone with dementia who may want to leave after a short period visiting friends. Caring was also tiring which made it harder to socialise and maintain friendships. It may be particularly difficult for carers to have social contacts at weekends when few day care services are available. Carers also talked about the lack of understanding of carers' lives that they may face with friends.

Refugees and asylum seekers emphasised how isolation often resulted from limited opportunities to learn English and consequently, not being able to obtain a job. Communication barriers in accessing services and activities led to people staying at home and having reduced social contact.

Deaf and hearing impaired participants also highlighted the communication issues deaf people may face. These included not being able to use the phone, some deaf people not having learned to read or write English, and problems if carers of deaf people don't use sign language. Deaf participants and older carers also highlighted barriers in accessing information about social groups and activities that was only available on the Internet. This could be difficult for people for with limited computer literacy to access, reducing their social participation.

5.3 How does social isolation and loneliness affect people's health and wellbeing?

Unsurprisingly, all interviewees and focus group participants considered LSI to be detrimental to health and wellbeing, although the extent of the impact depended on an individual's personal coping strategies, situational and societal factors. Most participants considered LSI to be of greatest detriment to mental and emotional wellbeing, citing low mood, anxiety and worsening mental illness as key impacts. Equally, it was noted that being lonely or isolated can negatively affect an individual's identity, self-confidence and sense of belonging.

Despite mental and emotional effects taking precedence, it was acknowledged by practitioners and service users that LSI can and does have implications for physical health because *"our physical and mental and emotion is much more interconnected than we realise sometimes"*. Participants at risk of homelessness highlighted the way that loneliness drained their energy, mentally and physically, but could also lead to loss of appetite and poor eating habits, as one woman observed:

> *When loneliness mentally drains you then it physically drains you, because then you physically don't want to get up. [...] So, it drains your energy in itself [...] So then you don't want to eat. Then you become malnutritioned [sic]. It all then plays a link in itself so it's all connected.*

Similarly, a practitioner supporting people who have experienced bereavement regarded this experience as affecting the whole body and impacting on people's physical health:

> *bereavement affects the whole body not just the mind, all the fight and flight symptoms [...] Things like dry mouth, abdominal pain, all sorts of things, hallucinations, dreams all that happens after a bereavement. So physically they can go downhill, it affects the immune system, and if your immune system's lowered you become ill and you're back to the NHS again.*

A practitioner supporting people with dementia highlighted how a lack of social engagement clearly led to a deterioration in the health of people with dementia, as well as impacting on the health of carers who *"tend to neglect their own health and their own social needs"*.

Several practitioners also pointed to the links between LSI and inactivity, and unhealthy coping behaviours which affected people's physical health. As a practitioner working with people with mental health challenges commented:

> *If you are socially isolated, you're probably not having good diet. You probably have ongoing health issues and all that stuff, so all those things, and dependency, alcohol dependency as a means of fighting isolation and loneliness. It will start to build up. So, you get multiple problems.*

A practitioner who worked predominantly with students commented that students may use certain behaviours to *"fill the gap of social life,* [behaviours] *that look not particularly frightening but aren't really very healthy, and they don't get out of the problem"*.

With regard to teenagers with autism, one practitioner suggested being lonely or isolated means these young people are more likely to:

> *play computer games all day long, and order in takeaways, they will get clinically obese pretty quickly, and they won't have a routine to their life. They won't wash; they will smell, and they will get morbidly obese pretty quickly.*

Similarly, it was suggested by a practitioner supporting people with mental health problems, that lonely and isolated individuals have a higher risk of substance and alcohol dependency, *"as a means of fighting isolation and loneliness."*

Thus, as previous research suggests, poor health is considered a risk factor for LSI, while LSI exacerbates existing ill-health and disability. This inter-linked relationship is also apparent in situational challenges, such as homelessness; practitioners suggested people were isolated because of their volatile housing situation, while their poor housing makes them unwell.

Moreover, many interviewees suggested that being lonely or isolated increases the burden of existing health, situational or personal issues. For example, in the context of bereavement, one interviewee suggested LSI, "*makes their grieving a lot worse,* [simply] *because they don't have anybody to talk to"*. Similarly, one practitioner considered that LSI impacted on how people with life-limiting conditions, *"engage with things that are available, and if they want to take their medication....and if they attend their appointments"*.

Loneliness and isolation may affect the health and wellbeing of both parents and children, especially among mothers in Black, Asian and Minority Ethnic (BAME) communities. As a practitioner from an organisation representing BAME communities commented, *"the social isolation of women then stems it* [loneliness and isolation] *down into the wellbeing of their children...so it becomes a generational issue"*. This suggests the potential intergenerational transmission of LSI and its negative consequences for health and wellbeing for younger generations of BAME groups.

The negative impact of LSI for health and wellbeing can also be considered from the perspective of the exploitation of those who are already vulnerable. A practitioner supporting people at risk of homelessness relayed her experience of how particularly vulnerable, isolated individuals are at increased risk of exploitation through cuckooing – a crime whereby drug dealers and other organised criminals take over the home of a vulnerable person. Isolation means an outsider is able to *"just take over someone's place, and they start running their little empire from there....That's a big problem, and that is something happening to isolated people because they haven't got the normal branches of support there"*.

5.4 Conclusion

This section has summarised key vulnerabilities identified by participants from marginalised groups and by practitioners supporting them. It has highlighted the multiple links between LSI and health and well-being, affecting not only mental and emotional wellbeing but also physical health and disability. The next section explores how existing services and support are working to tackle LSI, identifies best practices in alleviating LSI and synthesizes participants' views about how best practices can be strengthened, enhanced and developed in future.

6. PREVENTING AND TACKLING LONELINESS AND SOCIAL ISOLATION IN READING

6.1 Introduction

Having explored the dynamics of loneliness and social isolation in Reading, the vulnerabilities of particular groups and the relationship between LSI and health and wellbeing, this section focuses on how LSI can be prevented and tackled in Reading. It seeks to answer the final research questions guiding the study: Which services, practices and approaches are most helpful in preventing or reducing loneliness and social isolation in Reading? How can best practices to prevent or reduce loneliness and social isolation in Reading be strengthened and developed in the future? The section draws on practitioners' experiences of providing services and support for vulnerable groups who may be at risk of LSI, as well as analysing the views of community members, service users and volunteers about what would be most helpful in reducing LSI in Reading and how best practices can be strengthened and developed in future.

6.2 Which services, practices and approaches are most helpful in preventing or reducing loneliness and social isolation in Reading?

Since vulnerability to LSI varies according to a complex interaction between societal, situational and personal factors (see Section 4), best practices and approaches for preventing or alleviating loneliness and social isolation and loneliness in Reading also vary according to the needs of particular groups and individuals.

6.2.1 Specialist support and safe spaces

Dedicated support groups within safe, understanding environments that provide opportunities for conversation and building supportive relationships with peers were identified by many practitioners and service users as crucial in reducing loneliness and social isolation. Older carers commented on how helpful it was to meet other carers in similar situations once or twice a week as part of a regular support group. Similarly, a practitioner working with young carers observed:

> *I know one young person who comes to Young Carers because she wants to be around people, her own age group, where she can sit down and talk about what's happening at home…she's able to sit down and talk about what's happening at home and show us her photos. I think it's a space where they can talk, talk, and people will listen.*

A practitioner working with deaf people emphasised the importance of deaf clubs in creating safe spaces where deaf people could communicate with each other through sign language:

> *…going to a deaf club is very important and it's like their second home. It releases their frustration as well, of isolation at home that they've got. They can go and they can enjoy themselves and it's forgotten that we're signing. And then they've got that satisfaction when they go home.*

Equally, a practitioner working with BAME groups highlighted the importance of the Rose Centre, a specialist community-led centre for Female Genital Mutilation (FGM), which ran women's and men's groups as spaces where community members were able to talk openly and freely, not only about FGM but about domestic abuse and healthy relationships, health concerns and so on. The Rose Centre provides a monthly drop-in for women from FGM practising communities, which helped to reduce their isolation, as this example demonstrates:

> *We had one lady referred in and she said she had been dreading it for the whole month [...] She couldn't believe how welcoming it was and how she was helped. That she'd be coming back every month now [...] It's a time when women can really come together and in a really informal way having tea and coffee and cake and things and the same with the men's group.*

Similarly, although the monthly men's group was originally started as a space to talk about FGM, it was now a space for men to discuss a wide range of health and other issues they were concerned about and had led to gardening and other activities that enhanced their social connections and wellbeing:

> *now the men themselves say, "Can we talk about this, can we talk about that, can we talk about mental health, can we talk about prostate cancer, can we talk about why men don't talk to each other." They've now got an allotment and they're going to start doing gardening and things. [...] it makes a big difference to people.*

For older carers, respite opportunities, such as day centres or respite care, were crucial in order to give them a break from caring and several called for greater availability of respite services at weekends and longer opening hours to reduce carers' isolation. Carers also highlighted how helpful they found specialist support and group activities for people with particular long term health conditions, both for those with a disability/ health condition and for carers.

Such safe spaces where people are able to meet others in similar situations may even lead to the development of support networks that are sustained outside of the specific support group 'time'. A practitioner supporting refugees and asylum seekers explained that creating safe spaces and opportunities to engage in group activities are advantageous because they give people, "*something that they can do to a) keep themselves occupied, but b) to continue to make friends*". Similarly, a practitioner working with people with autism and their families commented: *"What we've found now is that the parents are meeting up outside of that* [group activity], *and they're going off doing their own outings……there are a group of them going together, and they can support each other, and they realise that they're not alone."*

6.2.2 Focused group activities

Many practitioners suggested that focused group activities were important for preventing or tackling social isolation and loneliness in Reading by providing opportunities for people to have social contact and develop friendships. Activities where participants could meet others through shared interests, such as craft or sport, were regarded as beneficial because they give people a different focus, particularly from mental health challenges or other difficulties they may be experiencing, in a way that simply meeting to 'have a chat' cannot. A practitioner representing a sports organisation that supports people with mental health problems thought that bringing people together for an activity such as sport was particularly important in reaching men experiencing mental illness and facilitating good social encounters:

> *The problem for men is... [they] potentially don't want to sit down and have a chat about their problems. [...] We provide a space for men to come together with sport at the centre of it. So it's not coming together because they want to chat but the reality is, is people are going to have a bit of chat when they come to the sessions. More often than not, those friendships develop and actually they all go and play football together. They'll end up going to watch some football together or join a five-a-side group together and things as well.*

Carers valued group activities for people with long-term health conditions, such as art classes run fortnightly by the Stroke Club. Such activities could help to provide a sense of self-efficacy that fostered wellbeing. As one female carer commented: *"I notice that when*

he's in art, he gets totally absorbed. So I think that is good for him because it's something that he can actually, for an hour or so, he can actually concentrate on what he's doing".

A practitioner supporting blind and visually impaired people acknowledged that some people came more for the social interactions enabled by group activities: *"We do have people who come to the craft clubs who don't actually want to do craft, they come to chat, have tea and coffee, we provide lunch and it gives them a day out. They have the opportunity to meet up with friends".* Such group activities gave people a reason to attend an activity and the opportunity to make social connections and develop supportive friendships without having to admit, to themselves or others, that they may be lonely or isolated.

6.2.3 Making services and activities socially, financially and physically accessible

There was key emphasis among practitioners on the need to make services and activities accessible, with accessibility defined by the diverse needs of particular groups or individuals.

Ensuring activities were located in a place that was accessible for public transport was considered vital in facilitating group activities to tackle LSI, because as one practitioner working with people with physical disabilities expressed, *"what's the point in me offering a pub lunch if someone can't get there?"* The costs of public transport were also identified by service users and practitioners as a barrier to engaging in leisure and social activities.

Carers highlighted the importance of ReadiBus transport in enabling older people with mobility impairments, particularly those living alone, to 'get out of the house', go shopping and attend other social activities. As a male carer commented: "*Without that ReadiBus they really can't get anywhere at all even if they're pushing a trolley. They go into the town centre, to go just locally and they're picked up again and it's very good".* A practitioner working for ReadiBus suggested the service was about enabling people to maintain their independence and empowerment which are *"strong tacklers of loneliness and isolation".* Furthermore, practitioners found that by using ReadiBus transport regularly, people often developed friendships and support networks with other bus users:

> *the process of using ReadiBus can bring them into contact with other people in similar circumstances so they've got something in common [...] and so you get these informal social groups evolving [...] There are no outside agencies doing this, it's just people doing it for themselves.*

While accessing the 'mainstream' bus network may be desirable, ReadiBus practitioners had found than only a small number of people were able to change from using ReadiBus to mainstream transport and required initial one-to-one support to build their confidence: *"That was the difference. They wouldn't have done it if someone wasn't going to go with them to make it safe".*

Practitioners working with people with learning disabilities identified a range of concerns and anxieties that this group may face around getting to venues and participating in activities:

> *booking the bus [ReadiBus] and making sure... "What happens if the bus is cancelled or can't come," or, "It can take me one way and not the other, so how am I going to get home?" So, there is all that, and then, "Am I going to be able to get in the house when I get back?" All these things, and then, "Am I well enough? Have I been to the doctors and is my health good enough for me to, actually, be able to come out?" Oh, and continence issues [...] can they come out for long enough before they need a change. You know, loads of stuff around just being able to get here...*

For older and disabled people, accessibility may also be related to information about activities and support groups being available in print and in accessible formats. Older carers, for example, identified a need for more information about social groups and activities

available in the community, particularly for those who are not computer literate and who cannot access the Internet: *"I've got friends who can't or won't [access the internet], and it's very difficult because nobody wants to send you information in an envelope. That's 65ps, isn't it? So you are cut off in some ways which is a bit unfair"*. Practitioners also highlighted the need to tackle "digital exclusion" and provide information in print, videos in British Sign Language rather than just giving a number to telephone and other accessible formats.

In the context of families with children with autism, a practitioner suggested flexibility was very important. The length of family fun days (4 hours) was specifically designed to encourage attendance, as this practitioner explained: *"they* [the family] *might only come for two hours, but it* [they] *can be a little bit more flexible about getting there"*. This was seen as an essential to "*get the whole family out."*

For some BAME groups, women-only activities may be needed to ensure they are accessible to women, such as English language classes, healthy eating, Zumba and seated exercise classes. As a practitioner working with migrant women at Reading Community Learning Centre commented:

> *....very few women [go to mixed groups] because it's not culturally acceptable. [...] We do know women who get stopped even coming to us. I met one the other day who said, "My husband doesn't know I come here. I'm not sure, if he knew, he'd let me." So we have to accept.*

Ensuring activities were affordable was recognised as crucial by many practitioners, because as articulated by a practitioner working with people at risk of homelessness, *"If you can't pay £2.50 for a coffee, you're not going to be going into cafés"*. Similarly, ensuring people have access to 'mainstream' leisure facilities was important in enabling people to engage in healthy activities that promoted their wellbeing, such as swimming: *"Going swimming used to be free for unemployed people. It's not free any more"*.

In circumstances where there was a cost attached to group activities, it was important that costs were kept consistent. One practitioner working with people with autism and their families explained:

> *What we found that's really difficult is when you get given a large grant at short notice, either by the local authority, or by the NHS, where they want you to put on lots of activities.... free of charge... then it [the free activity] only runs for a certain period of time.*

This could lead to problems with the sustainability of service provision, since charges may need to be introduced when the grant came to an end, which was very unpopular:

> *there has to be a £5.00 charge on this so we can keep running it, and then people don't want to have to pay. If you start it at the beginning where it's a charged for group, and everybody is making a contribution, and it's their group, they're much more likely to continue doing that. Whereas, if it's free, and then they've got to start paying, they don't like it, and that can be a real pain.*

Financial consistency was thus important for both service providers and users.

For some people, smaller, less intimidating groups and activities may be easier to access because, as an interviewee working predominantly with students argued, *"a small event that's [is] quite easy for someone to come into, [it's] not that threatening, [and] you're more likely to make personal encounters."* Some practitioners acknowledged, however, that although group sessions or events can be useful for some people, for the most severely lonely or isolated, group activities or events may be simply too overwhelming. A practitioner working with people with mobility impairments suggested that:

> *if you take a view that the way to tackle social isolation and loneliness is to put on events, and you expect people to come, even if you put on transport, it might work for some, but there're a lot of people that [it] won't work for because of the reasons why they're socially isolated and lonely in the first place. So, I think some of those things [activities and events] miss the point.*

6.2.4 Advocacy and assistance 'taking first steps'

Practitioners recognised the need for one-to-one tailored support, confidence-building and assistance with 'taking the first steps', in order to tackle loneliness and social isolation, particularly amongst the most vulnerable groups. Ensuring support is available to help people take the first step in overcoming personal factors for LSI, such as low confidence, self-esteem and social anxiety, and fostering the development of social networks was regarded as highly important. For example, a practitioner working with deaf people said, *"Because they can't communicate,* [they feel it's] *better to walk away....but if they've got someone with them, they can build up their confidence."*

Similarly, a practitioner working with refugees and asylum-seekers stated that:

> *I can't over-emphasise enough that somebody from Iraq, for example, might love table tennis. [However,] them knowing there's a table tennis club in South Reading is not dealing with their isolation and loneliness, because the chance of them turning up on a Monday night on their own, not knowing anybody, is absolutely zero".*

Equally, a practitioner working with people at risk of homelessness suggested it is important to ensure that there is, "*Someone to hold your hand.... somebody there, maybe to do it for you at first but then to build up the confidence in them slowly* [and say]*: "Now you speak to them," or, "Now you do the whole thing".*

Several practitioners felt that people would benefit from taster sessions and initial one-to-one support to build people's confidence before attending appointments, making phone calls or coming to group activities on their own. A practitioner providing sports activities for people with mental health challenges, for example, felt that establishing a buddying system of volunteers who could provide individually tailored support would encourage people to attend the initial sports sessions.

Indeed, an interviewee working predominantly with students felt that "*encouraging people to have courage and agency that they can do something"* was important because, *"in the end I* [as a support worker] *can't make your social life. Only you can do that, but I could help you do that."* These approaches are significant because they focus on empowering individuals, and in some circumstances enable them to manage, and potentially tackle barriers to social participation, thereby reducing social isolation and loneliness. However, as noted in Section 4, wider societal and situational factors may also prevent good social encounters.

6.2.5 Peer support, befriending and volunteering

Peer support, befriending and volunteering were identified by many practitioners and community members as very helpful in reducing and preventing loneliness and social isolation. Indeed, a practitioner supporting people with life-limiting illness highlighted the positive impact of befriending schemes on the wellbeing of end-of-life patients; research had found such social interventions could potentially lead to longer lives.

Carers and parents saw volunteer activities they engaged in within their local neighbourhood as important for their wellbeing and helped to reduce social isolation. Mental health peer support volunteers felt that their role was very important because of their lived experience of mental illness and psychotherapy support:

> *"We bring, and it's possibly something the other side of the table can't, really. That is what we bring, that lived experience, and that, really, is our speciality. I think it's valuable, as well, I really do". (male participant)*

> *"Yes, and also the fact that we're volunteers, not paid staff, also can make quite a difference to a lot of people". (female participant)*

Peer support volunteers who had benefited from mental health support as service users wanted to *"give back"* to others experiencing similar problems. They also saw volunteering as providing useful workplace experience that helped to prepare them for returning to work. As a practitioner working with people with mental health problems articulated, peer support volunteers, *"offer such hope for people and they are very easy to engage with",* due to shared life experiences.

Peer support volunteers also acknowledged however how hard it was to always *"instil hope in other people"* while experiencing their own mental health challenges. Thus, while people may benefit greatly from volunteering in a peer support role, they may still need support and advocacy to attend groups and activities themselves.

Furthermore, some practitioners acknowledged that some people may find it particularly challenging to commit to, and sustain their participation in, groups or volunteering over a period of time, due to their particular circumstances, disability or illness. As a practitioner working with people with mental health challenges recognised, *"people don't want to sign up for three months of….doing pottery with elderly people, for example. But they're quite happy to go and hand out bottles of water at the Reading Half Marathon."*

6.2.6 Signposting to 'someone to talk to'

Several practitioners emphasised the importance of signposting people on to existing support groups or activities, such as Cruse Bereavement Care volunteers signposting their clients on to Age UK or friendship groups in their neighbourhood.

All of the focus group participants highlighted the importance of being able to talk to someone – a professional or peer support volunteer – about feeling isolated and lonely. One mother, for example, highlighted the importance of one-to-one support from someone *"who cares"*:

> *At my lowest, if I'd had someone who is impartial to speak to, I might not have got into the position I was in. So if I'd had someone, someone who didn't know me, who didn't judge me […] You need that person […] who cares. Even if it's for 15 minutes, that time with you – you just feel that you need to be cared for.*

Similarly, peer support volunteers commented on how people with mental health problems sometimes just wanted someone to talk to: *"Sometimes there are just people, you're set to ask them about their condition, and then you end up just chatting to them, and it ends up, you're in a mental health group and you're talking about ukuleles, and I'm not making it up"*. They highlighted the importance of good social interactions for people who experience social anxiety and may be isolated: *"a lot of the time it is just about making a connection between human to human, we are two people, let's just be humans together in a situation where we understand we're all a bit socially awkward"*.

Peer support volunteers also highlighted the importance of the Samaritans telephone support service for people who may be lonely:

> *there are certain shifts in particular where you won't get the really desperate people, you'll get the really lonely people. Who can also be desperate, but a lot of the time they haven't spoken to anybody all week. […] That was all the contact she had for a week, and she left that call feeling so much better for just that tiny, tiny bit of contact. It was less than 15 minutes and it made such an important difference to her life.*

Given the 24 hour nature of the telephone support provided by volunteers through the Samaritan's, this appears to be a helpful resource for people experiencing loneliness.

6.2.7 Support from healthcare professionals

Carers of older people with long-term health conditions such as dementia highlighted the importance of consistency of support from General Practitioners (GPs) and how helpful it was to be able to see the same doctor as much as possible. They also thought that regular walking groups organised by GP surgeries to promote health and wellbeing (such as 'Walk for your Heart' aimed at people with heart conditions) were helpful in reducing isolation.

Mothers highlighted the important role that primary healthcare professionals could play in signposting people on to support groups and specialist services, such as for new mums experiencing post-natal depression:

> *...if your doctor just said, "Well, look, I can't talk to you now but speak to this person and they might be able to help you". Sometimes [...] it's just talking to someone and listening to them that will make them feel better. It will give them a reason to get up in the morning.*

Participants who had experienced mental illness identified a need for greater recognition of loneliness and social isolation in mental health services. They commented on the fact that mental health practitioners rarely mentioned or recognised loneliness or social isolation issues when treating their mental illness:

Male participant: *I've been in and out of psychotherapy and psychiatric institutes since about 2010, 2009, probably, but up until this year no-one ever came up and asked me about loneliness or social isolation issues.*

Female participant: *No, absolutely.*

Female participant: *Yes, no-one seems to care about that as an issue.*

Male participant: *[...] No-one had ever asked me, "Who are you going home to?" Never was it ever mentioned at any point. It was only until this year that it's kind of come about, really.*

This suggests a need for greater recognition across mental health services of the significance of issues of LSI for people experiencing mental illness.

6.2.8 Raising awareness about LSI, social anxiety and mental health

Many participants who had experienced mental illness called for greater awareness about LSI, social anxiety and mental health in schools, workplaces and among the public in order to tackle the stigma surrounding mental illness and foster greater understanding of how to support people experiencing anxiety, for example, in public places. The mental health first aider training scheme was seen as particularly helpful in this regard.

In the context of anxiety and communication difficulties in public spaces, participants with mental health challenges commented on the usefulness of emergency cards provided by the police which they could give to a member of the public or community safety officer to help call someone to help them get home in situations when people are unable to communicate.

Parents also felt that more effort should be made to encourage workplace wellbeing and foster greater support among colleagues to "*look out for people*" at work. They commented on an attitude that was sometimes apparent: "*'We're at work. We can't worry about that'. [...] But you can, because your wellbeing helps you do the job*". Participants suggested possible practices which could promote wellbeing in the workplace, such as hiding happy stones or having a bowl in the office where people could anonymously write down how they were feeling that day and someone else could reply anonymously with something positive that

they read and put back in the pot for someone else to also benefit from. Some participants acknowledged, however, that not everyone would be comfortable sharing personal difficulties at work and might actively try to keep their personal life *"private"*.

6.2.9 Befriending, good neighbourliness and faith communities

Groups of parents and older carers of people with long term conditions felt that befriending, reaching out and 'keeping an eye' on elderly neighbours, single parents and people who lived alone was important in reducing their isolation. Parents felt that befriending or companion services would be helpful for older people who live alone in their own homes and questioned why befriending services had been cut back Reading in recent years. Practitioners also felt that befriending schemes were helpful in enabling people to get out of the house and engage in community activities: *"accompany people to get out and about so that they start connecting what's all around them"*. The Reading Befriending Forum, which brings together different organisations running befriending schemes, appears to help participating organisations work in partnership to reflect on and improve practice in this area.

Parents also suggested that community members could help to welcome new neighbours and point them in the direction of community hubs, social clubs and community centres. Similarly, participants with experience of mental illness highlighted the importance of people being aware of community spaces and cafés where people can have positive social interactions:

> *just the ability for people to know, be aware, that there are places you can go where there's more social interaction, in terms of, there are available places like coffee and chat etc., but, I know that everything costs money but there's got to be an answer in terms of we can't all live alone (male participant).*

Older carers and practitioners supporting older people from BAME groups also highlighted the important role of churches and faith communities in welcoming people who may be isolated and providing activities that may help to foster social connections and promote their wellbeing.

6.3 How can best practices to prevent or reduce loneliness and social isolation be strengthened and developed in the future?

This final section draws on the interviews with practitioners and focus groups with service users, peer support volunteers and community members to identify priorities for action in improving, strengthening and enhancing best practices to alleviate and prevent loneliness and social isolation in Reading.

6.3.1 Raising awareness about LSI and links to health and wellbeing

Greater awareness of the issue of LSI, and the links to health and wellbeing, in addition to the issues faced by particular groups, were identified by practitioners as highly important in preventing and tackling loneliness and social isolation. Indeed, the Government Strategy on Loneliness (Department for Culture, Media and Sport, 2018) identifies the need to build a national conversation to raise awareness and reduce the stigma around loneliness. Practitioners in Reading suggested that LSI should be "*normalised*" and recognised by different statutory service providers, third sector organisations, employers and schools to ensure they are able to meet the needs of everyone and are reflective and outward facing. Raising awareness about loneliness involved the recognition that, "*Being lonely is a normal part of life. It's not a mistake*", as a member of the University Chaplaincy observed, and affects everyone at different times in their lives.

Indeed, the prevention of LSI was regarded by many practitioners as particularly beneficial and potentially more cost-effective in the longer term than waiting until people needed specialist interventions. A practitioner working with BAME groups commented: *"it is much more cost effective to help somebody before they become isolated and depressed and then get into the whole healthcare system"*. A member of the University chaplaincy observed, *"If you wait long enough, you'll probably get medical intervention – hopefully, not too late – but what you probably really need is nice people"*. Supportive relationships and enabling positive social interactions within an understanding and safe environment were key in addressing LSI at an early stage.

Practitioners supporting people experiencing drug and alcohol addiction emphasised the need to reduce the stigma surrounding addiction among 'mainstream' service providers so that their clients were able to access services and resources without being judged or being made to feel *"not welcome to access those services"*.

Furthermore, given the evidence presented in Section 4 about the barriers people faced in accessing healthcare and how people experiencing mental health challenges are at high risk of LSI and may experience a particularly profound sense of loneliness, greater recognition of this issue and ways to tackle LSI is needed at all levels of the NHS and mental health service provision.

Peer support volunteers with experience of mental illness felt strongly that mental health first aider training was very helpful in tackling the stigma surrounding mental illness and supporting people at times of crisis, which in turn reduced people's sense of isolation and loneliness. They felt mental health first aid training should be promoted in every school and workplace.

6.3.2 Increased availability of specialist support services for groups at risk of LSI

As discussed in Section 6.2, specialist support services are needed to address the specific needs of particular groups at risk of loneliness and social isolation. Some practitioners supporting disabled people and those with long-term health conditions recognised the importance of making 'mainstream' (non-specialist) activities and events inclusive and accessible to all. As a practitioner working with people with dementia articulated, *"in an ideal world, we wouldn't have separate services for people living with dementia"*. This view was also reflected by a practitioner who worked with people with autism: *"what we would really like is a future where the world is autistic-friendly, so that people could access any service they wanted to access. They don't have to have specialist services for them."*

Many practitioners however acknowledged that dedicated support from trusted professionals and/or peer support was often still required to address particular situational or personal risk factors for LSI. Indeed, given the significant stigma that many vulnerable groups face within statutory service provision and the wider community, as discussed in Section 4.2, specialist services are often needed address their specific needs.

Specialist support services were valued because they are underpinned by an understanding of the particular needs of that group and can be tailored to the individual. Individually tailored support was identified as crucial by practitioners supporting people with life limiting illness, for example: *"...really being led by the patient and what they would like and going at their pace with it."*

Several practitioners emphasised the importance of support groups and activities being available at weekends in tackling loneliness. As a practitioner working with people experiencing bereavement observed, feelings of loneliness and isolation may be particularly acute at weekends:

> *weekends for lonely people are the worst, Saturday and Sunday are terrible. On a weekday you can go out shopping, Saturday and Sunday families go out to the park and students go and do their own thing or go home, but isolated people are just very lonely.*

An NHS mental health practitioner also commented on the need to provide services at weekends, when people experiencing mental health challenges may be particularly lonely: "*the emphasis is what we can we do that is cheaper and that is accessible? What can I do on Saturdays and Sundays? During the week, people who work have some kind of structure to their week, but then, all of a sudden, Sundays, there's nothing to do.*"

Many refugees and older carers identified a need for longer opening hours of specialist support groups, day centres and respite care, particularly at weekends. A female refugee and carer for example, commented that more dedicated support groups or day centres were needed for refugees, given their often limited social networks in settlement countries: *"It seems like there is a need for a day centre where refugees can meet, have access to own country, family abroad. Communication is a big barrier [...] have many services available"*. A need for a significantly increased availability of dedicated support services for refugees was identified, with much longer opening hours than was currently available – "*open seven days, not just two hours a week*".

Similarly, English language and life skills classes in women-only spaces at Reading Community Learning Centre provided valuable opportunities for women refugees, asylum-seekers and vulnerable migrants to build their confidence and develop supportive relationships, as also evidenced in the RCLC/ Participation Lab (2018) report. As a practitioner commented:

> *Alongside all the classes, the other thing they [minority ethnic women] really talk about is the friendships they built within the centre across nationalities, across cultures, across religions, sometimes in some cases across different sides of civil wars. They make friendships. And support each other. They quite often talk about the centre as their second family. It's that kind of feeling of women supporting each other.*

Alongside building life and social skills support among vulnerable groups, including refugees and migrants and people with mental health challenges, several third sector organisations provided opportunities for volunteering which helped to prepare people for work and improve their employability.

6.3.3 More collaborative working between organisations, and RBC, 'joined-up' thinking and signposting

Collaborative working was identified by many practitioners as a key priority for action, despite the acknowledgement that this was challenging in the context of austerity and cuts to statutory and third sector services:

> *People are suspicious of working too closely with other people. And the problem is that now that the resources are getting thinner and thinner people worry about collaboration, because they feel as though they're going to lose their money to somebody else. It's sad, but it's sort of true* (practitioner working with refugees).

> *I think we've always got a tendency to safeguard our own interests. I think it would be great if there was more joint working across, because this [loneliness and social isolation] happens in all the areas, in all the estates in Reading, especially where there is poverty* (practitioner working with people with mental health challenges).

Funding cuts, suspicion and safeguarding of interests appear to be significant barriers to the development of closer working relationships in this context.

Greater 'joined up thinking' about LSI and recognition of the need to meet the needs of Reading's diverse population was considered paramount for reducing loneliness and social isolation in this context of austerity, funding priorities and social policy. Several practitioners highlighted the importance of considering how local needs differ according to geographical location: *"in West Reading, maybe, their needs in relation to loneliness and isolation will be different from those of the people who live in Woodley"*.

Practitioners suggested drawing on the local knowledge of community groups and leaders, faith communities and third sector organisations working at the grassroots when planning and implementing services. As a practitioner supporting older people from BAME groups suggested: "*the council knows that there are these social needs, but yet it's how to implement it, how to get to the people. [...] We have to use the local people, we have to ask them questions"*. Indeed, some practitioners called for greater recognition of the needs of BAME groups in Reading, since they may be subjected to racial harassment and discrimination and may be particularly vulnerable to social isolation: *"through their policies* [RBC need] *to show that they are committed to diversity and that they are committed to the needs of each of their residents in Reading and not just the majority population"*.

Practitioners working with people with learning disabilities also expressed frustration that the needs of this group were often overlooked, both at national and local levels:

> *...even the Green papers at government level, when they were looking at disability, learning disability was not included. When Reading Borough Council consider anything, learning disability is not included. You cannot just ignore a whole section of the community.*

While funding constraints were identified as the greatest barriers to implementing many of the priorities and best practices identified in this report, the need for 'joined-up thinking', however, was also related to the interlinked and cumulative nature of LSI, which meant that a seemingly unrelated action can have a significant impact on the occurrence of LSI among vulnerable groups. As a practitioner working with people with learning disabilities expressed: *"it's joining the dots up to look at the bigger picture, and seeing how one thing affects the next, rather than just actually thinking, 'How am I going to save money in my department?'"*.

Third sector practitioners specifically called for more collaborative working with Reading Borough Council that recognised their specialist expertise in working with particular groups who are vulnerable to LSI: *"listen to us and work with us [...] We want to make this work"*. A practitioner working refugees pointed to the value, for example, of jointly bidding for central government funding with Reading Borough Council (RBC): *"I think that works for the council and for us"*. Given how resource-constrained many small voluntary and community organisations are, one practitioner working with BAME groups suggested how helpful it would be to have *"backing"* from RBC when applying for external grants: *"giving real, active support to grant applications"*.

A practitioner supporting young carers thought working in partnership with other organisations to bring together different groups who may be experiencing similar issues, such as young carers and young refugees, was helpful: *"for young carers and refugees to know what each other is going through and talk about their experiences, because, right, the same issue, they're going through it over here, the same issue"*.

Closer, more collaborative working and signposting on to other services and support was also identified by practitioners as enabling different services to refer cases onto each other and enable support for those who were socially isolated to be sustained over longer time periods. This was perceived as helping to reduce the occurrence of people *"falling between the cracks"* of an increasingly rigid system. As a practitioner working with people experiencing or at risk of homelessness expressed:

it would be really good for the social isolation if we could, when we're finishing working with somebody, we could liaise with some volunteers to say, "This person is going to be moving. They could really just do with a visit once a week, or go out shopping, or take them somewhere".

Some practitioners working with BAME groups emphasised the importance, not just of signposting, but supporting people to access statutory and third sector services since they had often developed relationships of trust with vulnerable migrants over time. They saw their role as enabling and supporting people to access specialist support and resources regarding for example, domestic abuse: *"Our job is not to say, 'Oh, we can deal with this'. It's to actually open up the resources that they didn't even know about".*

Third sector practitioners involved in facilitating social prescribing also highlighted a lack of knowledge among general practitioners (GPs) about available services and support, which led to limited non-medical recommendations. Greater collaborative working across statutory health and social care services and the voluntary and community sectors to address these barriers could include raising awareness about the important role health care professionals could play in signposting people on to sources of support.

6.3.4 Increasing the affordability and social accessibility of transport

Ensuring transport is affordable and accessible to the most vulnerable groups was identified as a continued priority for action. This priority reflects the fundamental role transport has in enabling social encounters. Many practitioners acknowledged that Reading has an impressive transport network compared to surrounding areas, and that ReadiBus transport is a much appreciated and respected alternative service for people with mobility impairments that should continue to be supported.

Concerns surrounding the accessibility of transport were primarily associated with affordability and issues of confidence. For instance, even if there is a bus that goes to wherever a person wants to go, if a person cannot afford £2 per journey or does not have the confidence to travel via bus, the fact that there is a bus running is irrelevant. There was also considerable concern about potential changes to concessionary fares for people using ReadiBus in future.

Ensuring the most vulnerable individuals are able to access the transport network in Reading was seen as a priority. An interviewee who works with people with life-limiting illnesses observed, *"ReadiBus is great, but actually for a lot of patients who are ill, it's just too long to be sat on a bus".* Practitioners supporting people with complex health needs and those supporting older people from BAME groups suggested the introduction of a volunteer transport scheme in particular neighbourhoods would be beneficial:

"if they could invest more in transporting people from point A to point B, get people from the community itself... people from the neighbourhood, the community itself, individuals, who would want to bring people in... Just give us some more money to get drivers, to get people out of their homes" (practitioner supporting older people from BAME groups).

"...volunteer driver schemes where you'd actually have a driver pick you up and take you somewhere, which is much more appropriate for our patients" (practitioner supporting people with life-limiting illness).

In addition to volunteer car schemes, ReadiBus practitioners suggested that neighbourhood volunteer transport schemes, which enable a volunteer to accompany people to travel on the bus, may help to build people's confidence in using Reading Buses and ReadiBus. For some, this support may enable them travel independently after a few journeys.

6.3.5 Developing peer support, befriending and volunteering schemes

As identified in Section 6.2, many practitioners supporting diverse groups of people who may be vulnerable to LSI felt that peer support, befriending and volunteering schemes were very useful in providing tailored one-to-one support and assistance in enabling people to take the first steps to engage in social and leisure activities and to access support groups and services. A practitioner supporting disabled people with physical impairments, for example, thought that one-to-one support was more helpful in tackling loneliness than group support: "*I think that must be about feeling someone wants to be with you and be interested. So, groups don't stop isolation so much.[…] We are doing things very much on a one-to-one basis*".

There were concerns however about cuts to befriending services and several third sector practitioners commented on the difficulties they faced in recruiting and retaining volunteers to provide sustained support for service users. As a practitioner working with blind and visually impaired people commented: *"People find it very difficult when they trust somebody and then they're gone…volunteer recruitment is just constant, ongoing and it's really difficult"*.

Furthermore, several practitioners commented on capacity issues and the difficulty of having to rely on volunteers so much to deliver services due to funding constraints, as one practitioner working with BAME groups commented: *"the barriers for us are about capacity. I and another volunteer are leading on the friendship lunches. I cannot ask my staff to do one more thing. They are very close to burnout now. Very exhausted. They are very committed"*.

6.3.6 Fostering good neighbourliness, faith communities and community development

As discussed in Section 6.2, several of the focus groups with service users and community members identified a need to foster good neighbourliness, support from faith communities and greater community involvement to tackle LSI. This was also emphasised by some practitioners, particularly those working with BAME groups: *"It's the person next-door, it's a community effort, the church and the community, whichever thing is going on in the community itself. The council cannot look at every single thing, it's impossible. We have to get up and say, "Well, we're gonna do something…"*.

Practitioners working with BAME groups were concerned that although BAME groups often *"do really well at supporting each other within their [ethnic] group"*, social interactions and links between BAME and majority White communities were more limited and difficult to achieve. As a practitioner working with marginalised BAME women reflected: *"We need to do more of the whole cultural awareness side. We need to build more links with the outside world…. [with] people for whom, English is their first language. It could be a whole variety of people but local people"*. Community development and fostering good neighbourliness, particularly in welcoming migrants, was identified as a key priority for the longer term: *"it's actually about trying to turn neighbourhoods into more friendly, accepting places"*. Another practitioner working with BAME groups also felt that the emphasis should be on greater community engagement and ensuring that diverse ethnicities are represented in Reading:

> *if we could actually do more community engagement and work with our communities and all of them together and put the funding and the resources into making sure that people feel that they're equally represented in Reading I think that is how we would actually tackle the problem more.*

A practitioner working with people with dementia also felt community development was the cheapest and most effective way of preventing and tackling LSI: "*To me, that's the win/win […]. It will take time but later down the line I think we will reap the rewards of investing in that for now*".

6.3.7 More accessible information, communication and promotion of activities and services

RVA's (2017) survey identified a lack of knowledge about what was going on as a major barrier to people becoming more socially active, reported by 36% of respondents in Reading. In this research, greater accessibility of information and promotion of available services and activities was recognised by practitioners and community members as highly important. Older people who may not be computer literate and those without Internet access as well as several practitioners also identified a need for the promotion of services, support groups and activities in print formats to tackle *"digital exclusion"*. As a practitioner from a supporting organisation articulated, "*People really still crave and want printed things through their doors and these noticeboards, as well as accessing information online*".

As noted earlier, the lack of information about activities and services in inaccessible formats represented a major communication barrier for deaf people that hindered their social participation. As a practitioner working with deaf people commented:

> *at the moment it's barriers to service that's really a big problem. The information, it's really difficult to read it, and clients in Reading come and they tell me that they can't read it. And it says to make a phone call for more information, and it's really quite poor. There are no signing videos, there's no one doing British Sign Language, there's nothing, so there's no access for us.*

Equally, refugees and asylum seekers and other BAME groups pointed to the lack of interpreters and limited information available in languages other than English, which represented significant communication barriers that prevented them from accessing services and support.

6.4 Conclusion

This section has identified many best practices among existing services and support groups that help to alleviate and in some cases, prevent LSI in Reading and how these can be strengthened and developed in future. What is clear across the interviews and focus groups is that services, support and activities must be 'accessible' in terms of affordability, transport and tailored to the specific needs of particular groups who have been identified as vulnerable to loneliness and social isolation. The next section concludes and outlines the key recommendations for action.

7. CONCLUSION AND RECOMMENDATIONS

7.1 Introduction

This research project has explored the dynamics of loneliness and social isolation in Reading by analysing the vulnerabilities of particular groups from a range of perspectives. By focusing on societal, situational and personal risk factors and barriers that prevent people from developing good social connections and networks, the research has demonstrated the complex, multi-faceted nature of LSI and how for example, cuts in public services or barriers to statutory service provision may further marginalise people who are already vulnerable to loneliness due to their particular circumstances, such as mental health challenges, disability, ageing and loss of mobility, caring responsibilities, living alone or other significant changes, disruptions or transitions over the lifecourse. The project has demonstrated the closely entwined relationship between isolation and loneliness and health and wellbeing, with LSI representing both a cause and consequence of emotional, mental and physical ill health.

It has been widely recognised in the research literature that there is no one-size-fits-all approach to tackling loneliness and social isolation. The research has identified a number of best practices in alleviating and preventing LSI among statutory and third sector organisations working with vulnerable groups and community members in Reading (see Section 6). These include:

- Specialist support and safe spaces
- Focused group activities
- Making services and activities socially, financially and physically accessible
- Advocacy and assistance 'taking first steps'
- Peer support, befriending and volunteering
- Signposting to 'someone to talk to'
- Support from healthcare professionals
- Raising awareness about loneliness, isolation, social anxiety and mental health
- Befriending, good neighbourliness and faith communities.

The project also identified a number of areas where best practices to prevent or alleviate loneliness and social isolation in Reading can be strengthened and developed in the future (see section 6.3 and recommendations, section 7.2).

A key mechanism for successful loneliness interventions identified by Victor and others' (2018) review is in 'reconnecting' those who are experiencing loneliness within their community via the development of meaningful relationships. Central to such interventions is the need to tailor services, in terms of sociodemographic, spatial or loneliness experience characteristics, to individuals. There was also a need for recognition that loneliness interventions could potentially stigmatise users, if not advocated sensitively.

Service providers in Reading appeared to be aware of these issues and did not label or regard their work only as 'loneliness interventions', but rather felt that existing services they provided to marginalized groups aimed to facilitate good social encounters and could lead to the development of meaningful relationships among service users, with staff, peer support volunteers, befriending volunteers or community members. The research suggests that these practices and approaches could help to reduce loneliness in those already lonely and/or prevent loneliness among those at risk.

Victor and colleagues (2018, p.51) suggest the need for interventions to identify their goals in terms of either loneliness reduction in those already lonely or loneliness prevention for those at risk (or both). The evidence suggests that that tailored and/or targeted interventions towards those vulnerable to loneliness would be more likely to result in reductions in loneliness. This research in Reading was however only able to provide a snapshot of a small selection of service users' experiences. More detailed evaluations of particular services are required to assess whether particular approaches led to reductions in loneliness among those already lonely or whether they prevented loneliness, with long-term follow-up and appraisal of cost-effectiveness needed (Victor and colleagues, 2018).

It must also be acknowledged that this qualitative study does not seek to be representative of all social groups who may be vulnerable to LSI in Reading, but rather to give in-depth insight into a diverse range of perspectives and experiences of practitioners working across statutory and third sector organisations and those of service users, peer support volunteers and community members in diverse circumstances. The six focus groups sought to include the views and experiences of a range of people who may be vulnerable to loneliness and isolation due to situational or personal risk factors, including refugees and asylum seekers, deaf and hearing impaired people, people with experience of mental illness, people at risk of homelessness, older carers and parents. However, we found it difficult to recruit vulnerable young people to participate in the study, despite evidence nationally and locally that children and young people may experience relatively high levels of loneliness compared to other age groups (ONS, 2018; McClane, 2018). As Victor and colleagues (2018, p.51) observe, the lack of evidence specific to young and mid-life adults is "a clear gap in our knowledge base and reflects the conceptualisation of loneliness as a problem of later life".

We also were unable to recruit primary healthcare professionals to participate in the study and consequently, were unable to include their views and experiences, particularly of initiatives aiming to provide more joined-up thinking and signposting of support, such as 'social prescribing'. Our research has however identified a number of barriers to accessing healthcare services, particularly among people experiencing mental illness, homelessness and drug and alcohol addiction. The findings also highlight the important role that General Practitioners (GPs) and other healthcare professionals can play in signposting people experiencing loneliness on to voluntary and community organisations for one-to-one support, specialist support groups or community activities.

Social prescribing schemes are identified in the Government's Loneliness Strategy (2018, p25) as a key means of "helping people to secure the support they need". NHS England estimates that 60% of Clinical Commissioning Groups have commissioned some form of social prescribing scheme, which,

> enables organisations to refer people to a range of services that offer support for social, emotional or practical needs. This could include feelings of loneliness, as well as for debt, employment or housing problems, or difficulties with their relationships (Department for Culture, Media and Sport, 2018, p.25).

The Government Strategy notes that existing evidence from individual schemes suggests that social prescribing may improve outcomes for people and reduce pressure on the NHS.

7.2 Recommendations for action to alleviate and prevent loneliness and social isolation in Reading

Best practices for reducing LSI need to be specifically targeted to meet the diverse needs of the people most at risk of loneliness and social isolation according to socio-economic, geographical, gender, age and ethnicity differentials, in addition to situational and personal factors. These include immigration status, homelessness, drug and alcohol addiction, mental health, disability, loss of mobility and long term illness, caring responsibilities, living

alone, lifecourse transitions and so on (see Section 4). There was also a need identified for services, support and activities also need to be socially, financially and physically accessible and to address barriers in accessing statutory service provision.

To ensure that the best practices discussed in Section 6 are strengthened, enhanced and developed in the future, this project has identified the following recommendations for action:

- **Raising awareness about loneliness and social isolation (LSI) and its links to health and wellbeing among statutory and voluntary and community sector service providers, employers, schools, members of the public.**
- **Greater provision of specialist support services for groups at risk of LSI, encompassing tailored one-to-one support, as well as group activities, with increased opening hours, particularly at weekends.**
- **Fostering more collaborative working 'joined-up' thinking and signposting between organisations, Reading Borough Council and primary healthcare providers.**
- **Increasing the affordability and social accessibility of transport, including through concessionary fares, building people's confidence, supporting and raising awareness about alternative transport services for people with complex needs and carers, such as ReadiBus and neighbourhood volunteer transport initiatives.**
- **Developing and supporting peer support initiatives and befriending and volunteering schemes.**
- **Fostering good neighbourliness, supportive faith communities and community development .**
- **Providing more accessible information, communication and promotion of activities and services in appropriate formats.**

Finally, despite distinctions between the concepts of 'loneliness' and 'social isolation' being widely recognised in the literature, in this research, we often found the two concepts being used interchangeably among practitioners and service users. The government strategy published in 2018 focuses on loneliness, rather than loneliness and social isolation, with accompanying guidance about how to measure loneliness and resources to tackle it. Reading Borough Council's multi-agency steering group, thus, may wish to consider having a clearer focus on alleviating and/or preventing 'loneliness', specifically, as the work develops in future. These conceptual differences are important since they influence "the interpretation of evidence as to what interventions work, for whom and in what context" (Victor and colleagues, 2018, p.8).

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TACKLING LONELINESS AND SOCIAL ISOLATION IN READING, ENGLAND

For more information, please contact:

Ruth Evans, Participation Lab Leader

Participation Lab
University of Reading
Whiteknights, PO Box 227
Reading RG6 6AB
United Kingdom

r.evans@reading.ac.uk

https://mobile.twitter.com/DrRuth_Evans@DrRuth_Evans
https://twitter.com/participlab@participlab

Participation Lab
Co-producing knowledge for social change
https://research.reading.ac.uk/participation-lab

www.reading.ac.uk/ges/aboutus/r-evans.asp

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PARTICIPATION LAB

TACKLING LONELINESS AND SOCIAL ISOLATION IN READING

Ruth Evans, Participation Lab Leader

Health and Wellbeing Board

RBC, 13 March 2020

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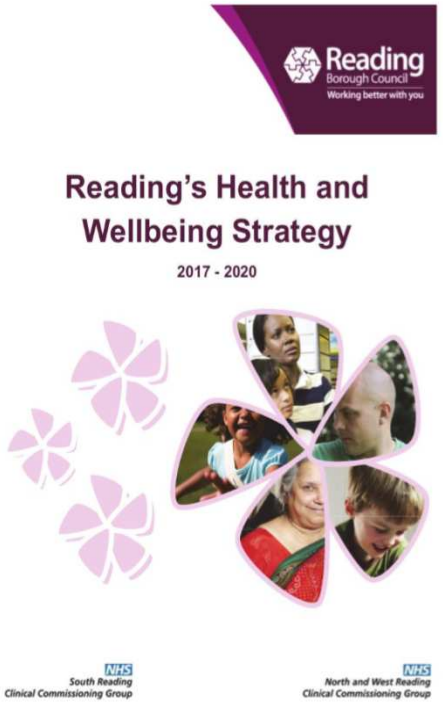
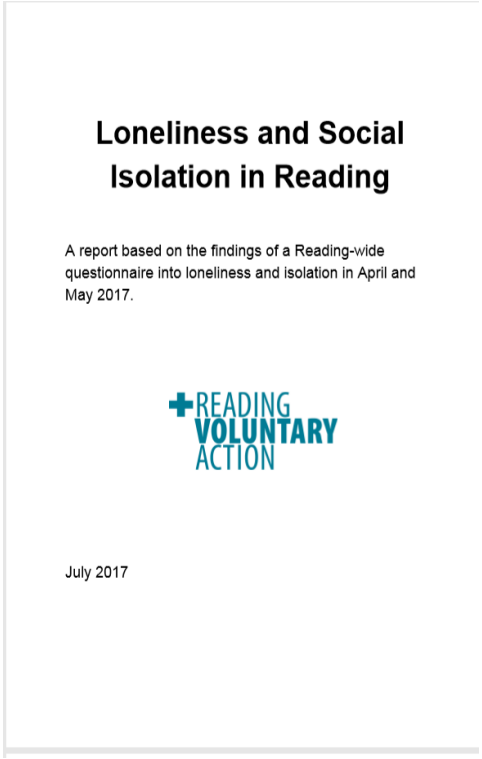
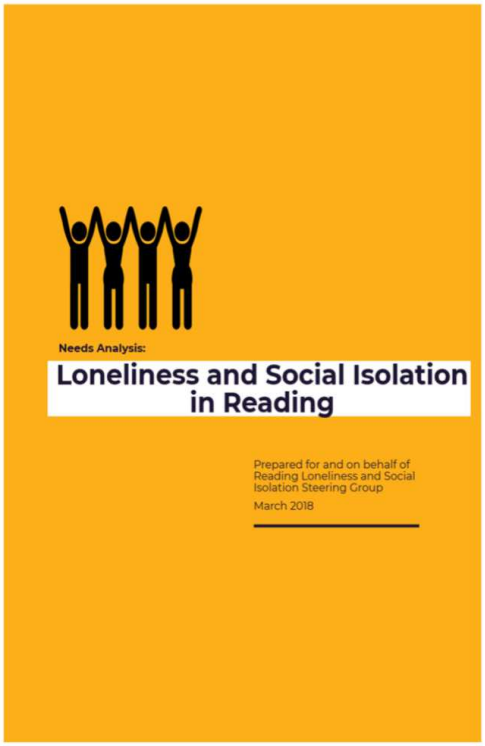
RESEARCH CONTEXT

- Government Strategy for Tackling Loneliness in England launched in October 2018







AIMS & METHODS

- To provide qualitative insights into the dynamics of loneliness and social isolation in Reading and to identify best practices which may prevent and tackle it.
- Qualitative methodology:
  - 21 interviews with diverse range of service providers
  - 6 focus groups with 65 participants: service users, peer support volunteers & community members

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RESEARCH QUESTIONS

- Which factors may lead to loneliness and social isolation? Which barriers prevent people from developing social connections?
- Why are particular groups vulnerable to LSI?
- How does loneliness and social isolation affect people's health and wellbeing?

SOCIETAL FACTORS

- Complex interactions between societal, situational and personal factors

Risk factor for LSI	Number of interviews with practitioners where mentioned (n=21 interviews)	Focus groups where mentioned (n=6 focus groups)
Stigmatisation of particular groups	9	2 (homelessness; mental health)
Access to transport	4	2 (refugees; carers)
Cuts to public services & infrastructure	2	3 (homelessness; parents; carers)
Barriers in accessing statutory services	3	2 (homelessness; parents)
Internet and technological changes	3	2 (carers; parents)
Unsupportive workplace	1	2 (homelessness; parents)
Exclusion from job market	3	2 (refugees; homelessness)

SOCIETAL FACTORS

- Hostile environment for refugees and other migrants, BAME groups, stigmatisation of people with learning disabilities, autism, mental illness, drug and alcohol addiction
- Attitudinal barriers to disability impacted on some disabled people's self-confidence and mood to the point where they did not want to go out and engage in activities in the community (Bridger, 2020).
- Cost of transport and importance of reimbursing travel expenses, esp. for refugees and asylum-seekers, ReadiBus helpful especially for older people living alone
- Impacts of austerity and cuts to public services affect vulnerable groups most: reduced opening times, sustainability of support services, infrastructure and leisure facilities:

"If we, as a society, do not look after our most vulnerable…. and we cut all of those services, then we are creating for ourselves a chronic problem of isolation and loneliness". (practitioner working with BAME groups)

SOCIETAL FACTORS

- Barriers to statutory services: NHS services regarded as inflexible and unresponsive to people's diverse needs, language barriers, role of GPs in signposting, stigma of drug and alcohol addiction, thresholds for accessing mental health services, respite care homes & limited availability of services.
- Online support networks could be helpful, but reduced social contacts and interaction with neighbours etc more generally?
- Unsupportive work environments, esp. for people with mental health and/or neurological conditions
- Asylum-seekers excluded from labour market, language barriers in obtaining employment for refugees and other migrants, drug/alcohol addiction and mental illness

WHICH SERVICES, PRACTICES AND APPROACHES ARE MOST HELPFUL IN PREVENTING OR REDUCING LSI IN READING?

- Specialist support and safe spaces provide opportunities for conversation and building supportive relationships with peers
- Focused group activities
- Making services and activities socially, financially and physically accessible
- Advocacy and assistance ‘taking first steps’
- Peer support, befriending and volunteering

BEST PRACTICES TO PREVENT & TACKLE LS

- Signposting to ‘someone to talk to’ & support from healthcare professionals
  - Awareness among GPs about other available services, greater awareness of LSI among mental health practitioners
- Raising awareness about loneliness, isolation, social anxiety and mental health
- Befriending, good neighbourliness and faith communities

RECOMMENDATIONS

1. **Raising awareness** about loneliness and social isolation (LSI) and its links to health and wellbeing, among statutory and voluntary and community sector service providers, employers, schools, members of the public
2. Greater provision of **specialist support services** for groups at risk of LSI, encompassing tailored one-to-one support, as well as group activities, with increased opening hours, particularly at weekends
3. Fostering more **collaborative working, 'joined-up' thinking and signposting** between organisations, Reading Borough Council and primary healthcare providers

RECOMMENDATIONS

4. Increasing the **affordability and social accessibility of transport,** including through concessionary fares, building people's confidence, supporting and raising awareness about alternative transport services for people with complex needs and carers, such as ReadiBus and neighbourhood volunteer transport initiatives
5. Developing and supporting **peer support initiatives and befriending and volunteering schemes**
6. Fostering **good neighbourliness, supportive faith communities and community development**
7. Providing more **accessible information, communication and promotion of activities and services** in appropriate formats.

LSI STEERING GROUP'S PRIORITIES

- Ongoing need to raise awareness and challenge stigma around loneliness:
  - loneliness is a normal part of life, experienced at different times during the lifecourse, but some groups may be particularly vulnerable
- Need for more joined-up thinking - using Campaign to End Loneliness Framework (p.17 of report)
- Importance of supporting people to build their confidence and feel safe, addressing barriers to participation for particular groups
- Need for support to ensure transport is affordable and socially accessible.

Thank you. Questions?

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https://research.reading.ac.uk/participation-lab/
r.evans@reading.ac.uk

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	Reducing Loneliness and Social Isolation (LSI) **Supporting national indicators** PHOF 1.18i / ASCOF 1.i - % of adult social care users who have as much social contact as they would like PHOF 1.18ii / ASCOF 1.1 - % of adult carers who have as much social contact as they would like PHOF 2.23 i-iv – self-reported wellbeing				
Recommendation	**What will be done – the task**	**Who will do it**	**By when**	**Outcome – the difference it will make**	**Progress Update**
(1) Raise awareness about loneliness and social isolation, and its links to health and wellbeing, among statutory and voluntary and community sector service providers, employers, schools and members of the public	1a. Develop an LSI communications plan to spread key messages	PH & Wellbeing Team with Corporate Communications Team, RBC, to co-ordinate	May 2020	There is widespread awareness of the health benefits of social contact. Reading residents are offered a range of opportunities to connect with their community in ways which avoid stigmatising language	Initial scoping at February 2020 Steering Group
	1b. Review and update the Reading Joint Strategic Needs Assessment (JSNA) content on Loneliness and Social Isolation at least annually	Wellbeing Team, RBC	ongoing	We will understand the local loneliness issue, in particular which groups of Reading residents are at greatest risk of experiencing health inequalities as a result of loneliness	Loneliness & Social Isolation module published at: https://www.reading.gov.uk/media/10428/Loneliness-and-Social-Isolation-in-Reading-2018/pdf/Loneliness_and_Social_Isolation_in_Reading_NA_2018.pdf University of Reading (Evans & Bridger) report published October 2019 and to be added to Local Research section of JSNA. Children and young people, and the def community identified as priority groups for further analysis within future local research.
	1c. Support access to employment as a way of addressing loneliness and social isolation & raise the profile of loneliness and social isolation within workplace wellbeing programmes	Marc Murphy (Oracle)	Ongoing	The social contact benefits of employment are recognised and addressed within plans and policies.	**Oracle** has: - established with Brookhills school and Newbury College. - supported 19 adults to secure employment via the Step Into Retail scheme - worked in partnership with RCLC's pre-employment group - supported DWP's partner forum to improve services

	Reducing Loneliness and Social Isolation (LSI) **Supporting national indicators** PHOF 1.18i / ASCOF 1.i - % of adult social care users who have as much social contact as they would like PHOF 1.18ii / ASCOF 1.1 - % of adult carers who have as much social contact as they would like PHOF 2.23 i-iv – self-reported wellbeing				
Recommendation	**What will be done – the task**	**Who will do it**	**By when**	**Outcome – the difference it will make**	**Progress Update**
		Kirsty Heath (GBA) Rhiannon Stocking Williams- with Stronger Together Partners	On-going ongoing		- partnered with Brighter Futures for Children to form a hub where Oracle tenants can go to recruit staff - developed a new programme in focused on people at risk of homelessness. - offered ongoing confidence building, interview skills and work experience programme for single parents - offered a work shadowing programme for people who face challenges to work / integration **Get Berkshire Active** is working with Groundworks on a programme of experiential learning and inspiring, recreational physical and sport themed activities for unemployed people in Berkshire – targeting over 50s to improve employability and mental health. (8 Week programmes with 2x2.5hour sessions per week) **Reading Refugee Support Group** runs a job club for refugees, and there is a collaboration with **SupportU** for LGBT service users **Salvation Army** run Employment Plus, **Communicare** offer help with CVs and have translators. **RCLC'**s employability classes link pre employment work with support for language development.

	Reducing Loneliness and Social Isolation (LSI) **Supporting national indicators** PHOF 1.18i / ASCOF 1.i - % of adult social care users who have as much social contact as they would like PHOF 1.18ii / ASCOF 1.1 - % of adult carers who have as much social contact as they would like PHOF 2.23 i-iv – self-reported wellbeing				
Recommendation	**What will be done – the task**	**Who will do it**	**By when**	**Outcome – the difference it will make**	**Progress Update**
	Report to RBC's Public Health Board on how this Action Plan addresses PH budget consultation feedback around loneliness and social isolation	Janette Searle	Jan 2020	There is broader understanding across the Council of how LSI work supports Public Health outcomes	Completed
(2) Greater provision of specialist support services for groups at risk of LSI, encompassing tailored one-to-one support, as well as group activities, with increased opening hours, particularly at weekends	2a. Identify opportunities to increase specialist support by: - Using vacant spaces - Engaging with the private sector - Properly thanking and reimbursing volunteers - Helping smaller groups to develop	RBC PH & Wellbeing Team / Reading Voluntary Action	ongoing	Reading residents at higher risk of experiencing LSI can access specialist support services at a range of times across the week	Reading Community Lottery launched January 2020 and new RBC grants round announced February 2020, both means of increasing opportunities for smaller groups to access start up or development funding
	2b. Develop volunteering and employment opportunities for adults with care and support needs	Sarah Hunneman (Wellbeing Team, RBC) / Rhiannon Stocking-Williams (RVA) / Lorraine Briffit and Annie Wilmott (Connect Reading)	Ongoing	There will be more opportunities for adults with care and support needs to enjoy supportive and enabling social connections through work	The availability of volunteering and employment opportunities has been strengthened via: - work of RVA's officer who specialises in volunteering opportunities for people with additional needs - Berkshire West Your Way's service, which includes supporting people with mental health needs into employment - RBC's' Time to Change' pledge to end mental health discrimination within its own employer role, and spread best practice locally - Reading UK CIC's 'Better You Better Business' event at Green Park in November 2019
	2c. Raise awareness of services to reduce loneliness and social isolation with	Sarah del Tufo (RCLC)	ongoing	People who are not literate or who speak little or no English will be enabled to	**RCLC**, **Reading Refugee Support** and **Communicare** provide a service for

	Reducing Loneliness and Social Isolation (LSI) **Supporting national indicators** PHOF 1.18i / ASCOF 1.i - % of adult social care users who have as much social contact as they would like PHOF 1.18ii / ASCOF 1.1 - % of adult carers who have as much social contact as they would like PHOF 2.23 i-iv – self-reported wellbeing				
Recommendation	**What will be done – the task**	**Who will do it**	**By when**	**Outcome – the difference it will make**	**Progress Update**
	people who are not literate or who speak little or no English			access groups and services to reduce loneliness and social isolation.	people facing language or cultural barriers to social contact. Independent report into the needs of ethnic minority women in Reading and how RCLC meets those needs published July 2018. RVA and RCLC have launched a scheme targeting parents, mainly women, at school gates, to inform about different activities, support them to join or organise activities at school if convenient. Women with very limited or no English language skills often have little social contact but come to schools to drop and pick children,
	2d. Raise awareness of services to reduce loneliness and social isolation with people who are not literate or whose first language is a Sign Language, including supporting people to access alternative to BSL, e.g. .International Sign Language	Rhiannon Stocking-Williams /Sylvia Simmons	ongoing	People who sign will be better able to access information about services to reduce social isolation	**Reading Deaf Centre** provides a service to facilitate peer support and reduce social isolation for people who are deaf or hard of hearing **RVA** is seeking funding to develop an information translation project **Total Communication** can provide International Sigh Language or support people to access non BSL signers
	2e. Launch a Reading Safe Places scheme	Sarah Hunneman, PH & Wellbeing Team, RBC	May 2020	Vulnerable adults will be supported and encouraged to access community spaces	Formal letters of support secured from Reading Borough Council and Thames Valley Police [to be confirmed]

	Reducing Loneliness and Social Isolation (LSI) **Supporting national indicators** PHOF 1.18i / ASCOF 1.i - % of adult social care users who have as much social contact as they would like PHOF 1.18ii / ASCOF 1.1 - % of adult carers who have as much social contact as they would like PHOF 2.23 i-iv – self-reported wellbeing				
Recommendation	**What will be done – the task**	**Who will do it**	**By when**	**Outcome – the difference it will make**	**Progress Update**
(3) Fostering more collaborative working, joined-up thinking and signposting between organisations, including Reading Borough Council and primary healthcare providers	3a. Promote LSI awareness as part of policymaking and commissioning	RBC / (CCG) / RVA – as members of the Reading Health & Wellbeing Board	ongoing	The impact on LSI risk is considered across a wide range of policies and funding decisions There is recognition amongst policy and decision makers that cuts in basic services (e.g. food, housing) lead to increased loneliness with individuals having little energy to access services Organisations support and complement each other to increase social connection	Will be addressed within Communications Plan. See Action 1a (above).
	3b. Pilot a joint working project bringing Adult Social Care (ASC) and VCS staff together at the ASC Front Door	RBC	ongoing	Adult Social Care staff and Voluntary & Community Sector staff will have a better understanding of how to collaborate to reduce LSI for people with care and support needs	Pilot commenced November 2019
	3c. Raise awareness with local NHS staff about services to reduce loneliness and social isolation.	Rhiannon Stocking-Williams (RVA)	ongoing	NHS staff will have up to date knowledge of local services so as to signpost or refer people at risk of social isolation.	There is now a 'VCS focus' section in the weekly e-newsletter to GP practices, with a focus on support to reduce loneliness and social isolation. RBC/Berkshire West CCG have commissioned a Social Prescribing service which is receiving a high volume of referrals from NHS staff. Three of Reading's new Primary Care Networks have plans to take on Social Prescribing Link Workers
(4) Increasing the affordability and social accessibility of transport, including through	4a. Develop local schemes /approaches to encourage more people to travel	Rhiannon Stocking-Williams (RVA)	ongoing	Transport is seen as part of the solution rather than as a barrier to social contact	**RVA** and **Readibus** are collaborating on a Public Transport Confidence project: pilot will focus on Southcote (all who need support) and young people with

	Reducing Loneliness and Social Isolation (LSI) **Supporting national indicators** PHOF 1.18i / ASCOF 1.i - % of adult social care users who have as much social contact as they would like PHOF 1.18ii / ASCOF 1.1 - % of adult carers who have as much social contact as they would like PHOF 2.23 i-iv – self-reported wellbeing				
Recommendation	**What will be done – the task**	**Who will do it**	**By when**	**Outcome – the difference it will make**	**Progress Update**
concessionary fares, building people's confidence, supporting and raising awareness about alternative transport services for people with complex needs and carers, such as Readibus and neighbourhood volunteer transport initiatives				Transport is considered within the planning of activities, including general public transport as well as more specialist services, and how to address barriers of cost and confidence Transport facilitates independence Reading residents make full use of the transport services and support available to them	learning disabilities transitioning to adult (all areas). **Age UK** Berkshire is exploring an expansion of the Caversham Good Neighbours model across Reading.
(5) Developing and supporting peer support initiatives and befriending and volunteer schemes	5a. Promote peer support and befriending schemes through community media and local partners, e.g. GPs, buses, supermarkets, councillors Organise events to promote peer support and befriending	Rhiannon Stocking-Williams (RVA)	ongoing	There is widespread awareness of the peer support and befriending schemes in Reading, with opportunities for organisations to come together and learn from one another	**RVA** hosts a quarterly Ready Friends Befriending Forum to share ideas and best practice A Friendship Volunteers Evening was held in November 2019 to celebrate success and encourage recruitment RVA Awards annually in June celebrate befriending (and other) volunteers
	5b. Support the neighbourhood Over 50s groups to grow and be self-sustaining	Michelle Berry & Sarah Hunneman (PH & Wellbeing Team, RBC)	Ongoing	Older residents are able to be part of developing opportunities for neighbours to know one another better	There are now four thriving Over 50s clubs – in Caversham, Southcote, Whitley and Coley.
(6) Fostering good neighbourliness, supportive faith communities and community development	6a. Raise awareness of the organisational support available from RVA and from the Public Health & Wellbeing Team for groups aiming to increase social connection	Rhiannon Stocking-Williams (RVA) / Michelle Berry & Sarah Hunneman (Wellbeing Team, RBC)	ongoing	Community groups of all sizes aiming to encourage social connection can access support with: - marketing and communications - volunteer development - fundraising - accessing translation and interpretation services	RVA Street Party workshop planned fir spring 2020

	Reducing Loneliness and Social Isolation (LSI) **Supporting national indicators** PHOF 1.18i / ASCOF 1.i - % of adult social care users who have as much social contact as they would like PHOF 1.18ii / ASCOF 1.1 - % of adult carers who have as much social contact as they would like PHOF 2.23 i-iv – self-reported wellbeing				
Recommendation	**What will be done – the task**	**Who will do it**	**By when**	**Outcome – the difference it will make**	**Progress Update**
	6b. Promote the Ready-friends Toolkit	Rhiannon Stocking-Williams (RVA)	ongoing	People and communities can access an all-in-one-place resource (in hard copy and online) to inspire and equip people in Reading wanting to take action on loneliness and social isolation. The toolkit also aims to close the gap between those facing or at risk of loneliness and social isolation and the many services, activities, events and organisations currently available to them.	Toolkit launched May 2019 followed by ongoing publicity and distribution. Proposal to co-produce new versions with specific local communities and translation into other languages, subject to securing funding.
	6c. Review and promote tools to assess and evaluate services' impact on social connectivity	Rhiannon Stocking-Williams (RVA) / Michelle Berry (RBC Wellbeing Team)	ongoing	New and emerging community groups will have the knowledge and confidence to submit high quality applications for funding and other resources, and be supported to deliver high quality and effective services	Resources collated for inclusion in the Ready Friends Toolkit (as above). What Works Wellbeing guidance shared with Steering Group members February 2020.
(7) Providing more accessible information, communication and promotion of activities and services in appropriate formats including Plain English and British Sign Language	7a. Promote the Reading Services Guide /Family Information Service resource	Public Health & Wellbeing Team (RBC)	Ongoing	Individuals and community groups know how to access a comprehensive and easily updatable resource on local opportunities to reduce LSI	RSG usage continues on an upward trend with 65,931 hits and 53,350 unique visits recorded through Google Analytics for January 2020 (the highest numbers ever recorded in both cases).
	7b. Map out community notice boards, including owners and access criteria	Ebony George (Neighbourhood Initiatives), Matt Taylor (AUKR), Steph Francis (CCGs)	Nov 2019	Partners will be enabled to share information about services and resources to reduce loneliness and social isolation.	45 boards mapped: ○ 20 are RBC owned ○ 25 are managed by community groups ○ For 23 out of 45 notice board, we do not known who is key holder – including those owned by RBC

	Reducing Loneliness and Social Isolation (LSI) **Supporting national indicators** PHOF 1.18i / ASCOF 1.i - % of adult social care users who have as much social contact as they would like PHOF 1.18ii / ASCOF 1.1 - % of adult carers who have as much social contact as they would like PHOF 2.23 i-iv – self-reported wellbeing				
Recommendation	**What will be done – the task**	**Who will do it**	**By when**	**Outcome – the difference it will make**	**Progress Update**
					A volunteer has been recruited to take this forward under AUKR's leadership.
	7c. Map Facebook pages used for listing local events	Nina Crispin (Wellbeing Team, RBC)	Nov 2019	Partners will be enabled to share information about services and resources to reduce loneliness and social isolation.	Administrator details collated and shared, including contacts for the new Reading What's On website
	7d. Develop a Pop up What's on Hub and shared calendar	Rhiannon Stocking-Williams (RVA)	May 2020	A shared portable resource for community staff and volunteers from all sectors is available to use at public events such as fetes, fairs and festivals. It will help resolve the problem cited by community staff of being asked to attend for more events than their capacity permits, the idea being to work together and select one or two events each to cover on behalf of a groups of organisations.	
(8) Agree local measures	8a. Consider how to collate measures of the impact of local interventions, to supplement the new LSI measures to be included in national surveys: 1. How often do you feel that you have no one to talk to? (hardly ever/never, some of the time, often) 2. How often do you feel left out? (hardly ever/never, some of the time, often) 3. How often do you feel alone?	Janette Searle & Kim McCall (Public Health & Wellbeing Team, RBC)	May 2020	The impact of local interventions can be tracked and approaches developed on the basis of evidence	Impact measures collected by local VCS groups commissioned under the Narrowing the Gap framework to reduce isolation to be published as part of the March 2020 progress report to the Health & Wellbeing Board: Age UK Berkshire) social Reading Voluntary Action) prescribing Age UK Berkshire) peer support Age UK Reading) for older / Get Berkshire Active) frail people Globe Community Mission) Berkshire West Your Way – peer support for adults living with mental health challenges

Items **Respo**

	Reducing Loneliness and Social Isolation (LSI) **Supporting national indicators** PHOF 1.18i / ASCOF 1.i - % of adult social care users who have as much social contact as they would like PHOF 1.18ii / ASCOF 1.1 - % of adult carers who have as much social contact as they would like PHOF 2.23 i-iv – self-reported wellbeing				
Recommendation	**What will be done – the task**	**Who will do it**	**By when**	**Outcome – the difference it will make**	**Progress Update**
	(hardly ever/ never, some of the time, often) 4. How often do you feel lonely? (often/always, some of the time, occasionally, never)				

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Appendix 4 - Measuring the wellbeing impact: summary of Narrowing the Gap II monitoring (services 3.2, 13.1 and 14.1) – February 2020

Narrowing the Gap (II) Service 3.2 – Social prescribing

This service is delivered in partnership by Age UK Berkshire (AUKB) and Reading Voluntary Action (RVA), and funded jointly by the local authority and the Berkshire West Clinical Commissioning Group. The service is for:

- Reading residents / people registered with GP practices in the North and West Reading CCG and South Reading CCG areas
- aged 18+
- referred by nominated health and social care professionals

Reading Voluntary Action receives all Social Prescribing referrals, and supports all those under 55 and those over 55 lacking social contact. Age UK Berkshire supports older people with one or more long-term health condition plus an age related need for practical support and/or financial advice.

The aim of the service is to support people with a range of social, emotional and practical needs, preventing the escalation of those needs, particularly where this is likely to lead to inappropriate or unnecessary use of statutory care services. The service is intended to improve emotional and physical wellbeing as well as supporting individuals to take greater control of their own health and social care needs.

Tier 1: A signposting service for patients, their families and health/social care practitioners to access details of voluntary and community services and activities

Tier 2: A Social Prescriber (SP) will meet the patient, ideally at their GP surgery but frequently at other community venues or at home, for an initial appointment lasting 60 – 75 minutes. The SP will encourage the patient to talk about any aspects of their life that are impacting on their health and wellbeing. The SP will use an outcome star (Wellbeing or Older Persons Star as appropriate) as a tool to guide a holistic conversation, inviting the patient to assess where they are on the journey of change. The SP team will keep in touch by phone and arrange a follow up appointment to complete a 2nd star after 3-4 months.

Tier 3: SP "plus" for more complex cases, mostly for older patients who have long term conditions, are house bound etc., will usually include an initial appointment at home. In addition to the standard service, SP "plus" will offer follow-up visits and support to complete forms, attend appointments and activities.

From June 2018 to November 2019, the service accepted 303 referrals (and declined 43).

Satisfaction scores are very high (80%+) but based on a low number of returns. Both providers use outcome stars to measure the impact of their service at the point when clients are discharged from Level 1 or Level 2. From the start of the contract to date, AUKB reports an average 3 point improvement in people's 'feeling positive' scores, and a 1 point improvement in each of people's sense of their ability to 'stay well' and 'look after self or others'. AUKB has, however, noted an increasing number of referrals for people with memory problems, who find it difficult to complete the outcome star evaluations.

RVA reports an average 26% improvement in people's 'feeling positive' scores, plus an average 13% improvement in 'managing symptoms' scores and an average 5% improvement in 'looking after yourself' scores.

Narrowing the Gap (II) Service 13.1 – Peer supporting and reducing social isolation for frail / elderly adults

A partnership of Age UK Berkshire (AUKB) with Age UK Reading (AUKR), Engage Befriending (part of the Mustard Tree Foundation), Get Berkshire Active (GBA) and The Globe Community Mission delivers a service for:

- Reading residents
- Aged 50+
- At risk of social isolation because of frailty or long term health conditions / living with current or emerging care and support needs

This includes:

- support to take part in group activities which promote wellbeing and provide opportunities for social interaction and peer support
- some home visiting / contact for people who face particular challenges in leaving the home
- empowering people to take better care of their wellbeing, including through peer support where appropriate
- support to identify and access relevant services offered by other providers
- outreach to raise awareness of the service

From June 2018 to November 2019, the service had supported the following numbers of residents.

Provider	Individuals* supported to end of Q6
Age UK Berkshire	157 • 32 Out & About service • 83 Face-to-face befriending • 42 telephone befriending
Age UK Reading	115 • 55 face-to-face befriending • 49 telephone befriending • 11 both face-to-face and telephone befriending
Engage Befriending	128 people befriended (some supported to engage in group activities

	also)
Get Berkshire Active	263
The Globe	409

* some individuals may use the services of more than one of the providers. GBA and Globe figures may include returners each quarter, but the numbers for the other providers are cumulative

Age UK Berkshire measures the impact of its services on users' emotional wellbeing using the Warwick-Edinburgh Mental Wellbeing Scale. Completed scores show improvements in clients' self-assessment across all domains, although the scale is not completed for all users, e.g. when people stop using the service for within the first 6m for health reasons. Service user satisfaction scores are very high. A new tool to measure this was implemented in Q4 and the latest findings show:

- 67 % strongly agree that they have enough people available to talk to.
- 67% neither agree or disagree that having contact with a befriender has helped to improve their health and wellbeing.
- 100% agree that since being visited by their befriender they have things they look forward to.
- 67% agree that since being visited by their befriender they have felt less isolate
- On a scale of 1-5, (1 = being dissatisfied and 5 very satisfied), 67% were very satisfied with the service provided by Age UK Berkshire

Age UK Reading completed a client satisfaction survey in Q6, which generated the following feedback:

- When clients were asked about the frequency of telephone calls/visits 85% felt the frequency was just right and 15% felt that the frequency wasn't enough.
- Regarding feeling less isolated since being telephoned/visited 73% said they felt less isolated.
- When asked how well they got on with their befriender 100% of clients said they got on well or very well with them.
- When asked how they would feel if the service was discontinued, 46% used words like "devastated/bereft/very upset/very sad" as opposed to less emotive words such as "disappointed".

Age UK Reading completes an initial wellbeing questionnaire when clients first join the service. Of the new clients surveyed that have joined the befriending service in 2019, 100% reported having more social contact and feeling less isolated.

- New clients were also asked if they had things to look forward to, 67% agreed compared to 33% in the initial survey.
- When asked if clients felt they had enough people available if they needed to talk to someone, 100% agreed compared to 33% in the initial survey.

All of Engage Befriending's delivery under this contract is in the form of face-to-face sessions, including some facilitation of small group meets. Funding largely covers the costs

of a co-ordinator to manage and drive up quality. The service invites service users to self-assess their wellbeing at the start of the service then after 3m and 1 yr. The questions were revised in Q4 to align impact measurement across the partnership. Engage is maintaining or improving scores across all domains, i.e.

- I have enough people available to talk to
- Having regular contact with a befriender has helped to improve my health and wellbeing
- Since being visited by my befriender I have things that I look forward to
- Since being visited by my befriender I have felt less isolated

Service user satisfaction scores for Engage Befriending are consistently high (with an average score of 4.8 out of 5 in Q6).

Get Berkshire Active (GBA) has delivered a range of physical activity opportunities, including seated exercise, walking netball and short mat bowls. The programme has developed in response to partner / user feedback, including impact measures per lifestyle questionnaires. GBA has been flexible and agile in their approach, working with a wide variety of partners to enhance engagement, wellbeing impact and quality of sessions offered. Partners include sheltered housing, leisure services, and other voluntary and community groups.

The Globe service is co-ordinated by a core team of three volunteers. However, the service is very much user-led with those attending the weekly club actively engaged in developing and delivering it. A wide range of wellbeing topics have been covered by invited speakers and there is a regular exercise session within the club. There is also now a modest home visiting service for those unable to get to the club, as well as trips out organised for the group. Satisfaction and service impact scores are consistently high, with a number of 'satellite' activity groups now taking place as people become more confident and identify buddies to provide peer support.

Narrowing the Gap (II) Service 14.1 – Peer support and reducing social isolation for adults who have experienced mental ill health

Reading Borough Council and the Berkshire West Clinical Commissioning Group have collaborated to commission Together for Mental Wellbeing to delivers a local service under the banner of Berkshire West Your Way for:

- Adults (aged 18+)
- Who have experienced mental health difficulties

65% of service delivery is for Reading residents, and a further 17.5% of service delivery will be to residents in each of West Berkshire and Wokingham.

The service includes:

- A peer mentor development and training programme
- Support to develop self-management and coping strategies
- Support to access employment or volunteering
- Support to access training or education
- Supported referrals into specialist housing, benefits, debt or finance services as appropriate
- Support in accessing and maintaining access to activities to reduce social isolation
- Signposting and referral into other voluntary/community organisations including the Recovery Colleges
- Enabling the development of an empathic supportive community so that people who use the service help to keep one another well, reducing demand both on statutory services and on family/informal carers
- Facilitating a co-produced social and activity programme which is designed to meet any highlighted needs from service users, peer mentors and commissioners.
- Supporting service users to complete and review person-centred support plans such as the Mental Health Recovery Star and Plan
- Supporting service users to plan and execute a clear exit strategy for those leaving formal services.

From June 2018 to November 2019, 218 new referrals were accepted into the service. In addition, 87 individuals originally accepted into the service under the previous contract continued to access many of the groups.

Where Warwick-Edinburgh Mental Wellbeing scales were completed, service users showed an average improvement in their wellbeing across all domains. The average increase in scores in Q6 was 4.8 for individuals receiving 1:1 support, and 3.3 for those attending the self-management group (with 3 being regarded as a significant change in this context).

All attending the self management group reported improvements in their perceptions of:

- Confidence
- Ability to manage own mental health
- Sense of control
- Sense of acceptance
- Sense of hope.

In addition, most reported they were engaging more in social activities
Everyone exiting 1:1 support this quarter reported progress towards or with:

- achieving their identified goals
- developing new skills
- physical health
- connections with friends, family and community
- confidence
- emotional wellbeing

5 of the 6 clients were either satisfied or very satisfied with the service.

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READING HEALTH AND WELLBEING BOARD

DATE OF MEETING:	13 March 2020		
REPORT TITLE:	Future in Mind Update (Local Transformation Plan for Children and Young People's Mental Health and Wellbeing)		
REPORT AUTHOR:	Andy Fitton & Deborah Hunter	**TEL:**	
JOB TITLE:	AD for Joint Commissioning (interim) Head of SEND and Principal Child & Educational Psychologist	**E-MAIL:**	andy.fitton@nhs.net Deborah.Hunter@brighterfuturesforchildren.org
ORGANISATION:	Berks West CCG Brighter Futures for Children		

1. PURPOSE OF REPORT AND EXECUTIVE SUMMARY

1.1 To provide an overview of the refreshed Future in Mind Local Transformation Plan (LTP) which was published in October 2019 in accordance with national Future In Mind requirements. The LTP provides an update on service development and improvement across the comprehensive Child and Adolescent Mental Health Service (CAMHS) system. The full LTP can be found here. https://www.berkshirewestccg.nhs.uk/about-us/how-we-work-with-others/the-local-transformation-plan/. Our LTP has been assured by NHS England.

1.2 A wide range of initiatives across the system are underway to improve emotional health and wellbeing of children and young people. Initiatives reflect the THRIVE model

1.3 Like most other areas of the country, demand for emotional health and wellbeing services have increased and the complexity of presenting issues is increasing. The increase in demand and complexity is being seen across voluntary sector, schools and specialist services. This is having an impact on waiting times.

1.4 Appendix 1 – The Future in Mind Local Transformation Plan – October 2019 refresh

2. RECOMMENDED ACTION

2.1 The Board is asked to approve the refreshed Local Transformation Plan.

3. CONTEXT

3.1 The refreshed Future in Mind Local Transformation Plan (LTP) was published in October 2019 in accordance with national Future In Mind requirements. The LTP provides an

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

3.2 Like most other areas of the country, demand for emotional health and wellbeing services have increased and the complexity of presenting issues is increasing. The increase in demand and complexity is being seen across voluntary sector, schools and specialist services. This is having an impact on waiting times to access help.

3.3 The NHS Long Term Plan has been published and the local partnership is on track in the key areas of Children and Young People's Mental Health Services and our refreshed LTP matches the requirements for improvements expected.

3.4 Access to services by Children and Young people has increased again this year. Providers are seeing more children and young people for evidence informed help than ever before.

4. THE PROPOSAL

4.1 Key achievements

a) The NHS Long Term Plan has been published and the local partnership is on track in the key areas of Children and Young People's Mental Health Services and our refreshed LTP matches the requirements for improvements expected.
b) Access to services by Children and Young people has increased again this year. Providers are seeing more children and young people for evidence informed help than ever before.
c) We have continued to develop outcomes reporting and can evidence that most children and young people have positive outcomes across providers.
d) We can evidence that most children and young people feel listened to across providers.
e) We continue to meet the challenge of working with partners to flow CYP access data onto the national dataset, with 3 more now providers' data monthly and BHFT improving the quality of their returns.
f) We can evidence the impact of large scale training across partners. In particular the introduction of Trauma Informed/ adverse childhood experiences training, at School and a community level is expanding rapidly across the patch. Aligned to this is the start this year of the roll out of the regional Restorative Practise awareness and training in all three Local Authorities reaching 100+ multi-agency practitioners and snr leaders as well as CYP.
g) We are setting up Mental Health Support Teams in all of our Local Authorities. We have built on our existing strengths and learning from the Emotional Health Academy the Reading Emotional Well-Being Partnership to create an exciting offer.
h) Following the completion of a service review, more financial investment has been secured for our Eating Disorder Service that will enable our local Mental Health provider (Berkshire Healthcare Foundation Trust - BHFT) to meet waiting time standards by 20/21.
i) We were successful in becoming one of 9 pilot sites for a research project on improving mental health assessment for Children in Care. Training has been completed and the first 12 children in care have already participated in the project.
j) BHFT have secured funding from NHS England to build a new inpatient facility to replace Willow House in Wokingham. This will provide more capacity and reduce the number of children who have to be placed out of area.

4.2 Areas of Challenge and Development

a) There continues to be increased demand which in turn is having an impact on waiting times, across providers. Although we were successful in winning additional resources to reduce waiting times in our specialist CAMHs teams, recruiting the workforce continues to be challenge across the sector.

b) Availability of suitable skilled, qualified and experienced health workforce. There are recruitment and retention challenges for many parts of the wider children's workforce e.g. social care. The cost of living is high in Berkshire West.

c) Demand for emotional health and wellbeing services across the system has increased at all levels of need, see Local Transformation Plan Appendix 2 Needs Analysis and Appendix 5 Activity. Local analysis is that we continue to be part of the cycle of positive improvements in identification of likely unmet need alongside the lowering national of the stigma related to mental health is driving the demand. However, with challenging waiting times often the need is increasing thus increasing felt levels of acuity in cases across the system.

d) There continues to be concern about the in self-harm rates in all three Local Authorities for people aged 10 – 24. Self-harm rates for 15 to 19 year olds across all three areas continue to be higher than the national average. A set of clear recommendations have emerged from the CYP High Impact User project along with the introduction of the MHST will begin to make a difference.

e) Availability of suitable inpatient beds close to home. Lack of local inpatient beds for young people with Eating Disorders. The improvements in the local Willows provision as well as the work through the New Models of Care offer regionally will go so way to meeting this challenge.

f) Flowing data onto the national MHSDS data set involves multiple providers with differing IT systems and data governance arrangements. We continue to meet the challenge of working with partners to flow CYP access data onto the national dataset, with 3 more now providers' data monthly and BHFT improving the quality of their returns.

4.3 Priorities going forward

a) Our 2019/20 Local Transformation plan has identified 7 priorities to focus and act as a way to galvanise the partnership to collectively achieve improvement and change. These priorities are:
   - Priority 1 – Ensure that we embed and expand the Mental Health Support Teams in Berkshire West
   - Priority 2 – continue to focus on meeting the emotional and mental health needs of the most vulnerable CYP – particular attention to Children in Care
   - Priority 3: Continue to build a 24/7 Urgent care/ Crisis support offer for Children and Young People (CYP)
   - Priority 4: Continue to build a timely and responsive Eating Disorder offer
   - Priority 5: Improve the Waiting times & Access to support, with particular this year on access to ASD/ ADHD assessments and support.
   - Priority 6: To improve the Equalities, Diversity and Inclusion offer and access for Children and Young People in Berkshire West
   - Priority 7: Building a Berkshire West 0 – 25 year old comprehensive mental health offer

b) The Future in Mind Delivery Group meets regularly to consider, challenge and

champion the changes as well as oversee this LTP refresh document. The Future in Mind group is chaired by the Assistant Director of Joint Commissioning NHS Berkshire West CCG and reports into the Berkshire West MH and LD ICP programme board. Work-streams are set up to drive each priority forward that includes strong multi-agency representation.

c) Highlights of the work in the specific work in Wokingham can be found in the plan on pages 38 – 39 & 43 - 46 and specialist CAMHs pages 48 – 60.

5. READING MENTAL HEALTH UPDATE

5.1 Mental Health Support Team

Reading and West Berkshire were amongst the first trailblazer sites in the UK to develop a Mental Health Support Team, in partnership with the CCG. The MHST is unique in that it offers a school based mental health service, offering the right service at the right place at the right time.

The Reading MHST delivers evidence-based interventions for emerging mild to moderate mental health needs. It fits within the local systemic response to mental health concerns to meet local needs. It offers a service that is understood and accessed by Reading families, young people, schools and professionals, including an open referral system and MH triage.

Examples of what Reading MHST site has achieved to date:

- The MHST had its formal launch on 30th January.
- It covers 16 schools across the west of Reading, including Prospect, The Wren and Blessed Hugh Faringdon secondary schools and a number of primary schools.
- It has developed through a jointly established local governance structure, which enables education settings, parent/carer representatives, and partners to be members, and have a voice in how the MHST will develop and operate to meet the local need.
- It has a specific database to enable uploading data to NHS England and monitoring of outcomes for children and young people.
- The MHST has a full complement of staff, 2 Senior Educational Psychologists, 1 clinical psychologist, 4 Educational Mental Health Practitioners, 1 outreach worker.
- Referrals to the MHST: we have launched a Mental Health Triage as part of the One Reading Partnership Hub; referrals to the MHST are made via the website, including by schools, GPs, parents and self-referrals by children and young people and discussed at the multi-agency triage, to ensure a system response to the child/young persons' needs. Referrals to MHST can also be made via the CSPOA.
- MHST has received 80 referrals in total. Of that 80:
  - 50 were accepted and receiving/received MHST assessment/intervention
  - 19 have been screened and are on the waiting list for allocation of a MHST worker
  - 8 are pending triage, we need further info before accepting the referral.
  - 3 were inappropriate referrals for MHST and have been signposted to other services.
  - The majority of the cases are for anxiety and or depression.
- The MHST offers a comprehensive and tailored programme to support education settings with the design of their Whole School Approach.
- The newly qualified EMHPs have a structured workload and time, working directly from education settings on a regular basis and are able to build effective working relationships with key school staff.
- delivering evidence-based interventions for mild to moderate mental health needs. Delivered a number of bespoke activities to meet the needs of education settings, which include: mental health assessments, parent classes, mental health surgeries, training, individual therapeutic interventions for children and young people, support and consultation for school staff and parents.

- Multi-agency mental health surgeries are held 6 weekly in each participant school with each surgery discussing 3-6 children.

Developments:

• Identify and secure supplementary training for EMHPs enabling them to work with referrals that involve elements of self-harm, thus meeting a significant need reported by education settings.

5.2 Schools Link Mental Health Team

This is mental health service offered to all schools across Reading, and which has been taken up by 90% of primary and secondary schools in the area. It is offered by the Educational Psychology Service and Primary Mental Health Workers.

Deliverables:

- Initial whole school training
- 6 x mental health surgeries each academic year
- Each school will have regular mental health surgeries with EPs and PMHWs, to support and advise on individual or groups of pupils. Link staff
- 3 x network meetings each academic year
- Link staff training
- 12 mental health modules are run throughout the year for school staff to learn more about issues affecting mental health and wellbeing.

Educational Psychologists and Primary Mental Health Workers offer a range of group and individual therapeutic interventions, mental health assessments, consultations, training and signposting and liaison with CAMHS.

5.3 Secondary school mental health hubs

Two secondary schools in Reading are mental health hubs. They have developed mental health ambassadors, pupil workshops, leaflets and presentations for assemblies.

5.4 Therapeutic Thinking Schools

- The Therapeutic Thinking Approach to Behaviour and Inclusion has been adopted as Reading's approach to reduce exclusions and behaviour – it has been shown to reduce exclusions in other local Authorities and is in line with recent DfE advice "Mental Health and Behaviour in Schools 2018". It links directly to our commitment to driving trauma informed practice in the education sector.
- Being therapeutic means that school policy and the day to day practice in schools provides experiences that create sustained *positive feelings* within all children (regardless of their experiences of trauma, disability, difficulty and or neuro type).
- It is an approach that requires everyone involved in supporting a child to understand the drivers of dangerous or difficult behaviour and be consistent in how they manage children who are showing distress or anxiety through internalising or externalising behaviours.
- All BFfC staff whose role is to advise schools will be familiar with, and give advice that is in line with this approach.
- The approach was introduced to schools in December 2018 and, to date 57 schools in Reading have been trained.
- The Therapeutic Thinking Schools Approach offers tools, approaches and analyses (eg: policy audit, therapeutic plans, therapeutic tree, anxiety mapping, conscious and unconscious behaviours checklist).
- BFfC offers support to schools in this approach via visits, network meetings; clinical supervision for staff will be available.

5.5 Trauma Informed Reading

The One Reading Partnership has a commitment to leading the way on ensuring all services for children, young people and adults are trained in recognising and understanding the impact of traumatic experiences of people's lives. Training is offered to leaders, front line staff and schools.

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

6.1 The work of the LTP is contributing to Reading Health and Wellbeing Strategy priorities 3 & 4:

- Promoting positive mental health and wellbeing in children and young people
- Reducing deaths by suicide

7. ENVIRONMENTAL AND CLIMATE IMPLICATIONS

7.1 Not Applicable

8. COMMUNITY & STAKEHOLDER ENGAGEMENT

8.1 As a partnership we are committed to improving our services to CYP by continuously seeking their collaboration, feedback and involvement. The full range of providers regularly seek the views of CYP in a flexible adaptive way that encourages participation and involvement in not only feedback of experiences but how to improve our services. In preparation of our refreshed LTP we asked all providers to help us understand what they have heard over the last year, this is outlined in chapter 5 of the document.

9. EQUALITY IMPACT ASSESSMENT

9.1 Not applicable

10. LEGAL IMPLICATIONS

10.1 Not applicable

11. FINANCIAL IMPLICATIONS

11.1 Not applicable

12. BACKGROUND PAPERS

12.1 The full LTP can be found here. https://www.berkshirewestccg.nhs.uk/about-us/how-we-work-with-others/the-local-transformation-plan/.

Local Transformation Plan for Children and Young People's Mental Health and Wellbeing - REFRESH OCTOBER 2019

Berkshire West CCG area with Reading, West Berkshire and Wokingham Local Authorities

NHS
Berkshire West
Clinical Commissioning Group

Index

FOREWORD

'Our most urgent priority is to improve the outcomes and the life experiences of our children and young people in Wokingham, Reading and West Berkshire.

Unfortunately, many of our children and young people will experience times when their emotional health declines and they require additional help or support. Effective early intervention with children and young people experiencing difficulties with their emotional or mental health is crucial, and as leaders in Berkshire West we realise that this is best delivered in partnership with colleagues in health, schools, the voluntary sector and in social care and criminal justice services.

We must and we will work together to find creative solutions to get the right help, at the right time, in the right place for our children and young people, and their parents or carers. We are committed to listening and responding to what children and families tell us they need. We will review and learn from what's working well and agree together what we need to do to continue to improve.'

Katrina Anderson
Director of Joint Commissioning
Berkshire West Clinical Commissioning Group

Andy Sharp
Executive Director - People
West Berkshire Council

Carol Cammiss
Director of Children's Services
Wokingham Borough Council

Eleni Ioannides
Interim Director of Children's Services
Brighter Futures for Children - Reading

Chapter 1 - Introduction

What this document is about

This document describes how as a local system we are improving the emotional wellbeing and mental health of all Children and Young People across Reading, West Berkshire and Wokingham in line with the national ambition and principles set out in a range of government documents and most recently in the NHS 10 year Long Term Plan.

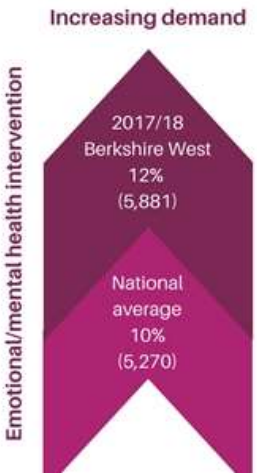
Our ambition has been not simply to adjust existing services, but to transform them across the whole system. This has been an important journey together with a range of partners and influences, with the story told in Appendix A. We are an ambitious partnership with collaboration at its centre. Over recent years there has been a marked culture shift towards a mature thriving system which seeks strong relationships and a solution focussed approach as key to improving services for children, young people and families.

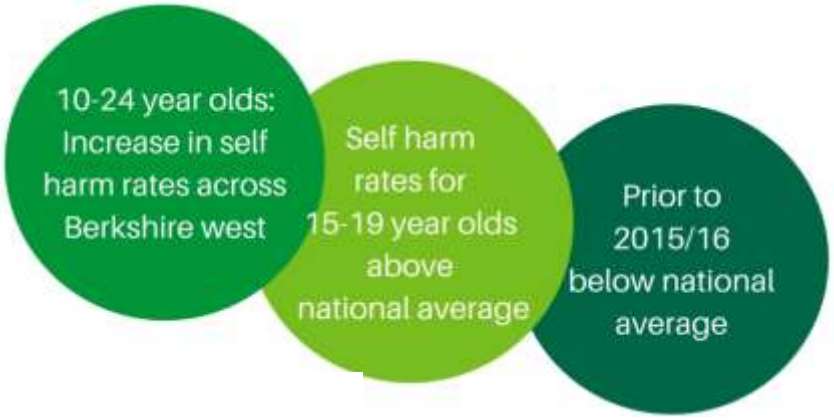
Our Local Transformation Plan is reviewed by partners including service users, refreshed and published annually and this is our 5th year of completing this task. Our Local Transformational Plan sets out our vision, progress and next steps to improve the social, emotional, mental health and wellbeing of children and young people.

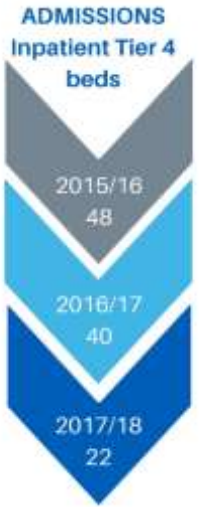
This document builds on the 2018 plan and provides an update through a THRIVE elaborated (see appendix 1) lens of

- What we have achieved so far
- Our commitment to undertake the further work that is required
- Local need and trends
- Resources required

The Berkshire West context







Chapter 2 - Our Ambition

We will ensure promoting resilience and good mental health and wellbeing is a priority across all partners, with a commitment to helping every child and young person experience positive mental health and wellbeing by using the right help, when and where needed.

By 2020 support will be individually tailored to the needs of the child, family and community – delivering significant improvements in children and young people's mental health and wellbeing. We have already made good progress in this. We want to go further.

Our Local Transformation Plan is about integrating and building resources within the local community, so that emotional health and wellbeing support is offered at the earliest opportunity. Our goal is to reduce the number of children, young people and their families whose needs escalate to require specialist intervention, a crisis response or in-patient admission. Our plan has been refreshed in line with the requirements of NHS 10 year Long Term Plan.

Successful delivery of the plan will mean that:

- Good emotional health and wellbeing is promoted from the earliest age and poor emotional health is prevented when possible
- Children, young people, their families and our communities are emotionally resilient
- Everyone who works with children and young people is able to identify issues early, enable families to find solutions themselves, provide advice and access help
- Staff feel supported in their own emotional health, wellbeing and resilience through nurturing working environments
- More children and young people with both an emerging emotional health needs and diagnosable mental health condition are able to access evidence based services in a range of settings.
- Agencies work more closely together so that vulnerable children* can access the help that they need easily.
- Fewer children and young people's needs escalate into crisis, but for those that do; good quality care will be available quickly and will be delivered in a safe place. After the crisis the child or young person will be supported to recover in the least restrictive environment possible.
- Fewer children and young people require in patient admission but for those that do this is provided as close to home as possible.

* Vulnerable groups include children in care and on a child protection plan; children who have experienced abuse and/ or multiple trauma, victims of crime, young people who are in contact with the criminal justice system, those with Special Educational Needs and Disabilities, those at risk of exclusion from school and traveller communities.

Collaborative working is a critical enabler for services working with Children and Young People. Therefore it is important that

- Help is provided in a coordinated, easy to access way. All services in the local area work together so that children and young people get the best possible help at the right time and in the right place. Help provided takes account of the family's circumstances and the child or young person's views.
- The child's journey is seamless. While there may be transfer of provision between providers, the child and their family experience joined up support with the child's needs at the heart of care.
- There is a smooth and safe transition into and out of forensic and in-patient services. Local services remain involved and support transition back into local community services so that there is timely discharge from in patient care.
- We learn together on a multiagency basis and when needed, change the way in which we work
- The number of young people who need services into adulthood is reduced, but for those who do, young people and families report a positive experience of transition.

Chapter 3 - Transformation in Berkshire West- impact and extent of transformation to date

The extent of our transformation so far has been recognised by CQC, OFSTED, NHS England Regional Team and the Children's Commissioner for England. We are an ambitious partnership committed to continuous improvement.

Ethos

We continue to work on shifting from a traditional 'escalator' style tiered system to a systems approach informed by the THRIVE-elaborated framework. More information is in Appendix 1.

We are promoting a whole system framework of care, moving away from a specialist single agency mental health response to families, to one where communities, schools, public health, social care and the voluntary sector sharing the same vision, work together on prevention, early help and building resilience. The same partnership approach applies to complex mental health difficulties and mental health crises among children and young people. This inter-professional collaboration and co-production will support a cultural change in the language used, the way in which systems and agencies work together, and the way in which children, young people and their families access support, care and treatment. We are interested in expanding the use of Restorative Practise across partners, as one of the shared tools fostering commonality for language and approach.

We have found multiagency emotional health triage at an earlier stage to be a particularly effective way of harnessing a swift community response before needs escalate. This approach alongside regular consultation and surgeries for schools are embedded within our new model of service delivery in schools.

Building skills in the community

We have invested in workforce training across schools, primary care, the voluntary sector and social care. We continue to grow an evidence informed workforce across the whole system so that issues are identified and responded to earlier.

The Schools Link Mental Health projects and the Emotional Health Academy have built skills and support in schools and the community, as well as the impact of the Psychological Perspectives in Education and Primary Care (PPePCare) training offer locally. There is a growing understanding that a GP referral to Specialist CAMHs is not always the best solution as there is often a stronger community response available. Pilot Mental Health Support Teams are being established and will go live supporting pupils in local Reading and West Berkshire Schools in Jan 2020. A further team in Wokingham will go live 9 months later. There is more work to be done on ensuring that pathways meet the needs of all children and young people

Voluntary sector organisations provide important parts of our care pathways and these organisations are more connected with other partners through meetings and training. Organisations are learning from each other and reporting against the same outcomes framework and audit tools.

Joint learning across the system has led to workers speaking the same language more frequently. This in turn has built relationships and furthered collaborative working. This has only been strengthened by 2 further pieces of work this year;

- The increased focus on raising the awareness and response to Adverse Childhood Experiences (ACEs) and being Trauma Informed as Schools and services in response to children.
- The start of a regional programme to establish Restorative Practise as a core competency of the wider children's workforce. Training for senior leaders as well as front line staff is well underway that will create shared values and a strategic framework for managing challenge and support leading to a way of providing strategic permissions for innovation and creativity.

Focus on outcomes and the voice of children and young people

We developed an outcomes framework across all providers 3 years ago. Our focus on outcomes is driving service improvement. We learn from children and young people who use our services, their families and partners as to what is working well, how things might need to change, the impact of interventions, whether support needs are being met.

Listening to the voice and experience of children and young people is central to this review and refresh of the LTP.

We are better at using data to inform service planning and provision more consistently. This is underpinned by consistent data and outcomes reporting across different parts of the system and different providers. The majority of our local providers are already flowing data onto the NHS digital systems and within this next year we would expect all commissioned work will be providing information towards are targets.

Partnership

Our culture of joint ownership and accountability is driving transformation. Partners continue to describe how the culture has shifted to a thriving, more mature system over recent years. Stakeholders report that the partnership feels collaborative, supportive of each other and respectful. Barriers have been broken down between organisations and services, there is greater understanding of how each other contribute to meeting the needs of children and young people, language barriers between organisations have significantly reduced and there is greater trust between partners.

New partnerships have been forged and this is further driving transformation. An example is the relationship with the University of Reading which is proving to be beneficial to all parties as well as increasing the body of research in this field.

We acknowledge that there is further to go, especially given the context of rising demand and financial constraints across the system.

Cross cutting agenda

We continue to keep a strong strategic overview of the Future In Mind/ LTP developments through a multi- agency board that is embedded into related work streams and strategies that are driving and supporting transformation in Local Authorities and Health's Integrated Care Partnerships and Systems. Related strategies include Special Educational Needs and Disability work, Early Help and Transforming Care programme.

Chapter 4 - Headline messages for financial year 2018/19

It has been a very busy year in delivering our transformation plan and we are proud of what we have been able to achieve alongside young people, parents and our strategic partners from the local authority, health, education and the voluntary sector. What follows is a synopsis of the headline messages for this year. More detailed descriptions of the actions we are taking to further improve services are described in Chapter 6.

- We have continued to develop outcomes reporting and can evidence that most children and young people have positive outcomes across providers.
- We can evidence that most children and young people feel listened to across providers.
- We can evidence the impact of large scale training across partners. In particular the introduction of Trauma Informed/ adverse childhood experiences training, at School and a community level is expanding rapidly across the patch. Aligned to this is the start this year of the roll out of the regional Restorative Practise awareness and training in all three Local Authorities reaching 100+ multi-agency practitioners and snr leaders as well as CYP.
- Access to services by Children and Young people has increased again this year. Providers are seeing more children and young people for evidence informed help than ever before.
- There continues to be increased demand which in turn is having an impact on waiting times, across providers. Although we were successful in winning additional resources to reduce waiting times in our specialist CAMHs teams, recruiting the workforce continues to be challenge across the sector.
- We continue to meet the challenge of working with partners to flow CYP access data onto the national dataset, with 3 more now providers' data monthly and BHFT improving the quality of their returns.
- We are one of 20 national trailblazer sites to set up Mental Health Support Teams in two Local Authorities. We have built on our existing strengths and learning from the Emotional Health Academy the Reading Emotional Well-Being Partnership to create an exciting offer. Recently we have secured a further team for Wokingham.
- Following the completion of a service review, more financial investment has been secured for our Eating Disorder Service that will enable our local Mental Health provider (BHFT) to meet waiting time standards by 20/21.
- Demand for emotional health and wellbeing services across the system has increased at all levels of need- see Appendix 2 Needs Analysis and Appendix 5 Activity. Local analysis is that we continue to be part of the cycle of positive improvements in identification of likely unmet need alongside the lowering national of the stigma related to mental health is driving the demand. However with challenging waiting times often the need is increasing thus increasing felt levels of acuity in cases across the system.
- The number of children and young people with autism or seeking autism assessment in Berkshire West continues to be higher than in other areas. Our BHFT have reviewed our neurodevelopment service to find as many ways as possible increase the pace of assessment to reduce our waiting list. A successful pilot across Berkshire, has opened up the option of using online assessment delivery that will be further explored if we secure further

waiting time money into 19/20. We have worked with Berkshire East partners to review the current model of support across the whole system alongside the continued work locally to provide a graduated response rather than being diagnosis led.

- A set of clear recommendations have emerged from the CYP High Impact User project that require further attention. There continues to be concern about the in self-harm rates in all three Local Authorities for people aged 10 – 24. Self-harm rates for 15 to 19 year olds across all three areas continue to be higher than the national average with the biggest jump being in Reading. Prior to 2015/16 all three LA's were below or in line with the national average.
- For Health and Justice regionally the roll-out of all age Liaison and Diversion (L&D) services has started with a new provider (Berkshire Health Foundation Trust across Thames Valley and Hampshire) and implementing clear CYP pathways with dedicated CYP practitioners.
- The Thames Valley and Hampshire Sexual Assault Referral Centres are Commissioned to provide a 24/7 age service however there have has been some issues in relation to the Paediatric provisions due to availability of appropriately trained staff. A review of SARC services has been organised for Thames Valley to meet paediatric standards. A Senior MH Practitioner is now in our SARC to identify CYP emotional and mental health needs and training for SARC staff.
- Locally for Health and Justice there continues to be Multi-professional health input which plays an active and important role in our local Youth Offending Teams, offering a comprehensive advice, assessment and intervention service for CYP as well as staff.
- Children and young people who are under Specialist CAMHs continue to experience more severe symptoms and have more complex presentations than in comparator areas. We wonder whether this is related to earlier help being more embedded in Berkshire West as we have rolled out Future in Mind.
- We were successful in becoming one of 9 pilot sites for a research project on improving mental health assessment for Children in Care. Training has been completed and the first 12 children in care have already participated in the project.
- There is better working with specialist agencies to meet the needs of vulnerable children such as those who have been abused or are victims of crime. We know that these children do not always fit traditional care pathways and that there is more work that we could do. This is a priority for the coming year. Trauma Informed Communities work is developing. Since the CAMHs Rapid Response/ crisis service was implemented, fewer children and young people have been admitted to Tier 4 inpatient beds, over the last 3 years, although numbers increased again this year. Those who are admitted have a shorter length of stay. We are seeking additional resources to extend the Rapid Response service.
- We are working with partners on new Tier 4 network that is being developed to enable improved flow and access to inpatient beds within the geographical patch. This means that young people will be more likely to stay in the area when they require a bed. Work continues locally to move and expand our inpatient unit, including CYP with eating disorders.

An extensive overview of the work of our providers and partners is outlined in the appendix. This table provides an update on where we are now, the impact and outcomes to date. This includes activity data where available. While the table describes actions and organisations as separate entities for the sake of document presentation, in reality there is a whole system multiagency thread running through activities which is the hallmark of our transformational work in Berkshire West.

Chapter 5 - What our service users say about local service transformation

As a partnership we are committed to improving our services to CYP by continuously seeking their collaboration, feedback and involvement. The full range of providers regularly seek the views of CYP in a flexible adaptive way that encourages participation and involvement in not only feedback of experiences but how to improve our services. In preparation of our refreshed LTP we asked all providers to help us understand what they have heard over the last year, which has been distilled into these key points:

Things that our young people said they were most concerned about;

They say they want timely help and to be listened to without judgement. They are keen to be active in raising awareness of the stigma and misunderstandings surrounding mental health issues. They want mental health difficulties to be seen as a normal part of growing up. As well as:

- Wanting to see a future for themselves & creating a positive view on life
- Creating more trust in yourself
- Promoting and gaining more self-understanding
- Ensuring they have the right information about their rights and entitlements concerning their health
- Knowing where and how to get help
- Opportunities and access to self-help resources
- Getting it right for CYP in Schools; a good model of access to support & an opportunity to learn about mental ill and wellbeing (PHSE)

What else do young people want help with?

- Exam stress/Academic Anxiety
- Friendship difficulties
- Problems at home
- Pressure to fit in

We have reviewed the comments made last year from CYP on the focus of improvement going forward and we remain concerned that we have not made enough progress against these areas, which are:

- Waiting times are still a struggle but I don't know what CAMHS itself could do to aid that. (Waiting times were mentioned several times).
- The Autism Assessment Team pathway needs to be quicker than it is.
- A priority is 1 in 4 girls and 1 in 10 boys self-harm due to low self-worth and esteem.

- Mental health services should be as well-known and normal as a sexual health clinic or other 'selective' branches of the healthcare services. "I think this can really be tackled on a school level. All schools have a mental health module or lessons and talking about CAMHS and the other services should be a part of that to promote its role in the community".
- I feel that there needs to be continuity in care between tier 3 and tier 4 CAMHs, and with other services. Young people find themselves in-between services at times of great need.

It is though assuring that listed below are many of the comments and feedback that we have heard recently from CYP that they say about the services they have received:

- *"I was heard and respected. Whenever I had a serious problem, I was offered useful tools and solutions in order to fix them. The people working here are all very respectful and kind, offering loads of support and helping me recover"*
- *"I felt understood and cared for. My therapists were very kind and supportive, and they helped motivate me to get better"*
- *"I learned different ways to cope with a stressful situation. My care has been lovely, everyone I have seen has been so nice. I have loved it so much"*
- *Examples of representative qualitative feedback from children and young people:*
- *"I felt everyone involved in the care of my son showed care and compassion and understood his problems and needs. I also felt that I was included by being informed of treatment each week and that meant a lot to me, to enable me to help my son at home"*
- *"We have seen a massive improvement in our daughter. She seems calmer, more collected in her thoughts and actions. She seems bolder and less timid. The challenge will be to continue on this path"*
- *"The information received was really useful and has improved our daughter's anxiety. It was very easy to talk to our therapist, and my worries about being judged were not true"*
- *"The friendly staff, how they listened to my concerns, etc."*
- *"Made my child feel comfortable and listened to."*
- *"The patience and understanding we received. I really felt listened to."*
- *"People involved were amazing, very caring and understanding."*
- *"The clinicians were both friendly and made us feel relaxed. I felt that they were genuine and passionate about what they do and that they really cared. Thank you."*
- *"Personal, friendly and approachable."*
- *"Somebody listened and more importantly took what I was saying seriously."*
- *"Very friendly staff. I felt comfortable talking about my child and felt I was understood. My son felt more at ease the longer he was here, didn't feel like he was being questioned and had fun."*
- *"The doctors we saw were supportive and understanding of the situation and there was no judgement"*
- *"Very good, given time and listened too."*
- *"My daughter was not rushed as was seen as a person not as a number."*

Chapter 6 - Priorities moving forward and work plan - As with any major service transformation, it is important to identify priority pieces of work that provide focus and act as a way to galvanise the partnership to collectively achieve improvement and change.

This diagram provides a visual outline of the priorities from 18/19 (in red shapes) to the 19/20 priorities (in green shapes).

2019/20 Berkshire West Seven Priorities work plan

Priority 1 – Ensure that we embed and expand the Mental Health Support Teams in Berkshire West

More children and young people with both emerging emotional health needs and diagnosable mental health condition are able to access evidence based services in a range of settings by embedding and expanding the Mental Health Support teams in Berkshire West and meeting the access target for next year.

What does this mean?	There will be 3 Mental Health Support Teams in Berkshire West, one operating within each Local Authority area. Each multi-disciplinary team will offer consultation and training to schools, direct interventions for children, young people and families and a multi-agency triage system
What will we do next?	Reading and West Berkshire teams will go live with a full service offer from January 2020. Wokingham will mobilise its team over the next 9 months, training and recruiting its staff and go live as a full service offer September 2020. The CCG will bid for 3 more teams at the next anticipated round of funding in Summer 2020.
What will success look like?	3 MHST teams fully operational, KPIs' from Reading and West Berks –access, CYP feedback and outcomes A further successful NHS E bid to set up 3 more teams in Berkshire West in 20/21. BW will be on track to meet the 35% access target for 20/21.

Other work that is linked to this priority

- Reading and West Berkshire continue to roll our trauma informed schools programme to reduce exclusions and Wokingham are also exploring commissioning this training. Local roll out of Restorative practise training sponsored by the NHS continues through our LA partners across frontline and senior leaders.
- The CCG commissioned business as usual commissioned work continues across the specialist and non-specialist CAMHs service offer. This will be monitored and reviewed through the usual reporting mechanism with quality improvement work expected across all partners.

Priority 2 – continue to focus on meeting the emotional and mental health needs of the most vulnerable CYP

Agencies work more closely together so that vulnerable children can access the help that they need easily, starting with improving outcomes for Children in Care (CiC).

What does this mean?	West Berkshire Local Authority will finish the pilot CiC mental health project and report outcomes. The CCG will lead a process of review and actions to improve our current LA and Health arrangements to meet the emotional and mental health needs of CiC.
What will we do next?	Implement and monitor the pilot CiC emotional/ mental health project that is testing new ways to assess the needs of children as they enter care. This pilot will provide local and national learning and recommendations that will form the basis of an action plan for all 3 Local Authorities to implement into 20/21. Facilitate a joint CCG, Local Authority and Provider leader's workshop that will seek alternative delivery models and solutions to improve outcomes for CiC Emotional/ Mental Health outcomes. Agree a set of agreed actions, visit places with alternative offers to CiC that adds pace to improve or alter our arrangements and offers that will be put in place and monitored over the next year between partners.
What will success look like?	Ideally new joint commissioning arrangements will be identified and changes begun to establish clear local arrangements. More local choices of therapeutic support and interventions available Arrangement will include an integrated offer of physical and mental health alongside the social care role that leads on the care for CiC.

Other work that is linked to this priority

- Health and Justice regional work on the setting up of the Liaison and Diversion offer through BHFT will support the local work of the Health resource placed in our 3 Youth Offending Teams. In addition the review of SARCs paediatric offer will be important to monitor. BW CH is planned in the next 6 months to work with the regional Forensic CAMHs team to identify any case learning and gaps i
- Regional work through the New Models of care continues through the leadership of the Oxford Mental Health Trust, with our local provider BHFT heavily involved. The Lead Provider for the Thames Valley CAMHS Tier 4 Provider Collaborative is Oxford Health Foundation NHS Trust and it anticipates becoming the Responsible Commissioner for CAMHS Tier 4 mental health services, including for people with Learning disabilities and / or autism, by April 2020. During 2020 NHS E/I South East and South West Regions will review and update the South Region (SE and SW) CAMHS Bed Capacity Plan led by Clinicians via Task and Finish Groups and in partnership with Provider Collaborative, ensuring that the balance of specialist and general beds is appropriate to need.

Priority 3: Continue to build a 24/7 Urgent care/ Crisis support offer for Children and Young People (CYP)

As children and young people's needs escalate into crisis good quality care will be available quickly and will be delivered in a safe place. After the crisis the child or young person will be supported to recover in the least restrictive environment possible. We will prioritise the implementation of the High Impact User (HiU) project objectives, ensuring that support for CYP in a crisis is available every day, whenever that is needed.

What does this mean?

BW CCG will finish the mental health crisis review that is seeking to:

- Hear and appreciate the views of a wide range of stakeholders to understand the effectiveness of mental health crisis services.
- Identify opportunities to streamline and improve services and processes to better support and respond to needs;
- Identify gaps in service provision and seek solutions to these, for example an pre/alternative crisis offer
- Enable the CCG and partners to meet the NHS Long Term plan transformation goals

The partnership will implement the 3 key findings of the HiU project, which are:

1. The CCG with the 3 Local Authority Children's Services to jointly commission a Health/ Social Care/ Early Help rapid response service based at the hospital as well as a single pot for spot purchasing preventative services at home/ in community.
2. Health providers with support from partners to write a single discharge planning guidance and a standard operating procedure that is then available online.
3. Berkshire Healthcare Foundation Trust (BHFT) to organise a regular review of all tier 4 patients with partners to ensure discharge planning is coordinated

Additional CYP specific staff will be included in the liaison service at the acute hospital (RBH) that compliments the Rapid Response service opening hours covering CYP and adolescent needs when Rapid Response service is not available. Training to become trauma information in the local accident and emergency and ward settings.

What will we do next?

The Mental Health Crisis review will bring recommendations to the Mental Health and Learning Disabilities Integrated Care Partnership Programme Board in February 2020.

A specific working group will be set up to put action and pace behind the 3 HiU recommendations

BHFT will recruit 1 new staff member by Jan 2020 to join the Psychiatry Liaison service at the local hospital.

What will success look like?

Progress towards comprehensive coverage of 24/7 crisis provision for CYP which combines crisis assessment, brief response and intensive home treatment functions

- Linked to New Models of care work (see above)

Priority 4: Continue to build a timely and responsive Eating Disorder offer

More children and young people with a diagnosable eating disorder (mental health condition) are able to access evidence based services in a range of settings and in a timely way, meeting the national standard.

What does this mean?

The current Berkshire Healthcare Foundation Trust (BHFT) service will be fully recruited and all Children and Young People who are urgent cases will start service intervention with 5 working days and routine cases will start within 20 working days.
In addition Berkshire West will review the need for additional resource required into the service to enable a home visiting / intensive support element to be included in the service offer.

What will we do next?

BHFT will continue to recruit staff into the service. CCG will regularly monitor the mobilisation phase of the service alongside the impact on performance/ access targets up to the end FY 19/20 – Considerations for a wider range of skills mix to meet the recruitment/workforce demands
The CCG will review the evidence and need for a hone visiting and intensive support offer in light of the need, impact on RBFT and pilot in Berkshire East.

- Better liaison between BEDS and GPs as they have a shared protocol in place- the pilot scheme to include this.
- Improving the communication with schools/educational partners when discharge care planning happens to ensure the CYP continues meeting their educational needs & continue the part time integration back into schools.

Ensuring there is support available as the impact affects family units and others.

What will success look like?

Fewer children and young people's needs escalate into crisis due to their Eating Disorder – access targets reached.
Those young people that need a hospital stay for their Eating Disorder will get this regionally or even locally through the New Models of Care and their length of stay is appropriate and as short as possible.

Other work linked to this priority

- Linked to New Models of care work (see above)

Priority 5: Improve the Waiting times & Access to support, with particular this year on access to ASD/ ADHD assessments and support.

More children and young people with both an emerging emotional health needs and diagnosable mental health condition are able to access evidence based services.
We need to tackle growing waiting times, in particular within the ASD and ADHD pathways for assessments.

What does this mean?	We will meet our growth target for 19/20, with 34% of CYP accessing support. More organisations will be flowing data to ensure that this is evidenced. We will lay the foundations for meeting the 20/21 access target of 35% by agreeing a way forward for all organisations to flow data. LA and Health offers and approach will be defined as needs led vs diagnosis led. This will enable providers to work towards a graduated response to need within all settings, supporting families and their child's needs rather than relying too heavily on a medical style diagnosis.
What will we do next?	4 organisations will be regularly flowing data onto MHSDS An agreed course of action for the 3 youth counselling organisations to flow data onto MHSDS Following an internal Quality Improvement review of the autism assessment service, BHFT have made changes to the pathway for children and young people. Eeg. administrative processes have been reviewed and streamlined Joint ADHD and ASD assessments clinics. This work on the current pathway will continue. A Shared care protocol for ADHD medication prescribing with Primary Care will be established and used. Following a successful trial of online autism assessments for children a procurement exercise is underway so that this becomes business as usual. This will provide an opportunity to increase capacity to carry out autism assessments using the online provider which will help to reduce the backlog.
What will success look like?	CYP receive the right services at the right time Meeting the 34% access target and ground work set to meet the 35% target. Improving the waiting time in both ASD and ADHD pathways for assessment – our actions will impact waiting times, but it is noted without a radical course of action the waiting times will continue to increase but not as quickly as previously.

Priority 6: To improve the Equalities, Diversity and Inclusion offer and access for Children and Young People in Berkshire West

With more children and young people with both an emerging emotional health needs and diagnosable mental health condition accessing evidence based services the LTP must ensure that this access and help is inclusive of children and young people from across the protected groups.

What does this mean?

Starting this next year, there will be a focus on the protected groups of LGBTQ and Disabled CYP seeking to ensure there is appropriate and good access to the range of help they need.

What will we do next?

Set up a work-stream to look at access for disabled children to support their emotional and mental health needs.
Start a conversation with LGBTQ advocacy groups, seeking to both understand and co-produce solutions to areas of concern.
These two pieces of work will

- seek evidence by collecting the data from CYP Services to understand the specific needs
- Understanding what the cultural norms, stigma related to the needs identified within CYP and the interpretation of problems within specialist groups
- Discuss 'Are we providing services that are accessible?' Engaging some of the leaders from different cultures to improve the access and how to address some the stigma with parents of CYP. Using some of the education for Parents (increased access to information and generational gaps- this could be through Parent workshops with MHST)

In addition this year we will seek to understand the access of BAME groups into service.

What will success look like?

Inclusion in all services evidenced, Cultural and language accessibility, Increase in access where relevant
Assurance that access is focused and responsive
Assurance that LD/ Disabled CYP accessing Specialist services. (check if this need to be targeted)

Priority 7: Building a Berkshire West 0 – 25 year old comprehensive mental health offer

Explore with CYP and Adult service how to ensure there is a comprehensive 0 – 25 year old that reaches across mental health services for CYP and Adults by 2021/22

What does this mean?	Over the next year partners will complete a needs assessment of the under 5's and 18 – 25 year old group and align this to what services are currently on offer within these age ranges (including the skill mix) and review the transition arrangements. This work will help inform next years (20/21) local commitments for improvement and change, that will build towards the Long term plan ambitions.
What will we do next?	Public health to complete a full assessment of under 5, 5 to 18 and 18 to 25 children young people/ adults emotional and mental health needs for Berkshire West residents. Review and update the work already completed by Public Health on the under 5's service offer to identify the offer and any gaps. Set up an adults and children's task and finish group/ work stream group to identify the range of services currently on offer for the 18 to 25 age range
What will success look like?	Our Future in Mind, Local Transformation Plan 2020/21 will include a strong action plan based on the needs and current offer strengths and gaps to ensure that by start of 2022 there is a comprehensive 0 – 25 year old offer.

Chapter 7 - A summary of current challenges, risks and mitigation

Any major service transformation has challenges. Over time risks may change, below are the headline risks and challenges currently experienced in Berkshire West.

a) Demand- there has been a significant increase in demand for services resulting in longer waiting times. Self-harm rates in young people are rising. Demand for Eating Disorder services outstrips the nationally modelled rate. We have seen an increase in complexity of young people in services. In addition there continues to be increased public expectation of the NHS and from the NICE guidance to include service offers (for example new guidance on treating Avoidant Restrictive Food Intake Disorder into the eating disorder offer).
b) Workforce- Availability of suitable skilled, qualified and experienced health workforce. There are recruitment and retention challenges for many parts of the wider children's workforce e.g. social care. The cost of living is high in Berkshire West.
c) Infrastructure- Availability of suitable inpatient beds close to home. Lack of local inpatient beds for young people with Eating Disorders.
d) Finance - Financial pressures across the system as demand continue to grow requiring increased investment within a tight fiscal arrangement for Berkshire West.
e) Data- Flowing data onto the national MHSDS data set involves multiple providers with differing IT systems and data governance arrangements
f) System arrangements - The complexity of the Berkshire West system adds a level of challenge.
    a. The number of different Local Authorities and agencies involved in providing mental health care across Berkshire West means there is a risk of alternative access points, emerging gaps between services and a need for extensive partnership work and communication that is time consuming for staff in all agencies.
    b. The emerging new Integrated Care System, of Buckinghamshire, Oxfordshire and Berks West footprint will create new commissioning arrangements that will require additional capacity in the next year of this ICS forming. It may add confusion and take capacity away from transformation work.
    c. Some organisations and individuals are more open to change than others. Schools, GPs in particular have competing demands on their time so while there may be a desire and recognition to change, external factors prevent change from happening at the pace required.

It is important to begin a process of agreeing the right controls and mitigating actions against risks/ challenges. These areouttlined in the table on the next page. This is reviewed by partners regularly for their impact.

Risks and challenges	Mitigating actions
Workforce - Inability to recruit / retain sufficient staff with experience required to undertake the work. Risk associated with removal of backfill funding for CYP IAPT training from NHSE. Risk associated with changes to national training requirements for youth counsellors	Our specialist CAMH service is trialling new skill mix when appropriate – learning from other specialist CAMHs services where possible. A specific review of neurodevelopment services seeking ways to streamline. Pilot of using third party organisations to provide online/ remote assessments Membership of local CYP IAPT collaborative- prospective staff find this attractive, existing staff from health and local partners are encouraged and supported to undertake additional training. BHFT have provided clinical supervision for IAPT trainees. There is no longer central funding so this is now a risk. Recruitment, retention and training of Educational Mental Health Workers in partnership with Uni of Reading for each Local Authority PPEPCare and Mental Health First Aid Training for staff – focus on Children's services and primary Care and voluntary sector. Supervision training for MHST and assuring other providers arrangements in place for practitioners, not just trainees. Providers held to account when projects/ milestones delayed- recovery plans required and monitored via the contract process Commissioners & Providers are working with commissioners and Health Education England to model the future skill mix and staffing numbers required to deliver the required changes to deliver Future In Mind Recruitment and retention initiatives are in place. Train, recruit, retain.
Complexity of the local system	The emerging Berkshire West ICP governance structure and plan to establish an ICP Children's Board The three Health and Wellbeing Boards review the Local Transformation Plan annually. Children's Service Director level sponsorship in this process. Improving emotional health and wellbeing in CYP is a multiagency priority for ISP Children's work-stream as well the new BW Safeguarding arrangements and therefore being championed by system leaders. Reported on regularly through these governance structures.
Risk that the increase in crisis/urgent care presentations continues to be the norm and to be higher than the current capacity. Risk of:	Investment in whole system training and working to enable earlier intervention and crisis prevention including on self-harm. Implement the investment in the PMS team for CYP Implement the HiU project recommendations.

• 4 hour breaches attributable to CAMHs • Increase in avoidable incidents in hospital setting	
Number of CYP needing support from the CAMHS Eating Disorders Service exceeding service capacity, with an increase in acuity of cases and higher numbers requiring inpatient care and/or Tier 4 admission	Implement the investment into Eating Disorder services. Review need for a home visiting/ intensive service offer
Financial- insufficient funds to cover all required investments	CCGs and partners working collaboratively across Berkshire/STP / ICS to identify opportunities for economies of scale. CCGs and partners proactively bidding for grants and resources – both regionally and locally We are working with partners at the Early Help stage to reduce the number of cases that require a specialist CAMHs response. The evidence base for the economics of low intensity versus high intensity evidence based interventions is well established. CCG with BHFT to review the LT plan transformation priorities and investment potentials to plan where to target any Mental Health Investment standard resource over the next 5 years.
Poor quality of referrals resulting in delays in the child accessing the right help at the right time	Training for referrers (from?) Regular communication updates to referrers. Proactive outreach by providers to referrers Updated referral guidelines and forms put on DXS. Triage systems set up in each LA to begin to improve the flow of work into Specialist CAMHs
Submissions to MHMDS do not capture non NHS delivered treatment resulting in our cover data being reported as lower than the reality	Complete the recovery plan Agree a course of action for youth counselling to flow data.
Impact of longer waiting times	All referrals are risk assessed and managed Help while waiting is offered via face to face, written, telephone and online resources. Partner organisations are commissioned to provide help to families, particularly those pre and post autism or ADHD assessment.

Chapter 8 - Governance and Quality Assurance.

The Future in Mind Delivery Group meets monthly to consider, challenge and champion the changes as well as oversee this LTP refresh document. The Future in Mind group is chaired by the Director of Joint Commissioning NHS Berkshire West CCG and reports into the Berkshire West MH and LD ICP programme board. Our new ICP governance structure which is outlined in the diagram on the next page, was launched in July 2019. The current STP will becomea new Integrated Care System (ISC) on the STP footprint of Buckinghamshire, Oxfordshire and Berks West (BOB). This will further strengthen working with other systems, providing opportunities to see where improvement and transformation can be delivered at an ICS level (BoB) or remain at place level (Berkshire West).

The local transformation plan is signed off by the three respective Health and Wellbeing Board's in our Berkshire West area. Progress is overseen by the Health and Wellbeing Boards at least annually.

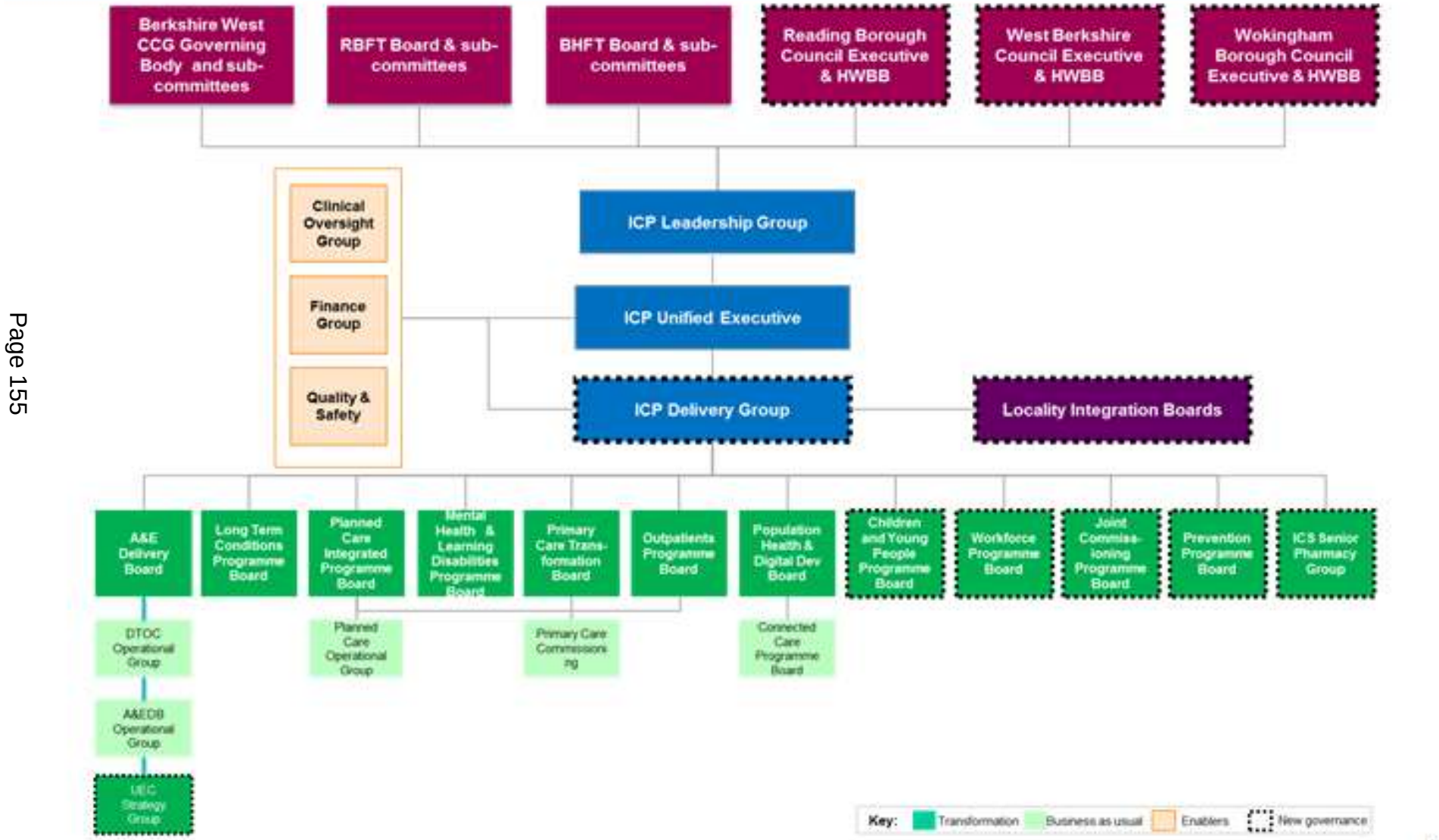
Each Local Authority has CYP partnership groups where Future In Mind initiatives are integrated into other work streams. For example the Children's Delivery Group in West Berkshire, Berkshire West SEND Joint Implementation Group.

Berkshire West's new partnership safeguarding arrangements have been updated in relation to the LTP and consulted on the priorities. Emotional Health and Wellbeing will be one of their priority action areas in the coming years.

The CCG will continue to coordinate the place (BW) level of assurance through the ICP governance process for the coming year whilst the ICS arrangements take shape (see page 30). This primarily will be through the Future in Mind group, where we intend to:

- Create work-streams to focus on the 7 priorities in the LTP
- 4 times a year review the risks and mitigating actions and check in with CYP groups about our progress
- Annually review the provider level achievements and challenges

Place: Berkshire West ICP - Governance



Integrated Care System (ICS) emergence – Oct 2019 position.

BOB (Buckinghamshire, Oxfordshire and Berkshire West) ICS is one of the four largest 'non metropolitan' ICSs in England – each health and care place are larger than some ICSs elsewhere. As part of our journey to becoming a 3rd wave ICS we have strengthened our governance arrangements, including a Delivery Oversight Group that include county place leads. Our challenges drive the requirements for integration of health and social care across BOB ICS to improve care and quality, reduce variation and outcomes for our population and accelerate transformation across the system.

The Buckinghamshire, Oxfordshire and Berkshire West ICS comprises a large number of NHS Trusts, Clinical Commissioning Groups, and Local Authorities as well as federations and Health & Wellbeing Boards. 2019/20 is an important transition year for the Buckinghamshire, Oxfordshire and Berkshire West (BOB) as it develops following the decision to become a 3rd wave ICS. A number of work streams have already formed including Mental Health, which has included the transformation work for Children and Young People's mental health and wellbeing within their remit. This is positive as the children's work stream emerges over the next 12 months.

Chapter 9 - Overview of commissioned work delivered in 2018/19 and outcomes achieved

Our last refreshed Local Transformation Plan in 2018 provided extensive narrative on our reasons for putting certain initiatives in place. The table below provides an update on where we are now and the impact and outcomes to date. While the table describes actions and organisations as separate entities for the sake of document presentation, in reality there is a whole system multiagency thread running through activities which is the hallmark of our transformational work in Berkshire West.

Thriving - Getting advice Signposting, self-management and one off contact. Thriving is supported by prevention, mental health promotion, awareness raising work and early help in the community.	
Where we are now	**Impact and Outcomes**
Building resilience in young people underpins the work we are undertaking in schools, communities and on line. This includes #littlebluebookofsunshine, School Link projects in Reading and Wokingham, the Emotional Health Academy in West Berkshire as well as the work of the voluntary sector.	It is difficult to measure specific outcomes for this work. We are working with organisations such as the Charlie Waller Memorial Trust and the University of Reading to get better at this. Two secondary schools in Reading were designated Mental Health Hubs and will be trialling a range of screening and whole school measurements of emotional and mental health. This will allow for measurements of resilience, interventions over the year, and provide longitudinal data.
Public Health West Berkshire: The Health and Wellbeing in Schools Programme Learning Well for 2018/19 now has two components.	Programme continued in 18/19 through Public Health. The first component is the universal offer which is free to all state maintained/Academy Schools in West Berkshire. The second component is the West Berkshire Wellbeing Learning Well traded offer to all school including independent schools within and outside of West Berkshire. The programme has been designed based on the Public Health and Wellbeing priorities – reducing the consumption of Alcohol, Reducing the prevalence of self-harm; supporting CYP's to maintain healthy weight.
#littlebluebookofsunshine continues to be promoted and circulated. The resource was designed and developed by young people and partners in Berkshire West.	Developers have received positive feedback and continued demand for the booklets.

Where we are now	Impact and Outcomes
PPEPCare training modules are offered across the system The emphasis was originally on training schools, the voluntary sector and primary care. This is now shifting to social care, health and justice workers and wider partners. Mental health first aid training is also available	During 2018/19, 1466 individuals received PPEPCare training in West Berkshire across 76 sessions. Delivery by geographical area is indicated below: • 491 professionals trained from Reading Borough Council • 321 professionals trained from Wokingham • 213 professionals trained from West Berkshire • An additional 441 individuals were trained from a mixed geographical area In addition to this, two main Train the Trainer programmes were run in 2018/19, enabling a further 42 individuals to deliver general PPEPCare training, and additional Train the Trainer events were run in January 2019 training a further 13 individuals to deliver the two ASD modules. Participants indicated that they regularly saw children with mental health difficulties relating to the training they attended. However, only around 37% of those attending a training session indicated having received prior training in mental health in children and/or young people, and this was not always in the area being trained through PPEPCare. As can be seen from Table 2, the most frequent training (in terms of *numbers* of individuals trained) included supporting young people (and children) with anxiety, supporting children and young people with ASD and supporting young people who self-harm. Table 2 Delivery of training modules across 2018/19

Training module	Number of individuals trained (number of sessions in parentheses)				Total
	Q1	Q2	Q3	Q4	
Overview of mental health difficulties					
Supporting young people with depression and low mood	13 (1)	21 (1)	53 (2)	39 (4)	126 (8)
Supporting young people with anxiety	38 (1)	49 (3)	40 (2)	132 (4)	259 (10)
Supporting young people who self-harm	51 (2)	139 (4)	29 (1)	41 (4)	260 (11)
Supporting young people with eating disorders	48 (1)	20 (1)	43 (3)	24 (3)	135 (8)
Supporting children with anxiety	38 (1)		21 (2)	26 (2)	85 (5)

Supporting children with behavioural difficulties		15 (1)	33 (2)	25 (2)	73 (5)
Supporting young people with OCD		12 (1)		8 (1)	20 (2)
Promoting resilience		36 (2)	44 (2)	89 (5)	169 (9)
Supporting children and young people with ASD	154 (3)	48 (3)	31 (3)	67 (7)	300 (16)
Supporting children and young people with PTSD		12 (1)			12 (1)
Supporting children and young people with specific phobia		27 (1)			27 (1)
Follow up session and/or other training					
Total	342 (9)	367 (18)	306 (17)	451 (32)	1466 (76)

Impact of training (self-ratings)

- Over all workshops, comprehensiveness of knowledge ratings increased from 4.96 (out of 10) to 7.71 (out of 10).
- Confidence to talk to a young person about their mental health difficulties ratings increased from 5.58 (out of 10) to 7.82 (out of 10).
- Having the necessary skills to support young people with mental health difficulties ratings increased from 4.67 (out of 10) to 7.89 (out of 10).

Extent to which the session addressed current concerns or worries

Mean rating of the extent to which sessions addressed prior concerns or worries was 7.89 (out of 10).

Evaluation of training

Each index was rated out of 5 – higher scores are indicative of greater satisfaction etc

- Satisfaction with training: 4.39
- Usefulness of training: 4.44
- Quantity of practical information: 4.24
- Pitched at correct level: 4.33
- Training has increased confidence in knowledge and skills: 4.27
- Plans to use knowledge in the future: 4.44

99.2% of those who responded indicated that they would recommend the training to a colleague.

Selection of qualitative comments:

- *An excellent refresher of Autism, particularly if someone needs to see things from a young person's point of view.*

	• *Seeing things so clearly from a young person's point of view was fantastic.* • *Useful in and out of school – both professionally and as a parent* • *A great combination of up to date research and clinical experience* • *Excellent delivery – trainer was a committed professional – well done* • *Really great training session* • *I didn't have a huge amount of confidence really – now I feel like I could initiate a conversation* • *It's made me think more about how I can put the child at the centre of everything that we do* • I've definitely got a better understanding and knowledge now
Where we are now	**Impact and Outcomes**
Supporting children, young people and families with neurodevelopmental needs- Autism Berkshire and Parenting Special Children These voluntary sector partners work together with specialist CAMHs and community partners to provide a range of help for families while they are waiting for assessment and/or with a diagnosis of autism and/or ADHD as part of the care pathway. Services include home visits, telephone helpline, family support groups, workshops for families and	**Parenting Special Children have delivered a number of workshops:** • 49 x 2 hour Pre and Post Assessment Workshops • 27 x ADHD pre and post assessment workshops, including: • Introduction to ADHD; ADHD & Anxiety and ADHD & Behaviour • 21 x Autism pre and post assessment workshops, including: • Introduction to Autism, Anxiety & Autism, Behaviour & Autism • 1 x Autism and ADHD Workshop 628 (includes repeat users) parent/carers attended workshops, 180 parent/carers attending two or three workshops. On average 75% of parent/carers access more than one service with the charity, which could include sleep interventions, conferences, family events. At least 25% of attendees are dads **Impact:** All parent/carers completed pre and post evaluation forms for all workshops measure the following: • Knowledge of Autism, ADHD • The links between diagnosis and behaviour • Strategies to help with behaviours Parent/carers indicated an average 4 point increase (one a scale of 1-10) when comparing their knowledge on the link between diagnosis and anxiety before and after the workshops. Feedback also showed that parent/carers gained more strategies to help with their child's anxiety. This was particularly relevant to parent/carers of children and young people pre and post ADHD diagnosis where anxiety wasn't always recognised. Parent/carers indicated an average 3 point increase (on a scale of 1-10) when comparing their understanding

young people, a sleep service, training and on-line support	of autism, how it affects their child's behaviour and strategies to help with behaviour. 99% of attendees would recommend Parenting Special Children to friends and family. **Feedback** • *"I have written 18 different and inspiring ideas from today's session. I feel fully motivated and* • *ready to improve many things, very empowering."(dad, Behaviour & Autism workshop)* • *"Very helpful in teaching me a new approach. The use of examples was so re-enforcing" (Dad, Behaviour & Autism workshop)* • *"I can be part of the anxiety and can help reduce it in my children by better managing my own" (Dad, Anxiety & Autism workshop)* • *"Fantastic information, feel much more confident" (mum, Introduction to Autism)* • *"Our family situation is so different now. I look at where we were before and I can't believe it is the same child. It is so positive, a complete turnaround"* • *"We understand our son better and we feel this has helped bring us all closer together and relate more to one another, making us a happier family"* • *"The workshops were massively helpful and helped me to cope. It set us on the right path to help our son"* • *"I have just finished 3 ADHD workshops and it has given me so much information and other sources of information. They were really informative and I now know that I have to parent totally differently and give him time to process things." (mum, ADHD workshops)*
	Autism Berkshire Autism Berkshire successfully delivered a number of group and individual sessions to parents and carers. We supported families that are waiting for or when they have a diagnosis by the services outlined below. We offer our highly valued **Home Visiting service** to families. We delivered 24 home visits, one less than target of 25. This outreach service targets hard to reach families, particularly those identified as of concern by BHFT. **Weekly drop in service** in Reading on a Tuesday from 10.30am to 1.30pm during term time. This enabled parents and carers to get face to face advice from one of our home visit workers, and to meet other families going through the same experience each week during term time. Our offices are based near Reading train station and Broad Street, so is easily accessible by train, bus, or car. We delivered 39 sessions with 123 attendances from 91 individuals. **NAS Seminars** are divided into 3 parts which can be delivered over a school day from 9.30 to 2.30, (5 hours). The seminars are delivered by the Home visit workers, so that there is continuity for families who have had a home visit or visited the Drop in sessions. • Understanding Autism, covers what Autism and Asperger's is, Strengths and Difficulties, Signposting to support.

- Sensory Needs, looking at sensory systems and how they work, how people with Autism may process sensory information differently, how children with Autism may have different sensory experiences, and strategies to help with sensory needs.
- Managing Anger, looking at distressed behaviour and meltdowns in children with Autism, how behaviour is communication, how to cope and how to help children to understand and communicate feelings.

We aimed to deliver 2 sets of the three seminars in Thatcham, Reading and Wokingham; 18 workshops in total. We aim to have 8 parents or carers per workshop.
Total attendance over 12 months 148 parents or carers, an average of 8.22 attendees per course.
Workshops are 5 hours long so this resulted in 740 hours of support for parents and carers.

Impact:
We scored each workshop and the averages fell in the ranges below. Where we identified particular parents who were struggling (typically a score of 3 or below), we followed up with a home visit or a recommendation to come to Drop In so we could support them further.

No.	Question	Average low	Average high
1	I have enjoyed attending the workshop	4	5
2	I feel my understanding of autism has increased	3.71	5
3	I feel that I have gained information to help me/ my child	4	4.625
4	I feel that I now have greater awareness of where to source additional support	3.71	4.5
5	I feel more confident in my ability to meet my child's needs	3.85	4.625
6	I feel the information was at the right level for me	4.14	4.8
7	I would recommend this seminar to other parents	4.29	5

We feel that the questionnaires show that we have met our outcomes of

- Strengthened and more resilient families
- Informed parent and carers that reduces anxiety and stress
- Family and child accessing support to manage/ cope with Autism

Comments from the workshops included:

- Great course, content was great and networking with other people with children with autism was priceless!
- Great course, has been a real eye opener.

	• Very friendly + helpful, knowledgeable staff • Lots of information which was so valuable • Very useful information (sources) focused, lots of practical suggestions + solutions provided based on own life experiences! • This course has been really informative and enjoyable

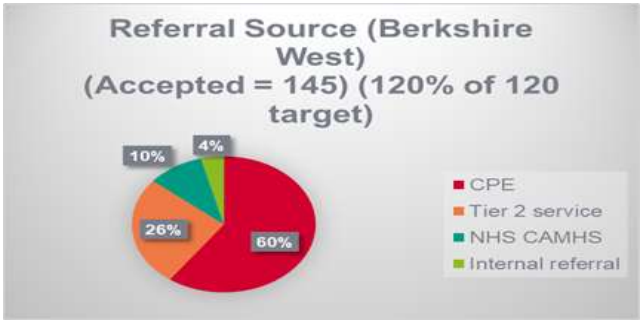
Thriving - Getting help. Goals focussed, evidence informed and outcomes focussed intervention. Improved step up/ step down arrangements.

Where we are now	Impact and Outcomes
Youth Counselling : 3 Youth counselling organisations operating in the three Local Authority areas. 2 of the 3 are cofounded with our LA partners. They continue to provide a self-referral as well as professional referral service. Each report against the same outcomes framework overseen by the Future In Mind group.	The youth counselling organisations report an increase in the number of counsellors employed and the number of sites where services are available. The number of children seen by youth counselling organisations continues to increase. Youth counselling organisations are part of the multiagency emotional health triage in West Berkshire. We plan to extend this model across Berkshire West Regular meetings between the youth counselling organisations, and specialist CAMHs to improve step up/ step down arrangements We have counsellors who are experienced and trained in working with CYP who have hearing difficulties, CYP on the autistic spectrum and those with mild Learning Difficulties. Organisations work closely with LA partners to facilitate engagement with Looked After Children. The activity for the financial year 18/19 has been broken down by Agency: **Referrals:** ARC / NO 5 / T2TWB / TOTAL NUMBERS REFERRED: 950 / 469 / 590 / 2009 % INCREASE ON LAST YEAR: 12% / 65% / 27% / % REFERRED BY GP'S: 20% / 52% / 37% / **Activity:** ARC / NO. 5 / T2TWB / TOTAL NUMBERS SEEN: 850 / 843 / 464 / 2157 SESSIONS DELIVERED: 4600 / 3604 / 4471 / 12675 WAIT TIME FOR ASSESSMENT: n/a / 15 weeks / 2.1 weeks / N/A WAIT TIME FOR SESSIONS: 2-10 weeks / 13.6 weeks / 6-8 weeks / N/A **Outcomes:**

	ARC	NO. 5	T2TWB
% that agree with statement; "Did you feel listened to?	95.5%		
% that agree with statement; "I would recommend counselling to my family & friends"	90%	73%	92%
Other summary points from outcomes measures	50.75% improvement in symptoms & 46.86% improvement in Emotional Wellbeing	41% improvement in symptoms & 52% improvement in Emotional Wellbeing	Average reduction in CORE score = 6.9, (total CORE is measured out of 40). Average reduction in severity of top presenting issue = 1.4/4

Service User Feedback:

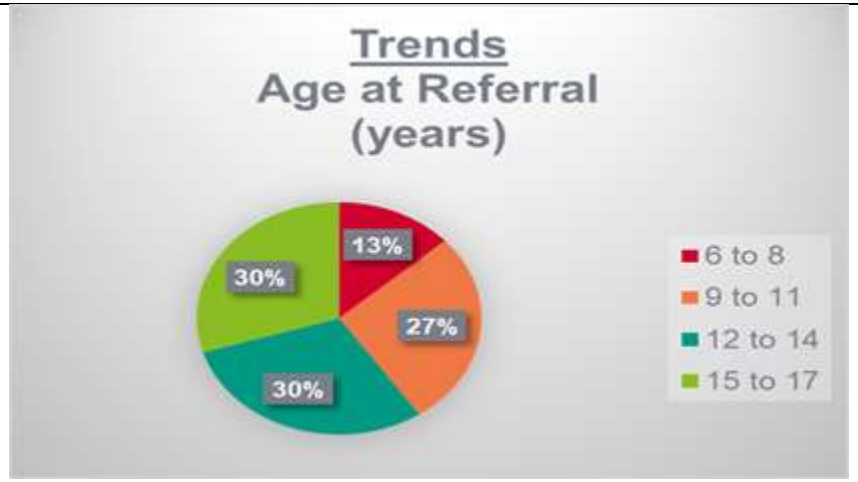
- *I feel less isolated and am comfortable with myself*
- *My thought processes have changed making it easier to manage anxiety*
- *I was able to talk and didn't feel judged*
- *I have a better attitude towards myself*
- *I haven't had any more thoughts about killing myself since counselling*
- *I could be myself; I could show all the emotions I've been hiding.*

Where we are now	Impact and Outcomes
AnDY Clinic - The Anxiety and Depression in Young People (AnDY) Research Clinic at the University of Reading delivers brief, evidence-based psychological interventions, in line with NICE guidance and the THRIVE model. The clinic is led by experienced Clinical Psychologists whose posts are funded by the University (1.4 FTE). Most	The AnDY Clinic accepted a total of 231 referrals in 2018/19 (145 from West Berks). The outcomes of the referrals is illustrated below:  The majority of referrals came from Common Point of Entry (CPE) followed by the tier 2 service.

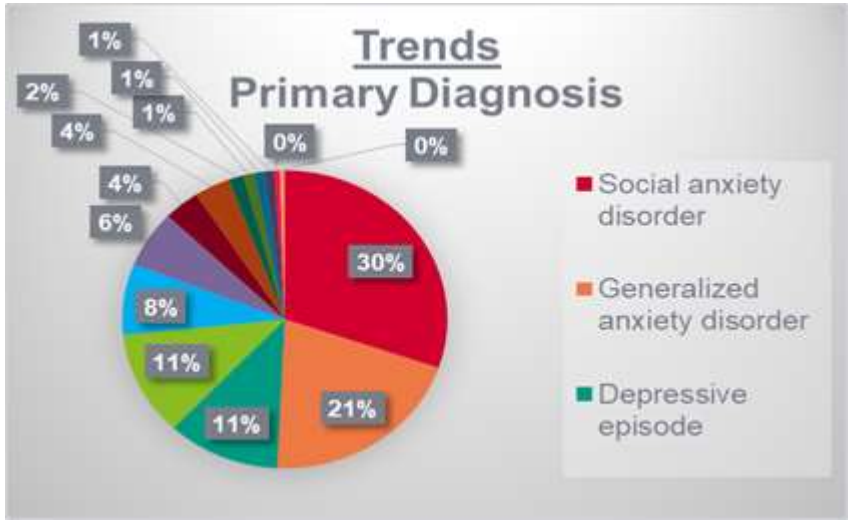
clinical work, however, is carried out by Children's Wellbeing Practitioners (CWPs) recruited and trained as part of the national CWP programme established to meet the target for offering an evidence-based intervention to 70,000 more children and young people annually by 2020. The clinic has been operating since December 2016 and delivered commissioned services for part of 17/18 by way of a trial.

The AnDY clinic provides

1. Comprehensive psychological assessments to understand difficulties and identify suitable treatment options.
2. Brief, evidence-based psychological treatment for anxiety disorders and depression (when indicated). Interventions include:
a. CBT-informed guided self-help for parents of children up to 12 years with anxiety disorders

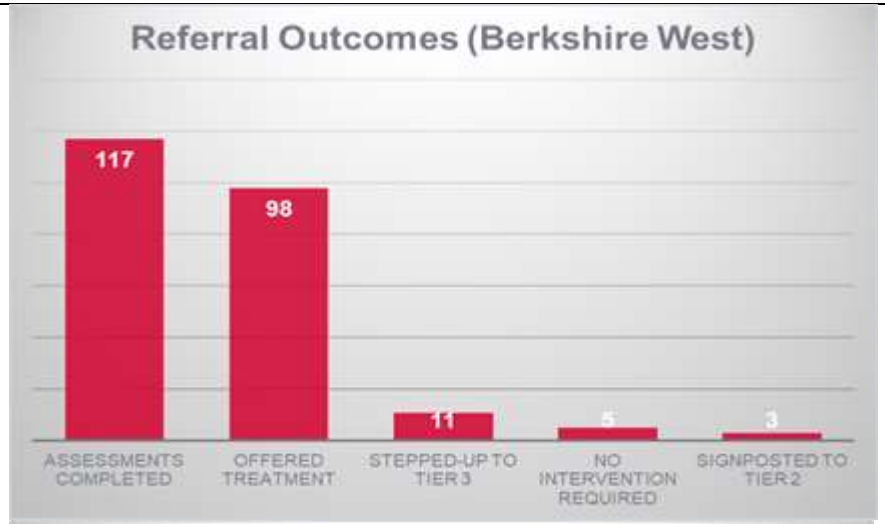


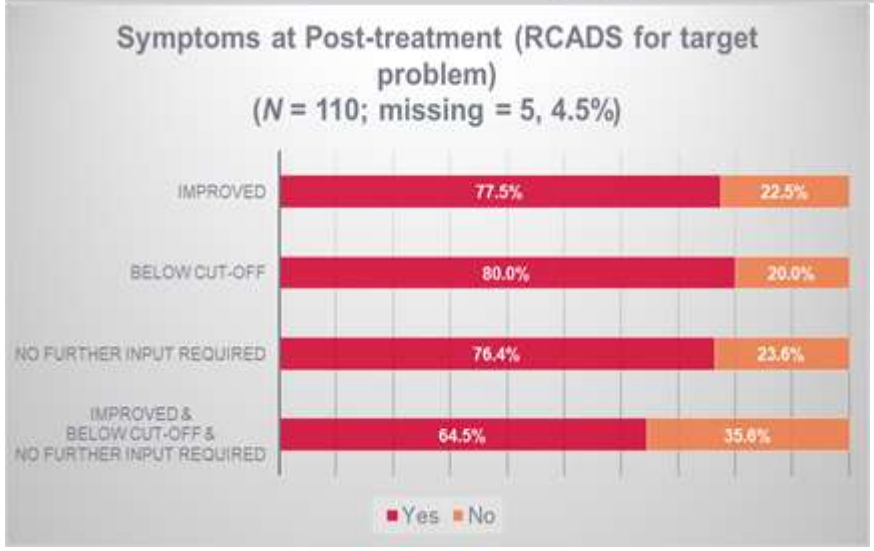
The referral age groups were split 60% secondary school age and 40% primary school age.



The most common primary presenting issue was social anxiety disorder closely followed by generalised anxiety.

b. Individual CBT for adolescents with anxiety disorders
e. Brief Behavioural Activation for adolescents with depression
f. Support for carers and families through online learning and CBT-informed workshops



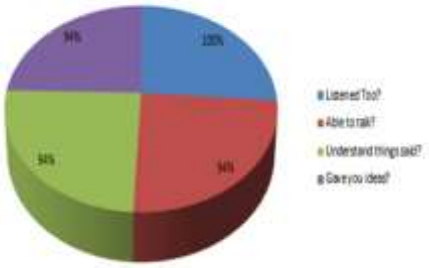


The majority of cases (84%) who completed an assessment were suitable for and received treatment at the AnDY clinic, with just a small number being stepped up or stepped down.
The majority of patients showed a marked improvement in symptoms related to their primary problem from pre- to post-treatment, with symptoms measured using the Revised Children's Anxiety and Depression Scale (RCADS). The

Page 168	majority of patients also showed marked improvement in functioning (measured using the Outcome Rating Scale) and significant progress towards goals (measured using the Goal Based Outcomes tool).
	
	Highlights and Achievements
	• Over 2018-19 (our first year of funding from West and East Berks CCGs), we conducted 117 initial assessments of C/YP and their parents (98% of target n=120) and offered/started treatment with 96 C/YP (88% of target n=108). Three quarters of C/YP were 'improved' at the end of treatment, only 15% required stepping up for further treatment and over 90% of C/YP and parents had high levels of satisfaction with the service. This was despite having around 75% of the clinician resource set out in the bid document (see later section on resource).
	• We successfully set up systems to report clinic data to NHS Digital via the MHSDS Cloud and will submit April (refresh) and May (primary) data on or before the June 20th Deadline. From this point forward, we will submit data on a monthly basis in accordance with guidance from NHS Digital received via the CCG.
	• We trained 6 CWPs in the clinic (and successfully recruited them all to work in the clinic following training) and are currently hosting 3 CWP trainees.
	• We continued to work with young people with lived experience of anxiety/depression and parents/carers of young people with anxiety/depression through our Friends of AnDY Group (previously AnDY RAG) in order to advise on research and service development.
	• We recruited 100% of C/YP into clinically relevant research (although research participation is optional) to allow us to improve the understanding and treatment of C/YP with anxiety disorders, with the aim of increasing access to evidence based treatments and improving outcomes.
	• Service Satisfaction Ratings (collected using the Experience of Service Questionnaire developed by the Health Care Commission):
	  ○ C/YP - 89% gave satisfaction ratings of 75% or above. (Mean = 90%)
	  ○ Parents - 97% gave satisfaction ratings of 75% or above. (Mean = 96%)

Where we are now	Impact and Outcomes
School Link Project Wokingham aims To train school staff in the PPEP care model. • To identify, train and support a key person per school to take a lead on emotional and mental health issues in school. • To hold regular joint consultation sessions on concerning children in identified schools. • To identify a clear model of school based stepped care interventions that School should be offering from their resources or in partnership with others. In addition Wokingham LA commission a Primary Mental Health service from Berkshire Healthcare Foundation Trust to provide a range of consultation, training, assessment and	**PPEP Care Training:** Approx. 20 schools applied to be part of the project following completion of an application form. 12 schools were successful. Training took place during school hours and within school "twilight sessions" A whole school approach was used and whole staff groups were trained in the following areas • Psychological Perspective in Education and Primary Care (PPEP Care) materials were used were possible and additional bespoke training packages were put together for school who wanted more specialist support. Areas of training have included: • Anxiety in Childhood • Anxiety in Adolescence • Overview of Common Mental Health Difficulties • Self Harm • Depression • Eating Disorders • ASD/ADHD • Resilience • Conflict and Behavioural Challenges  **Schools Link Wokingham Consultations** ▪ 84 young people were spoken about over the last 2years. (all CYP talked about anonymously)

interventions for referred CYP.	▪ Approx. 130 staff have attended consultation sessions. ▪ Approx. 80 hours of consultation have been delivered through the project To measure complexity and change the following questionnaires were used: o Teachers (self rated) Strengths and Difficulties Questionnaires (SDQ) o Session Rating Scale (SRS) o Staff confidence questionnaires were use. • SDQs were done at two time points; at the first consultation about the young person and then again at review following a period of time. • SRS and Staff confidence questionnaires were used with every staff member attending and for each young person discussed. The higher the score the more distress is reported.   Session Feedback Scales (CORC) used to gather consultation feedback from staff.



Wokingham Primary CAMHS

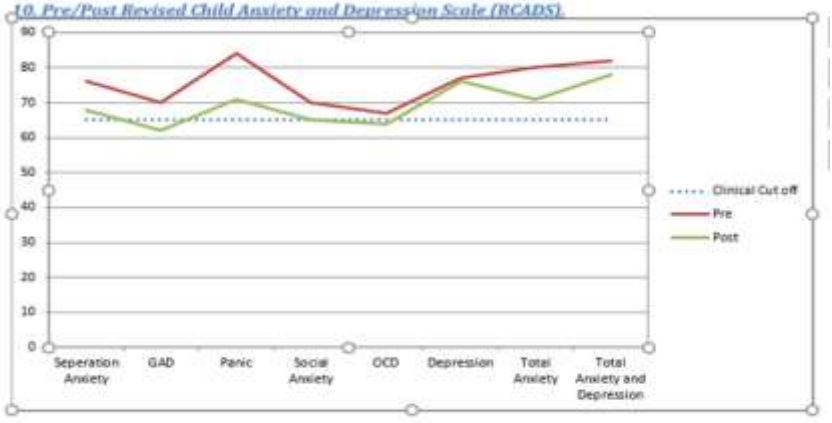
The Wokingham PCAMHs team received a total of 184 referrals for the financial year. All external waits remained under 0-6 weeks. Largest number of referrals were for: Anxiety inc. OCD, followed by issues relating to ASD/ADHD and Low Mood.

18/19 - 36% reduction in planned exit post treatment

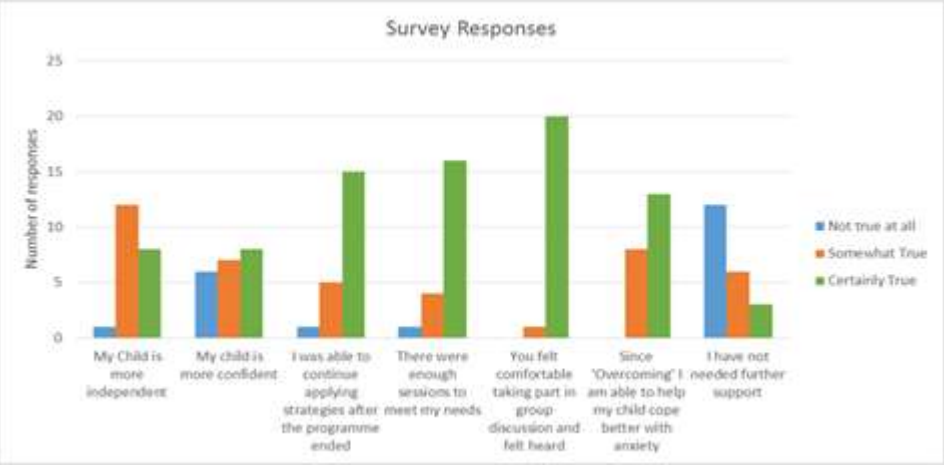
18/19 – 425% increase in discharge NFA from assessment inc. triage

18/19 – 70% decrease in unplanned exits from the service

Outcome Measures:

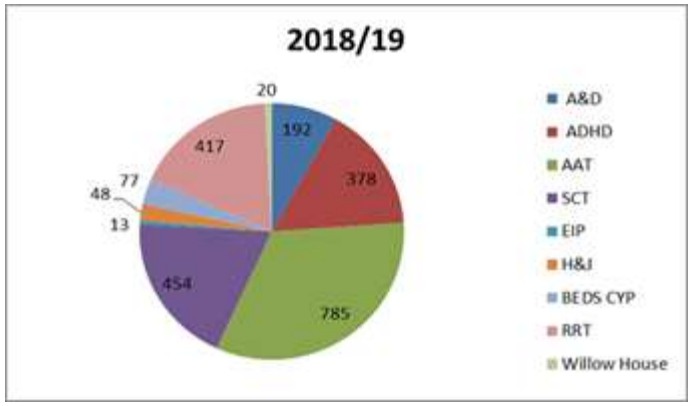


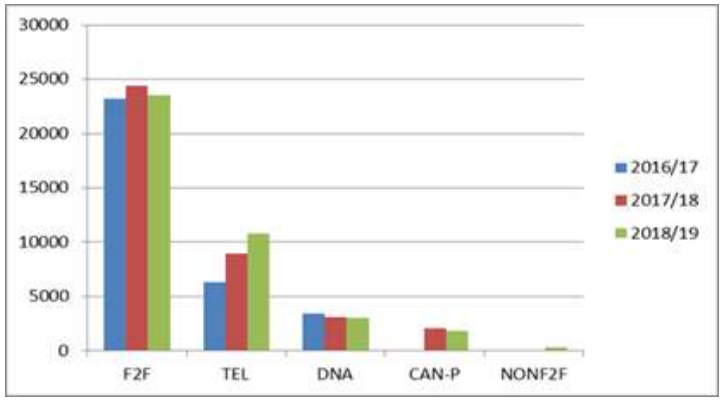
The RCADS this quarter are reflective of the complexity of presentation and referrals onto Tier 3

Where we are now	Impact and Outcomes
Emotional Health Academy (West Berkshire) The EHA was designed in restorative partnership with local children, police, health, schools, voluntary sector and social care partners. It reaches out into the community to local school, GP and community providers – where our children tell us they feel safe. Individual intervention is delivered according to NICE guidelines. The primary difficulties we provide support for include: ▪ Anxiety ▪ Mood ▪ Self-harm ▪ Attachment ▪ Emotional dysregulation/behaviour ▪ Friendship Problems ▪ Eating/Image Problems: ASD ▪ ADHD: ▪ Low level emotional health problems	The EHA has closed a total of 391 direct interventions this financial year (18/19), and reached a further 1,114 children and young people through large group or classroom based emotional health activities. <u>Six Month Follow-Up Evaluation of the Overcoming My Child's Fears and Worries programme</u> The EHA has conducted a 6 month follow-up of 21 families who completed this parenting programme for primary school age children with anxiety difficulties. This involved contacting randomly selected parents from the cohort of 39 who completed the programme greater than six months prior to December 2018. Parents completed an over the phone survey during which they were asked to comment on the progress of their child in the following domains: ▪ Coping with anxiety ▪ Independence ▪ Confidence ▪ Ongoing use of strategies Parents were also asked about the length of the programme, the facilitation and whether further support has been required. The findings of the survey are presented in the figure below: 

The EHA delivers a suite of evidenced based group programs: i. Overcoming your Child's Fears and Worries Programme ii. Choices, Chances Changes iii. Cool Kids ASD The EHA is also piloting Emotional Wellbeing Groups for vulnerable young people including those with emerging mood problems and parent attachment programmes. The EHA continue to deliver classroom wellbeing lessons, and mental health training for secondary school peer support workers as negotiated via a traded services model with individual schools. Looked After Children – Providing advice and support to SW, as well delivering	The responses indicated parents were comfortable working in the group setting and had seen improvements in mental health well-being overall. In regards to confidence, while the majority of parents did highlight they felt comfortable continuing applying strategies after the group ended, the request for further support and follow up sessions suggests that some individuals may not have been confident in continuing to support their child independently. In many cases children often had wider needs (e.g. SEN/Learning) of which the programme is not able to suggest. Programme facilitators support parents with further signposting or referral in such circumstances. Themes were also extracted from the survey relating to changes in the parents' response to their child's anxiety: <u>Parent's impact on child's anxiety</u> The responses indicated parents were comfortable working in the group setting and had seen improvements in mental health well-being overall. In regards to confidence, while the majority of parents did highlight they felt comfortable continuing applying strategies after the group ended, the request for further support and follow up sessions suggests that some individuals may not have been confident in continuing to support their child independently. In many cases children often had wider needs (e.g. SEN/Learning) of which the programme is not able to suggest. Programme facilitators support parents with further signposting or referral in such circumstances. Some parents became more aware of their own behaviour and how this impacted their child's anxiety, 'believing the anxiety and not saying *'you'll be okay'* or '*don't worry about it''* and described the need to use empathy *'I acknowledge that he's having a bad time and what he's going through. I'm more empathetic and try to draw out what he is feeling when he finds it difficult.'* Some parents described supporting their child through asking questions and working out options around the anxiety, *'We break it down, I ask why he feels the way he does. We work out options around the anxiety and ask questions like 'has it happened before?'* and *'what do you think might happen?'* Many parents responded that when approaching the situation, they are calmer, *'I approach more calmly, rationalising…revisit when he talk about it.'* <u>Encouraging independence</u> Other approaches taken by some parents/caregivers involved allowing their child take control over the anxiety and supporting them in independently coping with anxiety; *'He's capable of solving problems himself, he thinks it through and we pick the most suitable option.', '[Overcoming] gave her the tools to give to her child to guide them., 'We talk through and work out what aspect of anxiety is the problem and he comes up with the solution himself. So I just remind him of his own solutions.'* The main message collected from these responses seemed to be *'let [them] take control of the situation.'*

interventions for local CiC within the EHA remit.	<u>Utilising resources/techniques from course</u> Finally, parents/caregivers stated that using the resources and information they received from the course as valuable. Some described the methods they now incorporate when dealing with anxieties *'…rewards, small ones and a big one at the end, the snowball strategy, and the book is a helpful reference to have.', 'use the ladder to manage anxiety; break it down into manageable steps', 'using visual aids and breaking it down.'* The evaluation also highlighted areas for improvement, with parents suggesting that smaller group sizes would facilitate a great focus on individual plans or needs, and that some form of follow-up sessions to support ongoing progress would be of benefit. The findings also highlighted the limitations in group programmes to fully address all individual need and that attention should be given to ensuring parents completing the programme are offered time to consider next steps and to be given advice on signposting and referral for support with other non-anxiety related needs. <u>Stronger You Pilot</u> The EHA has completed its pilot of the Stronger You programme. Stronger You is an evidence informed resilience programme for young people developed by the EHA Primary Prevention Worker. This project was funded through a time-limited Public Health grant. The outcomes of the pilot suggest this is a universal programme with some potential. Both young people and school staff reported the programme to have a positive impact. There were a total of 51 participants in the pilot over 5 secondary schools. After the group, each student completed a review form expressing their views of the program: • 80% of the young people gave the Stronger You group a 6/10 or more for having a significant and positive impact (45% rated 8/10 or more) • 84% of the young people gave the Stronger You group a 6/10 or more for understanding their concerns (58% rated 8/10 or more) • 80% gave a 6/10 or more for whether they would seek help from the Emotional Health Academy in the future (58% rated 8/10 or more) Using the feedback given by the young people and also the reflections and notes gathered by the facilitator throughout the group, the session plans have been reviewed and amended accordingly ready to be rolled out to more young people in the West Berkshire area and further afield.

Thriving - Getting more help - providing extensive treatment	
Where we are now	**Impact and Outcomes**
Berkshire Healthcare Foundation Trust (BHFT) Specialist Child and Adolescent Mental Health Services (CAMHs) – overview BHFT services are part of the relevant national training schemes such as the national quality improvement programme for eating disorders, CYP IAPT and outcome research consortia such as CORC.	**Waiting Times** Waiting times for Berkshire Healthcare CAMHS (excluding the Autism assessment team) are broadly in line with national averages and, also in line with the national picture, are unfortunately increasing. 2343 young people from Berkshire West 'accessed' treatment from Berkshire Healthcare CAMHS in 2018/19. The graph blow gives a breakdown of the referrals accepted.  Just fewer than 50% of referrals require input from the neurodevelopmental teams. Referrals to the Berkshire CAMHS AAT were 37.5% higher than the national mean in 2017/18 at 532 per 100,000 population compared to a mean of 387. However according to the national benchmarking survey, only a minority of CAMH services provide specialist ASC services with provision sitting in Community Paediatric or Learning Disability Services in other counties. Many of these young people then go on to require input from other teams, with approximately 50% of the locality Specialist Community team caseload having a co-morbid neurodevelopmental diagnosis and/or learning difficulty.

	Activity for All CAMHS Teams Face to face to face activity has remained fairly stable over the past 3 years but there has been a reduction in the number of DNA appointments and appointments cancelled at short notice, which reduces waste and improves service efficiency. Issues related to data quality and recording of activity have been identified and action put in place to address these over the past year. Monitoring has shown that although progress has been made, for example with increased recording of telephone activity and some recording of non-face to face clinical activity, this is limited and there is further work to do. 
Common Point of Entry for BHFT CAMHs that receives all referrals for CYP**.**	**CPE Referrals** Referrals to the service for Berkshire West have increased year on year over the last 5 years, with the service seeing an increase of 8% last year and 43% since 2014/15. Graph 1 shows the trend in terms of all external referrals to CAMHS through the CYPF Health Hub for the Berkshire West CCG year to date with data reported from 2014/15 onwards for comparison purposes.

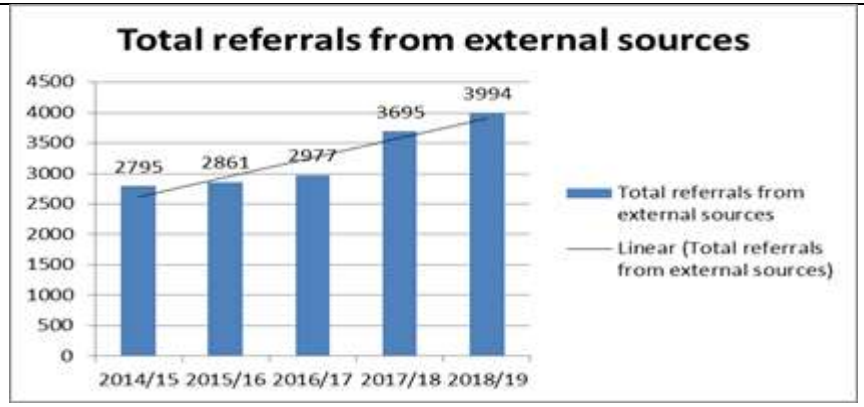


Figure 2 shows the national trend in referrals to NHS CAMH services, with the numbers given relating to referrals per 100,000 of the population. Referrals to Berkshire Healthcare CAMHS in 2017/18 were 5% above the mean at 3288 per 100,000 registered population (Berkshire-wide data)

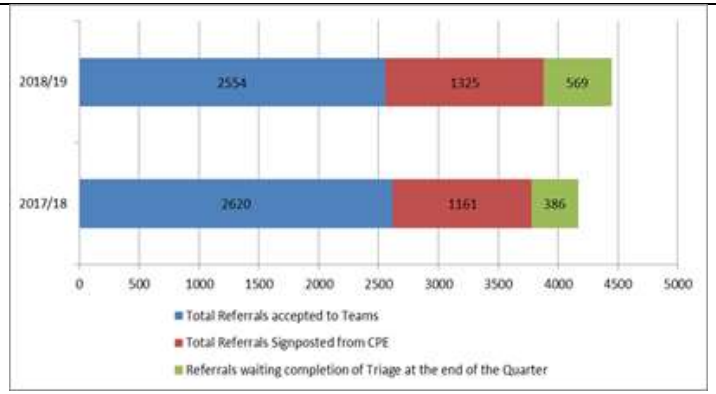
Figure 2

	2012/13	2013/14	2014/15	2015/16	2016/17	2017/18	National trend
Mean	1857	2748	3051	2666	2730	3126	

35.3% of referrals were for young people living within the Reading Borough Council locality, 34.5% from West Berkshire and 30.2% from Wokingham.

Information on referral source has been provided in the CPE deep dive audit but in summary, 40% of referrals received came from GP's, 22.5% from education colleagues, including school nurses, 6.5% were self-referrals and 11% came from other emotional wellbeing services.

Graph 3 Total Referrals to CPE - Destination



Graph 3 gives the breakdown of destination for referrals accepted to the service. Benchmarking data shows that on average 76% of referrals to CAMHS are accepted and 69% of those go on to receive treatment (excluding referrals for Autism Assessment). Numbers for Berkshire CAMHS are lower, with 66% accepted and 62% going on to receive treatment. The most likely explanation for this difference is the variation in commissioning and delivery of CAMH services with a high proportion of other areas delivering early intervention (Tier 2) services. However some young people may be appropriately referred to CAMHS and receive an intervention in CPE. We will be developing the EPR system in the coming months to enable us to more accurately record where referrals receive and intervention in CPE versus those who are not appropriate for the service and are sign-posted following triage.

Anxiety & Depression Pathway

The Berkshire CAMHS Anxiety & Depression (A&D) Pathway provides specialist assessment and treatment of children and young people under 18 years of age who have a diagnosable moderate to severe anxiety

Anxiety & Depression Pathway

Most of our young people have complex presentations; neurodevelopmental difficulties, comorbidities, family relationships difficulties, parental mental illness, learning and educational needs and risk of self-harm. On assessment, the two most common diagnoses given to young people are moderate depressive episode and obsessive compulsive disorder with social phobia and generalised anxiety the second most common diagnosis. The majority of young people (75% of those assessed last year) have more than one diagnosis and just over 30% have a diagnosis of autism spectrum condition or are waiting an assessment.

We are forward thinking services, which look to innovate to constantly improve the quality of provision we provide for our patients. Our developments over the years have included: a high quality comprehensive assessment model, adolescent anxiety groups, parent led CBT group, pre assessment workshops, intensive home based treatment for OCD, parent led

disorder, depression, obsessive compulsive disorder (OCD) or single event post-traumatic stress disorder (PTSD). We deliver interventions for young people who due to the complexity of their difficulties require specialist and substantial support.	intervention for OCD, parent workshops, cognitive therapy for social anxiety, brief intervention for insomnia (CBTi) and parent led CBT for anxiety and ASC. Our future developments include training and skills development for the wider CAMHS workforce, treatment for body dysmorphic disorder and pre menstrual disorder. Referral, assessment and treatment Data for 2018/2019 Last year (2018/19) the anxiety & depression team accepted 385 referrals. All these Young People and their parents were offered our introductory workshop which explains in detail the treatments we offer, provides high quality information on the mental disorders we treat and what they can do to help their young person/themselves and explains how they can access other resources that they may find helpful. Following the workshops, young people and families can opt into an assessment appointment. Specialist assessment and formulation are a key component of treatment. All of our assessments are carried out over 2-3 appointments and include psychoeducation, advice and care coordination. Last year we carried out 260 assessments, an increase of nearly 50% from the year before. 127 young people started treatment and 90 young people successfully completed treatment packages. The standard package of care, for most young people is individual CBT. Enhanced care packages for those who do not improve quickly or for whom their clinical presentation indicates they would benefit include intensive home based CBT, adjunction psychopharmacology and/or systemic therapy and attachment based family therapy for depression. Experience of the service The A&D pathway have been heavily involved in the CYP IAPT programme, and led the way in CAMHS in developing a culture of session by session outcome measurement. We have high rates of routine outcome measurement for our patients e.g. 91.4% for the Experience of Service Questionnaire (ESQ), 94.3% paired goal based outcomes and 77.1% paired symptom trackers (RCADs). Our ESQ feedback is consistently excellent. Between April and June 2018, 98% of parents and 95.1% of young people reported the statement: • *'I feel the people who saw me listened to me/my child' was 'certainly true'.* • *98% of parents and 78% of children reported 'It was easy to talk to the people who saw me/my child' was 'certainly true'.* • *100% of parents and 97.6% of young people reported that 'I was treated well by the people who saw me/my child' was 'certainly true.'* • *100% parents and 98.6% young people reported that the statement 'My views and worries were taken seriously' was 'certainly true'.*

<table>
<tr><td></td><td>The main negative comments received concerned the waiting times for appointments, with also some mention of the location and timing of appointments being inconvenient.

New developments made between April 2018 and March 2019
We piloted a new system for young people who were referred to psychiatry at assessment, where the psychiatrist joined the assessing clinician for the follow up assessment appointment where possible. This reduced waiting time to see a psychiatrist for a first appointment, allowed for more joined up care planning, and enabled clinicians to seek consultation from the psychiatrist about formulation and care planning.
We improved our support to parents so that they can support their children in treatment and piloted three new sets of workshops (4 sessions each): 1. For parents of children and adolescents with OCD; 2. For parents of young people with depression; and 3. For parents of children with anxiety and autism &/or ADHD.
We developed and extended the clinic offering Attachment Based Therapy for Depression and offered this to young people who were deemed at risk of hurting themselves as well as suffering from depression.</td></tr>
<tr><td>Autism Assessment Team and ADHD Pathway

Berkshire Healthcare CYPF Neurodevelopmental Teams include the Autism Assessment team and the ADHD Pathway.

The Autism assessment team assess children and young people of all ages up to the age of 18. The Assessment team are commissioned as an assessment only service</td><td>Autism
Current figures show an overall increase of 7.9% in referrals accepted by the Autism Assessment Team in 2017-2018 compared to 2018-2019.

<table>
<tr><td>Referral Year</td><td>Q1</td><td>Q2</td><td>Q3</td><td>Q4</td><td>Total</td></tr>
<tr><td>2017-2018</td><td>217</td><td>208</td><td>202</td><td>227</td><td>854</td></tr>
<tr><td>2018-2019</td><td>269</td><td>196</td><td>262</td><td>200</td><td>927</td></tr>
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ADHD
Current figures show a minor decrease of 0.9% the number of referrals for the ADHD Team.

<table>
<tr><td>Referral Year</td><td>Q1</td><td>Q2</td><td>Q3</td><td>Q4</td><td>Total</td></tr>
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and work closely with local providers and charity organisations to provide informed signposting and advice both pre and post assessment. Due to the increase in demand and waiting times the team has also worked on a number of projects to support children, young people, parents, carers and their families whilst they are waiting for an assessment. The ADHD team sees and assesses children and young people from 6 up to their 18th birthday. Children and Young people who are given a diagnosis of ADHD and who require medication to access education are prescribed both stimulant or non-stimulant medication to help manage their symptoms. Medication is prescribed and reviewed as part of a shared	2017-2018	92	87	115	122	416
	2018-2019	118	100	107	87	412

Average waiting times for the Autism Assessment Team from acceptance into the team to first face to face appointment is: **79 weeks** (end of financial year figure)
Average waiting times for the ADHD Team from acceptance into the team to first face to face appointment is: **51 weeks**(end of financial year figure)

Total number of CYP in contact with the ADHD and/or Autism Team (June 2018-July 2019)
A total number of 833 children and young people or parent/carers have had contact with Autism Assessment Team clinicians either in a face to face appointment or through telephone contact and support via the helpline in the past 12 months. (This number does not include numbers supported via SHaRON-Jupiter our online support and resource service.)

A total number of 885 children and young people or parent/carers have had contact with ADHD Team clinicians either in a face to face appointment or through telephone contact and support via the helpline in the past 12 months.

Autism Diagnostic Rates
73.11% of the Children and Young people in Berkshire West whose assessments were concluded in the past 12 months received a diagnosis of Autism

Children and Young People waiting for both an Autism and an ADHD Assessment
There are currently 74 children waiting for both an Autism and an ADHD assessment in Berkshire West (July 2019)

Digital Solutions
The Autism Team have recently piloted the provision of Autism Assessments via live video-link through a digital provider. This Pilot included 30 assessments for Children and Young people from Berkshire West. Assessments, which are completed by an external provider, are informed by NICE Guidelines and are completed in collaboration with the Autism

care arrangement with local GP's. **<u>SHaRON – Jupiter</u>** The autism assessment team provide support to parents and carers whose child is on the waiting list or who has received a diagnosis of autism via SHaRON – Jupiter our on-line information and support service.	Assessment Team who maintain clinical responsibility throughout the process. The pilot was successful and we are actively working to incorporate the provision of further assessments of this type as part of our on-going offer. Additional Services and Provision for Children, Young People and their families provided by the Neurodevelopmental teams. Whilst the Autism Assessment Team is an assessment only pathway and the ADHD Team are assessment and medication review we acknowledge that waiting for/or receiving an assessment of Autism and/or ADHD can be a very emotional time for families. In order to provide additional information, training and support we have worked with a number of different charities and collaborated with other CAMHS pathways to provide the following: **SHaRON – Jupiter** In the last 12 months (June 2018-July 2019) 215 Parents and Carers have opted into ShaRON-Jupiter with a total of 680 opting in since the service was first provided. Support on Sharon is provided by members of the Autism Assessment Clinical Team and in collaboration with Autism Advisors and Charity Organisations such as Autism Berkshire and Parenting Special Children. We recently presented SHaRON-Jupiter at the Autistica Research conference and asked for some feedback from some of its users for the presentation. They gave the following feedback: '*SHaRON is a fantastic resource that allows users to connect with staff from CAMHs whilst waiting for their appointment. It's an opportunity to learn about options for support and to check in with others to discuss approaches to situations that occur. For us it has been an invaluable tool. One situation that I posted about led to telephone contact with a SLT which was a game changer in progressing the conversation with my daughter's school*' '*SHaRON was invaluable for me when we were waiting for our diagnosis. Being able to access people who could actually answer our questions made so much difference to our lives and stress levels. Every NHS Trust needs a SHaRON!*' **Autism and ADHD Team Helplines**

	Both the Autism Team and the ADHD Team provide a helpline for parents and carers whose children are on the waiting list in order to provide support and advice, respond to any queries, to provide signposting and to assess for risk and change in circumstances. The helpline is not an emergency service and is provided 3 afternoons a week for the Autism Assessment Team and two afternoons for ADHD. If there are concerns about immediate risk and harm, due to an escalation in mental health concerns, calls are passed to the Specialist CAMHS duty worker.
Eating Disorders pathway	Referrals to BEDS CYP reduced in 2018/19 but remain higher than the commissioned capacity of the service. The team received 134 referrals in 2018/19, 58% of which were for Berkshire West young people. 78% of referrals had been accepted by year end (national capacity modelling was based on an expectation of 50% acceptance rates) with 9% still waiting assessment. There were 22 young people at the end of the year that had been assessed and accepted for treatment and were being supported by the team but have not yet started evidence-based treatment due to team capacity. Acuity and risk in this patient group remains high and the team have continued to work closely with acute unit colleagues and Willow House to prevent, where possible, and support young people needing admission.

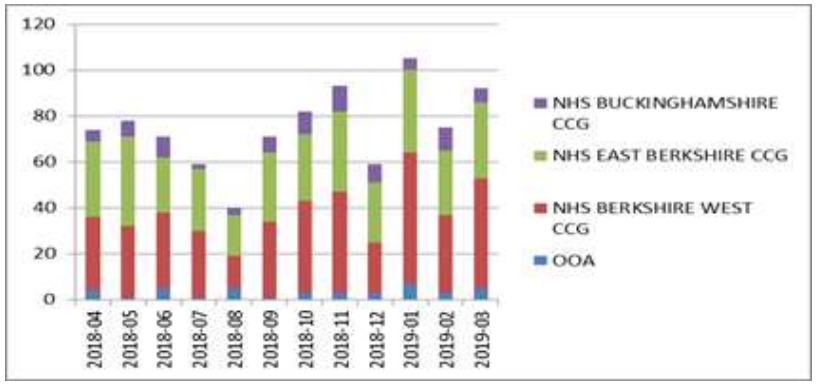
Thriving - Getting Risk Support - Risk management and crisis response	
Where we are now	**Impact and Outcomes**
Health and Justice service is operational, staffed by CAMHs workers, Speech and Language Therapists and nursing staff Resources used by Youth Offending Teams, magistrates courts, substance misuse providers and the wider Liaison and Diversion team have been adapted to meet the needs of Children and Young People with mental health, learning difficulties and/or communication impairments. The service works in partnership with the CAMHs Rapid Response/crisis service to provide step down care following attendance at the Emergency Department of Royal Berkshire Hospital. Health workers work closely with substance misuse services.	Over the past year, the main focus has been to bring together what was previously a number of individual clinicians working separately in the 3 YOTs together to provide an enhanced consistent and sustainable health service offer across the three YOTs with a single service specification and KPIs, and to develop aligned reporting. This is now in place and we are starting to see activity increasing and good feedback from both service users and YOT colleagues. In line with the aims of the new model there have been opportunities in the last few months for staff to work more flexibly across the West. This means that health practitioners have worked together sharing skills and good practice. It has also meant that where one practitioner has a specialist assessment skill this has been offered to a neighbouring YOT when required in order to provide an equitable and timely service across the West. YOT staff are familiar with the health staff embedded in their teams and know what they can offer in terms of specialist assessments and in supporting them in the work they do to reduce reoffending. MH workers are often asked to provide supervision to caseworkers when they are working with YP with histories of developmental trauma (this fits with the model of trauma informed working that is being used in Reading and West Berkshire YOTs). MH workers are also asked to advise where YP have diagnoses that might impact their offending. Physical Health Nurses provide support when YOT staff are worried about YPs sleep, diet, substance misuse, sexual behaviour, or general health. Increase in confidence of staff/partners (e.g. police) in identifying and supporting young people with communication, emotional wellbeing and mental health difficulties: The Mental Health practitioner has designed a tool to be used by YOT colleagues in West Berkshire to assess and open up discussions around trauma with YP. She has also written a document on understanding and working with complex trauma and ACEs to aid the team. Keeping young people safe from harm and reducing the risk of re-offending: One important aspect of the role of the Physical Health Nurses in YOTs is to promote reproductive and sexual health and this has involved helping young people to access free condoms and provide Chlamydia screening (under the C-card scheme offered by Public Health England). Offering free condoms has often been an effective way of encouraging YP at the YOS to attend Health appointments and this can then lead on to other support being offered.

	Training is delivered for staff, not only as a group and in structured ways but through demonstration and case discussion. The Speech and Language Therapist delivered some training to the Reading YOT on identifying communication problems in YP. The feedback she received indicated that everyone felt they had learnt and benefited from the training and would be more confident in the future in identifying that there could be an underlying communication problem and knowing what they could do to help YP understand them. The Speech and Language Therapist has also delivered training to staff in Wokingham YOT on how to interpret the speech and language parts of the Asset Plus to aid colleagues. She received feedback that this had been helpful. The Psychologist delivered training to Reading YOT Panel Members on attachment trauma and the link to offending behaviour. These panel members are trained volunteers who manage the YPs Referral Orders. The feedback was very positive.
Early Intervention Psychosis service	Established in 2016 as a 14 plus service, there is joint working with the local CAMHs service to ensure that CYP with psychosis receive the NICE approved evidence package of care. Service was recently awarded level 3 status that confirms it provides the suite of interventions to the appropriate quality standards. The service continues to meet its timeliness target that includes response to under 18's.
Response Team The CAMHS Rapid response team was developed in 2017/18 following successful The aims of the CAMHS RRT are: • To deliver initial assessment of a young person presenting to A+E in crisis – within 4 hours of referral (provided the young person is fit for assessment) • To deliver comprehensive mental	**CAMHS Rapid Response Team** The team received a total of 899 referrals last year of which 46% were from Berkshire West. The trend and split of referrals is shown in shown in Graph 7. The majority of referrals to the team are for young people who have presented to emergency services in crisis and come from the Hospital A+E departments or Hospital Paediatricians. With the short-term project to move 'getting risk support' activity from community teams to RRT, we had hoped to be able to provide more support in the community with an expectation that this would divert young people away from A&E where safe to do so. Despite recruitment difficulties, the team have worked to develop a model of community-based support. Last year approximately 80% of referrals were from A+E or Paediatric colleagues. We started to see a change in this pattern towards the latter part of last year and data from quarter 1 this year indicates that 33% of referrals have come directly from GP's and other external colleagues, specialist community CAMHS and Tier 4. The proportion of first contacts in the acute units has also shifted from 41% last year to 37% I Q1. 55% of referrals from A&E were recorded as having been seen within the 4 hour target. Reasons why 45% were not recorded as having been seen within this time frame are as follows:

health and risk assessments

- appropriate community settings until the risks are contained or alternative care provision is put in place (admission to Tier 4; community interventions).

- Referrals were made out of hours and initial contact delivered by the out of hours service and on-call CAMHS Consultant. We do not yet have systems in place to align this activity with the CAMHS RRT referral.
- Young person not medically fit for assessment.
- Assessment delayed due to unavailability of family/carer/social care.



We do not yet have the ability to report reasons for breach from our EPR without manual audit of clinical records but are working to develop that capability within the system this year.
Review of clinical records and liaison with RBH shows that numbers who were able to be seen within the 4 hour target but were not seen due to service capacity, were low.

Tier 4 New Models of Care
Berkshire Healthcare NHS Foundation Trust has been working in close collaboration with Oxford Healthcare NHS Foundation Trust (OHFT) and other partners on the development of a New Model of Care for Tier 4 CAMHS. This work is being led by Oxford Health, who are the lead provider in

BHFT continue to provide an 8 bedded unit, called Willow House in Wokingham. Information for last financial year on CYP flow into Tier 4, including Willow House is shown below.

Admission to:	**Willow House**	**To out of Area Tier 4 Unit**
Admitted	16	16
Clinical reason for admission	Eating Disorder x 1	
	Depression & unspecified behavioural & emotional disorder x 1	11 - Eating Disorder
	Psychosis x 1	3 - Psychosis
	Anxiety Disorder x 5	1 - Self Harm + Eating Disorder
	Major Depressive Disorder x 3	1 - Depression
	Emotional regulation difficulties x 1	

the new Tier 4 network that is being developed to enable improved flow and access to Tier 4 beds within the geographical patch.		Psychosis x 1 Self-Harm x 1 Eating Disorder + moderate to severe depressive episode x 1 Complex PTSD + Eating Disorder x 1	
	Average Length of stay	52.8 Days	120 Days (Does not include a YP who has not been discharged as at 21.10.19)
	A central bed finding process accessed via OHFT to enable improved access to local care for young people, greater integration across the geographical patch stated in April 2019. In the longer term it is hoped that there will be financial savings that can be invested to improve access to community crisis and admission avoidance services across the patch. Berkshire Healthcare continue to work closely with NHS England to relocate Willow House adolescent mental health inpatient unit, from its current site at Wokingham Hospital to a new location at Prospect Park Hospital. The move will enable improvements to the quality of service, including the provision of inpatient care closer to home for some young people for whom the current unit environment is not suitable. It is anticipated that this move will take place in early 2021. There is a dedicated Place of Safety suite for under 18s at Prospect Park Hospital. Local data for 18/19 indicates that 34 CYP went through to the place of safety under a section 136 • 9 of these CYP went on to a section 2 • 3 of these CYP were transferred out • 22 of these CYP were allowed to leave	

Chapter 10 - Mental Health Services dataset submissions

NHS Digital collate the Mental Health Services Data Set (MHSDS), which contains record-level data about the care of children, young people and adults who are in contact with mental health, learning disabilities or autism spectrum disorder services. It is mandatory for partially and wholly NHS funded providers (including 3rd and independent sector providers) to submit data to the MHSDS and other providers may also be contractually required to submit data. There is a key target around access to treatment which NHS England is monitoring CCGs performance against. Data for this target is collected via the MHSDS. Our area continues to not be reporting enough of these contacts on the MHSDS system where we are reporting a rate of 27% rate (against a 19/20 target to 32%)

We know though that our local providers are working with enough CYP, having recently completed the NHS E task of providing 18/19 contacts data for their services. The submission for Berkshire West provides a total of 5162 children and young people accessing support, or 57% access target against the notional 9004 prevalence rate. There is a warning that this method of data capture does not root out all the double counting, so the figure will be inflated.

Into FY 19/20 the CCG was asked to deliver a recovery plan to improve the use of MHSDS. We are making good progress against the actions in this plan, with 3 more providers already flowing their data onto the NHS digital system. In addition to this BHFT CAMHs continue to work on improving the recording of contacts to accurately demonstrate the level of output of their teams. We predict that this work will ensure that we reach our 19/20 targets.

We will continue to work with our local Voluntary Sector partner and the, youth counselling services in particular, and within the next 12 months the CCG will reach a solution with NHS England support, on how to enable these contacts and service to be counted.

Chapter 11 – Workforce

Recruiting and retaining high quality staff remains a high priority for all partners, as noted in the risk and challenges chapter of this refresh.

Within BHFT, our specialist CAMH service, there is now dedicated support from recruitment resource to improve recruitment across difficult to recruit roles with the aim of reducing lack of capacity. In addition they are:

- Beginning to trial new skills mix when appropriate, for example piloting a new telephone enhanced specialist assessment & engagement model for Anxiety & Depression using psychology Assistants to improve access, efficiency and quality of assessments as well as wait times.
- Using third party organisations to provide online assessments mainly focused around CYP waiting for an ASD/ ADHD assessment process to start.
- Reviewing their Clinical Pathways and seeking to develop a shared understanding of capacity, skill mix, training & support required for the pathways to be delivered sustainable. In addition they are working and sharing with other providers both locally within the respective ICS as well as nationally. For example work with Cornwall providers on pathways and more locally with Surrey and Borders providers on eating disorder staffing.

There has been success this year with progress made in recruiting medical consultant staff to the service and other teams are now reporting higher retention rates. CPE remains a concern that is being addressed and staffing levels are a constant risk that needs attention.

Recruitment, retention and training of Educational Mental Health Practitioners (EMHP) in partnership with University of Reading for each Local Authority has continued at pace this year and will continue into the coming LTP year. Fundamental learning from being a trailblazer site has enabled the necessary fast paced mobilisation for the next wave and the Wokingham MHST has fully recruited its EMHP and started the course on time. In addition all our providers have supervisors in training or ready to start their training to meet the MHST programme standards.

Our current profile of the workforce delivering the range of commissioned services in chapter 9 is outlined below.

West Berks

Therapeutic thinking Support Team	FTE
Snr EP	0.2
Advisers	0.7
Workers	2.6
Emotional Health Academy (EHA)	FTE
Acting EHA Manager/Clinical Mental Health Wkr	0.8
Mental Health Worker	2
Emotional Health worker	1.8
Clinical Mental Health Worker	0.8
Referral Coordinator	0.6
Mental health support team	FTE
Snr EP	1
Mental Health Worker	1
EMHP	4
Outreach Worker	1
CAMHS practitioner	0.5
Educational Psychology (EP) Service	FTE
Snr EP	1.5
Eps	4.1
Unfilled EP (out to advert, covered by locums)	2.5
Total	**19.9**

Reading

Primary Mental Health	FTE
Snr Primary Mental Health Worker	
Primary Mental Health Worker	
Mental health support team	FTE
Snr EP	1
Primary Mental Health Worker	1
EMHP	4
Outreach Worker	1
CAMHS practitioner	0.5
Educational Psychology (EP) Service	FTE
Snr EP	
Eps	
Unfilled EP (out to advert, covered by locums)	
Total	**2.5**

AnDY clinic (UoR)

Role	FTE
CBT Therapist	0.5
Senior CWP (1+ year post qualification experience)	1
CWP	1.5
Office Manager/Administrator	0.35
Total	**3.35**

Wokingham

BHFT Service	FTE
Primary Mental Health Worker	3
Educational Psychology (EP) Service	
Principle EP	1
Snr EP	0.9
EPs	3.4
Trainee EPs	1.8
Total	**10.1**

Time to Talk (Youth Counselling)

Role	Number
Qualified and paid counsellor	11
Qualified and unpaid counsellor	23
Trainees counsellor	9
Total	**43**

ARC (Youth Counselling)

Role	Number
Qualified and paid counsellor	20
Qualified and unpaid counsellor	15
Trainees counsellor	15
Total	**50**

Number 5 (Youth Counselling)

Role	Number
Qualified and paid counsellor	6
Qualified and unpaid counsellor	21
Trainees counsellor	18
Total	**43**

BHFT Specialist CAMHs service and CPE

	Band 2	Band 3	Band 4	Band 5	Band 6	Band 7	Band 8a	Band 8b	Band 8c	Band 8d	Consultant	Other medical	**Total WTE**
Medical											6.7	1.36	**8.06**
Qualified Nursing				0.55	5.43	9.88	2.5	0.55	0.22				**19.13**
Clinical Psychology			4.99	1.14	6.09	6.65	0.89	0.72					**20.48**
Psychotherapy					1.72	2.27	2.37						**6.36**
Allied Health Professionals						1.84	1	0.52					**3.36**
Social Worker			1.33										**1.33**
Senior manager								0.33	0.44	0.89			**1.66**
Admin	2.11	7.67	4.42	0.55	0.33								**15.08**
Total	**2.11**	**7.67**	**10.74**	**2.24**	**13.57**	**20.64**	**6.76**	**2.12**	**0.66**	**0.89**	**6.7**	**1.36**	**75.46**

BHFT Willows House (Inpatient unit)

	Band 2	Band 3	Band 4	Band 5	Band 6	Band 7	Band 8a	Band 8b	Band 8c	Band 8d	Consultant	Other medical	**Total WTE**
Medical											0.8	1	**1.8**
Qualified Nursing			6.92	2	1								**9.92**
Support worker		7.61											**7.61**
Clinical Psychology							0.8						**0.8**
Psychotherapy							0.6						**0.6**
Education						0.32							**0.32**
Other								1					**1**
Admin			1	1									**2**
Total	**0**	**7.61**	**7.92**	**3**	**1**	**0.32**	**1.4**	**1**	**0**	**0**	**0.8**	**1**	**24.05**

Chapter 12 – An overview of our financial investment

The CCG continues to meet its financial investment targets within the NHS guidance for Children and Young People. Investing a further £157k this financial year (19.20) in a range of early intervention and waiting time initiatives. In addition to this the CCG has committed a further £150k (recurring) funding to the BHFT Eating Disorder service to support delivery of meeting the waiting time and access targets for 20/21.
This year and going forward Berks West have secured transformation money for the establishment of our first 3 mental Health Support Teams.

Below are two tables outlining the historical view of Future in Mind and more broadly the overall CCG spending on CYP mental health services.

Berkshire West CCG Future In Mind spend	**Amount 16/17**	**Amount 17/18**	**Amount 18/19**	**Amount 19/20**	***Amount Predicted 20/21***
Reading School Link project	£100,000	£100,000	£100,000	£100,000	*£100,000*
Wokingham School Link project	£100,000	£100,000	£100,000	£0	*£100,000*
West Berkshire Emotional Health Academy	£100,000	£100,000	£100,000	£100,000	*£100,000*
PPEPCare (to support schools, primary care, vol sector and non CAMHs staff)	£15,000	£45,000	£19,875	£45,000	*£45,000*
CAMHs urgent/ crisis care at RBFT (now in block contract 19.20)	£208,000	£329,368	£329,368	£329,368	*£329,368*
Voluntary sector support for families awaiting ASD diagnosis- Autism Berkshire	£40,212	£28,000	£20,000	£20,000	*£20,000*
Voluntary sector support for families awaiting ADHD diagnosis- Parenting Special children	£9,740 £35,823	£13,000	£20,000	£20,000	*£20,000*
Autism Appreciative Inquiry work	£5,225	N/A	N/A	N/A	*N/A*
Booklets & campaign for young people #littlebluebookofsunshine	£10,000	N/A	N/A	N/A	*N/A*
Additional money to Eating Disorder service (one off)	N/A	N/A	N/A	£50,000	*N/A*
Additional money to tackle waiting times ASD/ ADHD - TBC	N/A	N/A	N/A	£75,000 - TBC	*N/A*
AnDY clinic-Anxiety and Depression in Young People Clinic University of Reading	N/A	N/A	£99,893	£106,893	*£106,893*
Unallocated	N/A	N/A	N/A	N/A	*£125,000*
Total Future In Mind	**588,177**	**£715,368**	**£789,136**	**£846,261**	***£946,261***

Other CCG spend	**16/17**	**17/18**	**18/19**	**19/20**	**Predicted 20/21**
Specialist CAMHs block contract This figure excludes Berkshire Adolescent Unit which was transferred to NHS England in 14/15 and also includes investment in Community Eating Disorder and Rapid Response services over the last few years.	£6,306,000	£6,520,000	£6,674,000	£7,131,000	TBC
CAMHs Community Eating Disorders	£236K	£244K	£250K	TBC	TBC
Youth Offending/ Health and Justice- new monies from 17/18. New monies added to existing service value	N/A	£53,601	£53,601	£53,601	£53,601
Children and Young People's IAPT training backfill (pan Berkshire)- this is pass through money from HEE.	£251,000	£56,500	£53,601	£0	TBC
Non recurrent waiting list initiative funding from NHSE	£92,106	N/A	£110,000	N/A	N/A
Youth counselling Reading Wokingham West Berkshire CCG funding	 £30,000 £30,000 £29,500	 £30,000 £30,000 £29,500	 £30,000 £30,000 £29,500	 £30,000 £30,000 £29,500	 £30,000 £30,000 £29,500
Mental Health Support Teams	N/A	N/A	50,000 – project mgt	£376,195 £196,558 £100,000 - project mgt	£825,878 £356,709

Appendix 1 - How we developed our Local Transformation Plans- our story

In spring 2014 Clinical Commissioning Groups in Berkshire West asked service users, schools, doctors and mental health workers **what they thought about local mental health services**. http://www.berkshirewestccg.nhs.uk/about-us/how-we-work-with-others/the-local-transformation-plan/2014-review-and-outcomes-of-berkshire-camhs-service/

Their responses suggested that many children, young people and their families thought that services weren't good enough – explaining that waiting times were too long, that it was difficult to find out how to access help and, sometimes, that they didn't like the way that they were treated by staff. They said that there were delays in referrals and the advice given to families while waiting for their child's assessment was insufficient.

Future in Mind provided a structure for planned changes in Berkshire West. The ambition became not simply to adjust existing services, but to transform them. Our original Transformation Plans provide a snapshot of where we were in the Autumn of 2015, how we arrived at our plan and articulates the actions we felt were required.

Links to the original Transformation Plans can be found here

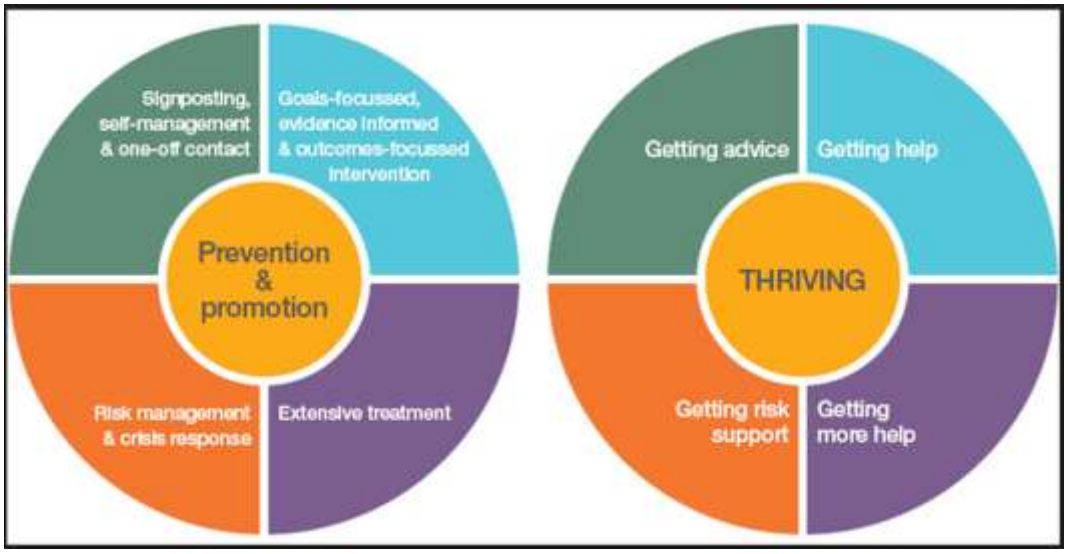
http://www.berkshirewestccg.nhs.uk/media/1738/westberks-transformation-plan-2015.pdf

The October 2017 refreshed plan can be found here

http://www.berkshirewestccg.nhs.uk/media/1741/refreshed-transformation-plan-jan17final.pdf

The October 2017 refreshed document describes our move away from the traditional tiered system to the THRIVE framework developed by Wolpert et al in the Anna Freud Centre (AFC) and Tavistock & Portman NHS Trust.

http://www.annafreud.org/media/3214/thrive-elaborated-2nd-edition29042016.pdf



The October 2018 refreshed plan can be found here:

https://www.berkshirewestccg.nhs.uk/media/2516/berkshire-west-future-in-mind-ltp-refresh-oct2018.pdf

A young person friendly version of the 2018 refreshed document can be found here:

https://www.berkshirewestccg.nhs.uk/media/2617/yp-friendly-summary-for-review-future-in-mind-ltp-refresh2018.pdf

Appendix 2 – Needs Assessment

Summary

The Berkshire Wests school population, as of the Jan 2019 census the 0 – 19 population stands at 86,144 pupils (+2000 CYP). Taking this as our baseline there are a number key factors that would indicate the level of need within Berkshire West CCG (covering the Local Authority areas of Wokingham, West Berkshire and Reading).

1. All 3 of our LA areas have u16 year old children living in poverty below the England average, with Wokingham well below that average.

	Wokingham	West Berks	Reading	SE	England
Children living in poverty aged under 16 years (2016)	6.4%	9.1%	15.7%	12.9%	17.0%

2. Our primary school population has a 36% Ethnic minority cohort and the secondary school population has a 30% Ethnic minority cohort – well above the SE and National Average, and includes significant variation between the 3 LAs (Schools Census 2018)
3. Our Looked After Children number is 557 (up 37 from last year) at the end of Q1 this financial year, across the 3 LAs'. In addition to this 445 (down 155 from last year) Child protection and 1679 – (up 145 from last year) Child in Need cases for the same footprint. (Safeguarding reports MASA Q1 – 18/19)
4. Public Health CHiMAT information 2017 indicates that approx. 11% of our school population may require support from Tier 2 CAMHs which puts our numbers in line with the green paper impact assessment assumptions of 10 – 15% with a mild to moderate MH condition.
5. Public Health CHiMAT information 2017 indicates that 8% of our 5 – 16 year population have a mental health disorder, just under the green paper impact assessment assumption of 10%.
6. Our demand management figures tell us that we are experiencing a significant level of demand against the Green paper impact assessment assumptions. The Estimated volumes (business as usual model) for 18/19 suggested that Berkshire West are:

	18/19 National Profile	**18/19 Berkshire West Profile based on being 0.85% of national figures**	**18/19 demand**	**17/18 demand**
Diagnosable	920,000	7,820		
Referred	620,000	5,270	4049 - Specialist CAMHs 3679 - Current T2 **7728 - total (47% over profile)**	3561 - Specialist CAMHs 2320 - Current T2 **5881 - total (12% over profile)**
Treated by CYPMHS	300,000	2,550	2273 – Specialist CAMHs 3739 - Current T2 **6012 - total (135% over profile)**	2350 – Specialist CAMHs 1840 - Current T2 **4190 - total (64% over profile)**

7. All 3 LA areas have a similar rate of child inpatient admissions for mental health conditions compared to the England average (Public Health profiles 2019)
    - Wokingham - The rate of child inpatient admissions for mental health conditions at 90.4 per 100,000 is similar to England.
    - West Berks - The rate of child inpatient admissions for mental health conditions at 89.4 per 100,000 is similar to England.
    - Reading - The rate of child inpatient admissions for mental health conditions at 83.6 per 100,000 is similar to England.

8. Our Hospital admissions for self-harm Self Harm rates have been above the SE and England region figures for last 2 reported years. With significant concern about the 15 to 19 year old age group. This is further supplemented by the recent High impact User work completed by the CCG that identified the high risk and impact of these CYP in the acute, secondary and community care arrangements. (Public Health profiles 2019)

Hospital admissions for self-harm: age standardised rate per 100,000 - Age: 10-24	2016/17	2017/18
South East Region	449.3	467.6
Reading	550.9	517.7
West Berkshire	579.1	529.3
Wokingham	493.1	483.9

9. School identified need from SEND January 2019 data is telling us that we are above national averages in our primary reasons for Education health and Care plan (EHCP) for both Social Emotional Mental Health and ASD categories. The summary table below indicates that Schools are identifying over 3600 pupils that will require a level of school based support in these areas above their full school population.

LA	Total (SEN and EHCP)	Est % SEMH as a primary reason	Est number of SEMH	Est % ASD as a primary reason	Est number of ASD	Total % (SEMH and ASD) primary reason	Total (SEMH + ASD) as primary reason
Reading	3766 (15%)	18%	686	13%	487	31%	1173
West Berks	4553 (15%)	8%	523	18%	798	29%	1321
Wokingham	3494 (11%)	17%	543	17%	577	32%	1120
Totals	11813	15%	1752	16%	1862	31%	3614

10. School identified need by exclusion is telling us that 64 (2 more than last year) pupils were permanently excluded in the last Academic Year (18/19) across the 3 LAs (88% in secondary school).
    And there were over 2000 pupils that received a fixed term exclusion (ranging from 1 to 10 days dependent) in the same Academic Year.

The majority reasons were consistently Persistent Disruptive Behaviour, Physical abuse against adult or pupil or Verbal abuse/threat on adult.
It is safe to assume that all of these pupils will need support from a mental health service to prevent further escalation into higher risk behaviours. (Sfeguarding reports MASA Q1 – 18/19)

Basic School Information

		State-funded primary	% known to be eligible for and claiming free school meals	State-funded secondary	% known to be eligible for and claiming free school meals	Special Schools	% known to be eligible for and claiming free school meals	Pupil referral units	% known to be eligible for and claiming free school meals	Independent	**totals**
Reading Schools		39		10		4		1		10	**64**
Pupils Jan 2018		14,277	14.0%	7,475	8.8%	273	48.4%	107	33.6%	2,897	**25,030**
West Berkshire Schools		66		10		3		1		15	**95**
Pupils Jan 2018		13,817	5.9%	11,273	5.7%	639	23.9%	58	31.0%	3,338	**29,126**
Wokingham Schools		53		10		3		2		11	**79**
Pupils Jan 2018		15,315	5.1%	10,699	5.2%	345	18.6%	17	35.3%	3,475	**29,852**
											238
BW Totals		**43,409**		**29,447**		**1,257**		**182**		**9,710**	**84,007**
BW state only		**74,295**									

Ethnic Diversity

Primary State school Jan 2018	White	Mixed	Asian	Black	Chinese	Any Other Ethnic Group	Unclassified	All pupils	Minority Ethnic Pupils
SOUTH EAST	592,596	45,237	55,836	20,196	2,903	7,201	7,091	731,060	187,246
	81.1%	6.2%	7.6%	2.8%	0.4%	1.0%	1.0%		25.6%
Reading	7578	1631	3093	1336	97	249	293	14277	8050
	53%	11%	22%	9.4%	0.7%	1.7%	2.1%		56%
West Berkshire	12170	680	519	153	44	101	150	13817	2392
	85%	4.8%	3.6%	1.1%	0.3%	0.7%	1.1%		17%
Wokingham	11099	1117	2191	387	167	160	194	15315	5116
	78%	8%	15%	2.7%	1.2%	1.1%	1.4%		36%

State Secondary Schools Jan 2018	White	Mixed	Asian	Black	Chinese	Any Other Ethnic Group	Unclassified	All pupils	Minority Ethnic Pupils
SOUTH EAST	416694	27193	38455	15319	1940	4789	6414	510804	117912
	81.6%	5.3%	7.5%	3.0%	0.4%	0.9%	1.3%		23.1%
Reading	3928	701	1844	598	115	130	159	7475	4061
	52.5%	9.4%	24.7%	8.0%	1.5%	1.7%	2.1%		54.3%
West Berkshire	10005	558	331	214	37	59	69	11273	1710
	88.8%	4.9%	2.9%	1.9%	0.3%	0.5%	0.6%		15.2%
Wokingham	8035	656	1304	395	62	87	160	10699	3146
	75.1%	6.1%	12.2%	3.7%	0.6%	0.8%	1.5%		29.4%

Public Health CHiMAT data (Taken from Berkshire Public Health Locality Profiles 2017)

CHIMAT's Needs Assessment for Berkshire West CCG estimates that children and young people may require support from CAMHS. This has been broken down for each of the CAMHS Tiers:

	Wokingham	Reading	West Berks	BW Totals
CAMHS Tier 1: (Service provided by professionals whose main role and training is not in mental health. These include GPs, health visitors, school nurses, social services, voluntary agencies, teachers, residential social workers and juvenile justice workers.)	5,235	6,478	5,097	16,810
CAMHS Tier 2: (Provided by specialist trained mental health professionals. They work primarily on their own but may provide specialist input to multiagency teams. Roles include clinical child psychologists, paediatricians, educational psychologists, child psychiatrists and community child psychiatric nurses.)	2,445	3,024	2,381	7,850 (11% of school pop)
CAMHS Tier 3: (Aimed at young people with more complex mental health problems than those seen in Tier 2. This service is provided by a multidisciplinary team, including child and adolescent psychiatrists, social workers, clinical psychologists, community psychiatric nurses, child psychotherapists, occupational therapists and are, drama and music therapists.)	650	803	632	2,085
CAMHS Tier 4: (Aimed at children and adolescents with sever and/or complex problems. These specialised services may be offered in residential, day patient or out-patient settings. These services include in-patient units, secure forensic adolescent units, eating disorder units, specialised teams for sexual abuse and specialist teams for neuropsychiatric problems).	30	38	27	95
Totals	**8,360**	**10,343**	**8,137**	**26,840**
Mental Health disorders - Prevalence number for 5 to 16 year olds	1,710	2,418	1,852	5,980 (10% of 5 - 16)

Children and Young People's Mental Health in England Profile – Courtesy of Berkshire Public Health team (from East Berkshire needs analysis (May 19)

Prevalence of diagnosed mental health disorders

Major surveys into the mental health of children and young people in England have been carried out in 1999, 2004 and 2017. These series of surveys are considered to provide England's best source of data on trends in child mental health. The official statistics and findings from the 2017 survey were published by NHS Digital in 2018 (Mental Health of Children and Young People in England, 2017) and the key national findings are highlighted below.

Children and Young People (CHYP) aged 5 to 19

All mental health disorders

- **12.8%** of CHYP have at least one mental disorder
- **5.0%** of CHYP meet criteria for 2 or more disorders
- Trend indicates that prevalence has risen over time for 5 to 15 year olds (9.7% in 1999 to 11.2% in 2017)

Emotional disorders

- *Includes anxiety, depressive, mania and bipolar affective disorders*
- **8.1%** of CHYP have emotional disorder
- Rates are higher in girls (10.0%) than boys (6.2%)
- Anxiety disorders (7.2%) are more common than depressive disorders (2.1%)

Behavioural or conduct disorders

- *Characterised by repetitive and persistent patterns of disruptive and violent behaviour*
- **4.6%** of CHYP have behavioural disorder
- Rates are higher in boys (5.8%) than girls (3.4%)

Hyperactivity disorder

- *Includes disorders characterised by inattention, impulsivity and hyperactivity*
- **1.6%** of CHYP have hyperactivity disorder
- Rates are higher in boys (2.6%) than girls (0.6%)

Other less common disorders

- *Includes autism spectrum disorders (ASD), eating disorders, tics and other low prevalence conditions*
- **2.1%** of CHYP have one or more of these disorders
- **1.2%** of CHYP have ASD
- **0.4%** have an eating disorder
- **0.8%** have tics or other less common disorders

Key findings by age group

Pre school children (aged 2 to 4 years)

- **5.5%** of 2-4 year olds have at at least one mental health disorder
- **2.5%** have behavioural disorders, consisting mostly of oppositional defiant disorder (1.9%)
- **1.4%** have Autism spectrum disorder
- Sleeping (1.3%) and feeding (0.8%) disorders were other disorders with specific relevance to this age group

Primary school (aged 5 to 10 years)

- **9.5%** of 5-10 year olds have at least one mental health disorder
- **3.4%** meet criteria for 2 or more disorders
- Behavioural (5.0%) and emotional (4.1%) disorders were the most common types in this age group
- Emotional disorders similar in both boys (4.6%) and girls (3.6%). However, other types of disorders were more than twice as likely in boys.

Secondary school (aged 11 to 16 years)

- **14.4%** of 11-16 year olds have at least one mental health disorder
- **6.2%** meet criteria for 2 or more disorders
- Emotional disorders (9.0%) were the most common type of disorder, followed by behavioural (6.2%)
- Girls were more likely to have emotional disorders than boys (10.9% compared to 7.1%)
- Boys were more likely to have behavioural disorders than girls (7.4% compared to 5.0%)
- Boys were more likely to have hyperactivity disorders than girls (3.2% compared to 0.7%)

Transitioning to adulthood (aged 17 to 19 years)

- **16.9%** of 17-19 year olds have at least one mental health disorder
- **6.4%** meet criteria for 2 or more disorders
- Emotional disorders (14.9%) were the most common type of disorder, followed by anxiety disorders (13.1%) and depression (4.8%)
- Young women aged 17 to 19 were more than twice as likely to have a disorder than young men (23.9% compared to 10.3%)
- **52.7%** of young women with a disorder also reported having self-harmed or made a suicide attempt

DRAFT 2018

READING HEALTH AND WELLBEING BOARD

DATE OF MEETING:	**13 March 2020**	
REPORT TITLE:	**Mental Health Strategy 2016-21 Progress Update**	
REPORT AUTHOR:	**Kathryn MacDermott**	**TEL:**
JOB TITLE:	**Acting Executive Director of Strategy**	**E-MAIL:**
ORGANISATION:	**Berkshire Healthcare NHS Foundation Trust**	

1. PURPOSE OF REPORT AND EXECUTIVE SUMMARY

1.1 The report provides an update on the progress of the Mental Health strategy. Key updates in national policy since May 2019 include the release of The NHS Long Term Plan with its ongoing commitment to investment in Mental Health services and new models of care, including: a new service model with development of out of hospital care through a new urgent care offer, Primary Care Networks, support to people in care homes and supporting people to age well – all of which are relevant to mental health and the design of mental health services; more action on prevention and health inequalities is highlighted – including the higher risk of poor health experienced by people with severe mental illness; further progress on care quality and outcomes – including children and young peoples mental health services as well as adult mental health services; NHS Staff will get the backing they need – including reference to increasing recruitment and retention in medical staff and development of new roles; Digitally enabled care will go mainstream across the NHS – includes the mental health GDE programme, digitally enabled therapy in IAPT services, and children's mental health services. Development of Population Health Management will be underpinned by development in capture/use of mental health data.

1.2 Berkshire West has prioritised the reduction of **out of area placements**, and although good progress has been made in achieving the required trajectory, this work continues to present a significant challenge.

1.3 Berkshire West was successful in securing wave 2 funding for mental health support teams in schools, building on the wave 1 funding secured previously. This will strengthen early intervention for young people, which is very important given the continuing high referral rates into our CAMH Services.

1.4 Good progress has been made with the New Models of Care for forensic tier four CAMHS and Eating Disorder Services, which has seen the establishment of provider collaboratives taking responsibility for provision of care closer to home and effective management of resources across the whole care pathway. This has reduced the number of placements made outside the patch and also secured financial savings in forensic services.

1.5 Appendix 1 – Berkshire Healthcare NHS Foundation Trust Mental Health Strategy 2016-21 Progress Update – November 2019

2. RECOMMENDED ACTION

2.1 That the report be noted.

3. POLICY CONTEXT

3.1 The Mental Health Strategy exists within the context of the NHS Long Term Plan and the BOB ICS five year plan.

4. THE PROPOSAL

Not applicable

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

5.1 The BHFT Mental Health Strategy contributes to four of the Reading Health and Wellbeing Strategy priorities:

- Reducing loneliness and social isolation
- Promoting positive mental health and wellbeing in children and young people
- Reducing deaths by suicide
- Making Reading a place where people can live well with dementia

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:

Safeguarding vulnerable adults and children

6. ENVIRONMENTAL AND CLIMATE IMPLICATIONS

Not applicable

7. COMMUNITY & STAKEHOLDER ENGAGEMENT

Not applicable

8. EQUALITY IMPACT ASSESSMENT

Not applicable

9. LEGAL IMPLICATIONS

Not applicable

10. FINANCIAL IMPLICATIONS

Not applicable

11. BACKGROUND PAPERS

Not applicable

Berkshire Healthcare NHS
NHS Foundation Trust

Mental Health Strategy 2016 – 21

Progress Update

November 2019

Berkshire Healthcare NHS Foundation Trust

Mental Health Strategy Summary 2016 - 2021

Berkshire Healthcare NHS
NHS Foundation Trust

Effective and compassionate help

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

Supporting our staff

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

Working with service users and carers

- Guiding development of our services
- Supporting self management.

Safer, improved services with better outcomes, supported by technology

Good experience of treatment and care

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

Straightforward access to services

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

Working with partners and communities

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

Our Mental Health Strategy – progress since December 2016

Berkshire Healthcare NHS
NHS Foundation Trust

The Trust Board approved our mental health strategy in December 2016, and the priority areas of focus were confirmed as:

Safer, improved services

with better outcomes, supported by technology

Progress updates were provided to the Trust Board in May and November 2017, July and November 2018, May 2019. This paper provides an overview of changes in terms of:

- Developments in national policy/local operating context since May 2019
- Our progress in taking forward our key initiatives, strategic intentions and achieving national targets
- Planned next steps

Developments in national policy since May 2019

NHS England published the NHS Mental Health Implementation Plan 2019/20 – 2023/24, which aims to use a ring-fenced local investment fund of £2.3bn to ensure high quality, evidence based mental health services. The document outlines a new planning approach to build on the Five Year Forward View for Mental Health and the Long-Term Plan commitments. There is a split for each deliverable into 'fixed' (national access or coverage with year-on-year trajectories),'flexible' (all systems to have in place by 2023/24, or before if specified, with flexibility in delivery approach and/or phasing and 'targeted' (targeted service expansion or establishment in select areas). Funding will be used to support work across the core ambitions of the NHS Long Term Plan (LTP) in:

- specialist community perinatal mental health
- adult severe mental illnesses (SMI) community care
- therapeutic acute mental health inpatient care problem gambling mental health support rough sleeping mental health

- children and young people's mental health
- adult common mental illnesses (IAPT)
- mental health crisis care and liaison
- suicide reduction and bereavement support problem

The LTP includes a number of priorities with specific relevance to mental health, including: a **new service model** with development of out of hospital care through a new urgent care offer, Primary Care Networks, support to people in care homes and supporting people to age well – all of which are relevant to mental health and the design of mental health services; more action on **prevention and health inequalities** is highlighted – including the higher risk of poor health experienced by people with severe mental illness; further progress on **care quality and outcomes** – including children and young peoples mental health services as well as adult mental health services; **NHS Staff will get the backing they need** – including reference to increasing recruitment and retention in medical staff and development of new roles; **Digitally enabled care will go mainstream across the NHS** – includes the mental health GDE programme, digitally enabled therapy in IAPT services, and children's mental health services. Development of Population Health Management will be underpinned by development in capture/use of mental health data.

Mental Health Strategy and system working

Berkshire Healthcare NHS
NHS Foundation Trust

Berkshire East

The Frimley Health and Care Integrated Care System (ICS) Mental Health Programme has prioritised 3 key areas of work:

- **Significantly reduce Out of Area Placements (OAPs) by 2020.** Targets for 2018/19 were achieved by the ICS, but remain very challenging to deliver in 2019/20.
- **Ensure there are easily accessible urgent, emergency and liaison Mental Health Services.** Liaison services are in place across the ICS, and this priority initiative is focussed on the overall pathway
- **Improving access to Children and Young People's Mental Health Services** – this replaced increasing access to perinatal mental health care as this was successfully achieved prior to the last update provided to the Trust Board.

The ICS Mental Health steering group is also accountable for oversight of delivery of LTP targets as well as to ensure that mental health is embedded within all ICS priority initiatives. The most challenging targets to deliver continue to be the OAPs and children and young people's access to services, but the majority of the remainder have been delivered or are on course for delivery.

Effective working relationships have been established with colleagues in Surrey and Borders Partnership Trust and local commissioners, and our staff have made a strong contribution to the work of the programme. A notable achievement has been securing Wave 1 Transformation Funding from NHSE for 2019/20 and 2020/21 which will enable design and implementation of changes to community mental health services in Frimley ICS. This will include an enhanced contribution within primary care, partnership working with the community and voluntary sector and adult social care. Benefits will include prompt support within primary care, including for those with serious mental illness and personality disorder.

Work is now in progress to finalise the mental health plan linked to the ICS 5 year plan - separately reported to the Trust Board.

Berkshire West

The Berkshire West Mental Health Delivery Group is the key forum for oversight of LTP MH targets and implementation of local strategy within the Integrated Care Partnership (ICP).
In common with Frimley ICS, Berkshire West has also prioritised the reduction of **out of area placements**, and although good progress has been made in achieving the required trajectory, this work continues to present a significant challenge.

A Mental Health Steering Group is now well established as part of the B**uckinghamshire, Oxfordshire and Berkshire West (BOB) STP.** This group is chaired by the CEO of Oxford Health NHS Foundation Trust, and the role of Senior Responsible Officer will transfer from our Director of Strategy and Corporate Affairs to our Regional Director for Berkshire West in December, thus maintaining the balance of leadership across the patch.

Berkshire West was successful in securing wave 2 funding for mental health support teams in schools, building on the wave 1 funding secured previously. This will strengthen early intervention for young people., which is very important given the continuing high referral rates into our CAMH Services.

Good progress has been made with the New Models of Care for forensic tier four CAMHS and Eating Disorder Services, which has seen the establishment of provider collaboratives taking responsibility for provision of care closer to home and effective management of resources across the whole care pathway. This has reduced the number of placements made outside the patch and also secured financial savings in forensic services.. NHS England has recently embarked on a process to request expressions of interest in leadership of provider collaboratives for Veterans Mental Health Services.

The planning landscape in BOB is complex, and the process of developing the ICS 5 Year Plan has been challenging, in order to ensure effective engagement of each "Place" while avoiding duplication of work. Key priorities and current progress is included in the Trust Board report about ICS Plans.

Mental Health Strategy priorities and governance - a reminder

Berkshire Healthcare NHS
NHS Foundation Trust

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

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

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

Our "True North" metrics relevant to our mental health services that are listed on our 2019/20 Plan on a Page for 2019/20 are:

- Reducing harm to our patients by reducing: self harm and suicide, falls, medication errors, pressure ulcers and preventable deaths from septicaemia
- At least 95% of our reported incidents will be low or no harm to patients
- All patient facing teams will have evidence based objectives for reducing patient harm in their plans for 2019/20
- All our support services will work with patient facing services to identify ways that they can support safety of patients
- **With our health and social care partners:** We will work to achieve reduced urgent admissions and delayed transfers of care.

Significant progress has been made in reduction of use of prone restraint, and also with reductions of self harm and reduction of staff assaults.

Our **Quality Improvement Programme** provides the infrastructure to enable us to achieve our objectives, and this approach will continue to be used to as we refresh our Three Year Trust Strategy and confirm our "Plan on a Page" measures for 2020/21.

Governance
Our **Mental Health Development Group**, accountable to the Business and Strategy Executive continues to oversee implementation of the Mental Health Strategy and enables project leads to understand and address interdependencies between initiatives,. Commissioners have been part of this group for approximately 6 months, aiding alignment and reduction of duplication of effort. Projects in scope of this group include:
Bed Optimisation,/Just to Zero, EUPD Pathway , CPE Development and CMHT Function and Workforce.
Formal progress reports are provided to our Business and Strategy Executive for all initiatives.

Our IAPT service development continues to be implemented as "business as usual", reporting progress into Trust Business Group and Quality and Finance and Performance Executive meetings as required.

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

Urgent Care developments are managed through our operational management structures and our membership of Urgent and Emergency Care Boards.

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

The following slide provides the high level implementation "road map" for the key initiatives included in the strategy approved by the Trust Board. This is followed by an outline of progress regarding each of the key initiatives listed.

Mental Health Strategy

Implementation roadmap December 2016

Berkshire Healthcare NHS
NHS Foundation Trust

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

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

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

Progress on Key Initiatives

Prospect Park Hospital Development

Bed Optimisation/ Just to Zero initiative:
This project was established to achieve:

- No Out of Area Placements (OAPs) as a result of acute overspill by 2020
- Acute adult bed occupancy consistently below 90%

Executive approval processes for OAPs remain in place, and work has been structured by the use of QI methodology. Reduction of out of area placements is a key area of focus in both ICS Delivery Plans as described on page 5. As planned, the initiative has now been re-scoped, with arrangements for optimising rehabilitation and recovery now "business as usual". The work to eliminate acute overspill has been organised into four new work streams under the initiative "Just to Zero" (which references the target). Acute Overspill has seen a reduction in October and for the first time in 2019 has reached zero and stayed at that level for 2 weeks.
The milestones set to deliver by end of Q3 are starting to show real progress. The bed escalation process which commenced in August 2019, is currently being re-evaluated prior to the second PDSA phase. Discussions with Rosebank continue to progress towards a new service model which will include step down, and work on Crisis beds is underway.
The Prospect Park Bed Management Team were worthy winners of our "clinical team of the year" award this month.

Staffing:
Having moved this initiative into " business as usual" arrangements, there is a strong focus on recruitment and retention within the PPH leadership team, supported by the dedicated HR Operations Manager and progress is reported into the Mental Health Development Group and Strategic Workforce Steering Group. 18 newly qualified nurses have commenced in post in October, and levels of band 2 – 4 staffing are good. Staffing levels on Sorrell Ward remain good, which is very pleasing given the previous high levels of vacancies.
However, we continue to be challenged by the shortage of supply of Band 5 nurses, and therefore are prioritising retention and using QI methodology to ensure continued focus on actions to address this issue.

IAPT

Our Talking Therapies key initiatives are now embedded in regular operational management and reporting arrangements, and our service continues to meet access and recovery targets. Waiting time performance may well be challenged in Berkshire West due to resource constraints, but planning for 2020/21 is still in progress. with commissioners. A Common Point of Entry/Wellbeing project is in progress to provide an effective response to those people coming through our CPE, who do not need secondary mental health services. This is required because of the very large numbers of referrals that continue to be made into CPE, to ensure appropriate assessment and management of risk, as well as a good experience for service users. Agreement of objectives has been achieved regarding the establishment of an integrated response incorporating IAPT and signposting to community and voluntary sector services . East and West of Berkshire are at different stages of development, and work is in progress to ensure we achieve the right balance between local requirements and overall service sustainability and an evidence based model.

Zero suicide

The Five Year Forward View for Mental Health called for multi-agency suicide prevention plans as part of major drive to reduce suicides in England by 10 per cent by 2020/21. Our Zero Suicide programme, initiated in 2016, has achieved its annual objectives and has three priority areas for 2019/20:

- Zero Suicides in our Inpatient Units
- Safety planning ,focussed on means restriction, problem solving and coping skills , enhancing social support, identifying emergency contacts
- Staff feeling that we have a learning not blaming culture

All new staff receive suicide prevention training as part of induction and we have a fully embedded 3 day suicide prevention training programme that is in its third year. The Zero Suicide Alliance eLearning course is available on our intranet and the "We need to talk about suicide: helping everyone to feel more confident to talk about suicide" e-learning package is now available via ESR. Our work has a focus on mental health inpatients, CRHT and Willow House, prioritising reduction of self harm. Now that the concept of Zero Suicide is understood widely across the Trust , it is time to embed it as part of our ongoing day to day operations, which will be overseen by a ***Suicide and Self Harm Prevention Strategy Group***

Progress on Key Initiatives

Berkshire Healthcare NHS
NHS Foundation Trust

Pathways and Clustering

This programme was set up to optimise service delivery and to understand and improve outcomes for service users, while also positioning the Trust to meet anticipated development of payment by results in mental health. While the policy focus has shifted to population based funding as part of Integrated Care Systems, this initiative will continue to make a significant contribution to our understanding of how well we are serving local people. Having achieved key objectives, in terms of pathway development, rates of clustering and use of e-pathways, this initiative moved to "business as usual" at the end of June. The project closure report will be provided to the Business and Strategy Executive in November, ensuring that we have effective arrangements in place to monitor required outcomes as part of established performance processes in our mental health services.

Emotionally Unstable Personality Disorder (EUPD) Project

This project was established to plan and deliver a consistent offer to service users – recognising the higher than average number of people with this diagnosis who were being admitted to our inpatient wards.

SCM (Structured Clinical Management) is now in place in all CMHTs. The numbers of CMHT "take up" into SCM is now part of the project metrics and Divisional Scorecards. **PICT** (Psychologically Informed Consultation and Training) is in operation and has completed a number of training modules which are now available and being provided. A plan for implementation of Assessment, Assertive Stabilisation and Service User Networks has been developed. The Steering Group task and finish group structure has been adapted to continue to develop and implement the operational model, deployment of new services into existing services, coordinated and innovative recruitment and risk management.

Longer term care

The **Eliminating Overspill, Optimising Rehab and Recovery** seeks to address the 5YFV aim of eliminating acute out of area placements as well as development of a range of rehabilitation & recovery options. Great progress has been made over the last 12 months against the initial aims and objectives. The rehab and recovery element has been concluded and arrangements are now business as usual .

Regional work to develop a New Model of Care for people needing **low and medium secure services** has progressed well achieving both quality improvements and financial savings. Work is currently in progress to move to business as usual arrangements, led by Oxford Health and NHSE Specialised Commissioning.

CMHT Function and Workforce

This initiative was commenced during 2018/19 and aims to have completed the following by March 2020:

- To have defined and implemented a revised service offer which removes unwarranted variation across Berkshire
- To address current challenges in recruitment and retention of CMHT staff, including the completion of a workforce plan

The resulting model will need to be delivered within existing resources. A successful Rapid Improvement Event was held in September to explore the initial processes in each Locality for CMHT service users. These processes were mapped out for each service, and compared in terms of obstacles experienced and what works well. Local services will be involved in developing a standard process with agreed metrics for piloting. This work provides the foundation for identification of required workforce roles, informing recruitment and retention activity.

Urgent Care

Work is continuing to optimise the performance of our Common Point of Entry, Crisis Response Home Treatment Services, and our Inpatient Wards. Progress has been made in ensuring that accurate data is used to inform agreed actions. through our Urgent and Emergency Care Boards in East and West of Berkshire, including numbers of bed days lost due to delayed transfers of care.

Transforming urgent care pathways was included as a "placeholder" in our strategy implementation plan from April. 2019, however, work on the development of our system urgent care strategy has been delayed, and we will include strategic direction for our own urgent care services within our over-arching three year strategy refresh.

Technology enabled service delivery

Berkshire Healthcare NHS
NHS Foundation Trust

The use of technology to enable the delivery of a new model of care in mental health is at the centre of our ambition as a "Global Digital Exemplar" for mental health, confirmed in April 2017.
Our GDE Programme (including roll out of ePMA) consists of 19 projects within four GDE initiatives:

- Direct Patient Access & Communication
- Digital Wards & Service
- Digital workforce
- Research & Quality improvement

The programme is in its busiest period and will be until December 2019 (when the final milestone is due). Project closure for 7 projects is underway.
We are joining our Fast Follower in September to visit the Centre for Addiction and Mental Health in Toronto (they achieved level 7 accreditation- the highest level possible from the Healthcare and Information Management Systems Society).
Our SHaRON blueprint has been published and is available on the digital platform.
Electronic Medical Record Adoption Model evaluation has been undertaken and our current level of adoption & maturity is HMISS Level 5.

Work will be focussed on the following activities in the next phase:

- Enhanced Online Support and Sign Posting
- Digital Appointment Correspondence
- Live Patient Safety Monitoring & Alerting
- Active alerting
- Second Generation Mobile Working
- Order Communications - Electronic requesting and reporting.

Progress in other related programmes

Information Technology Architecture Strategy Implementation Programme
This is planned to run until March 2020 and comprises six elements including Office 365 migration and movement of departmental systems to the Cloud. Good progress has been made with Community of Interest Network (COIN) capability being completed, e-mail migration completed, secure e-mail implemented and Windows 10 implementation on target.
Connected Care shared record programme
The Berkshire Connected Care Portal went live at the end of January 2016, and has been developed to enable access to GP data and acute hospital admissions, discharge & transfer data.
Berkshire Healthcare staff have continued to increase their access into Connected Care to view information which supports delivery of safe, good quality care, improved patient experience, and effective use of resources.
Governance arrangements for the programme have been reviewed to ensure effective links to work in progress in each locality, as well as oversight of the programme by the ICP Population Health & Digital Development Board.
We have continued our use of **online programmes** as part of our **Talking Therapies** service, enabling us to achieve access targets, including our offer across major long term physical health conditions. Our partnership with Silvercloud has enabled us to collaborate on the development of programmes for people with long term physical health problems , building on the initial online services for people with common mental health problems. We are finalists in the 2019 HSJ Awards Mental Health Innovation of the Year, recognising this work.
Informatics development
This remains an important priority – and we are able to access a wide range of tableau dashboards for our mental health services, enabling staff and managers to understand referral, activity and caseload information, at service and team level. We have aligned ESR and financial information to provide vacancy and other workforce information as part of the "People Dashboard" which will be available through tableau in 2020.
This work is crucial to the development of our Population Health Management capability – which is a key initiative within both ICSs of which we are a part. This will enable us to use data to better understand the needs of our population, patterns of activity and outcomes to improve patient experience and outcomes, as well as our use of resources.

Measuring our progress and next steps

Our contribution to the mental health sections of the ICS 5 Year plans has identified overall good progress in delivery of FVMH /LTP targets (please see page 11 for a RAG rated summary of the key targets from NHS England reported in previous updates).
Areas prioritised as requiring further work are:

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

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

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

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

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

Next Steps

In addition to continuing to progress our identified mental health initiatives, the following activities are currently being prioritised for action :

- Continued focus on our **Quality Improvement** approach to empower front line staff to work on improvements in priority areas identified in our Plan on a Page and at local level.
- Development of **Primary Care Networks** which include an effective response to the mental health needs of our population – across the range of need from mild-moderate difficulties through to serious mental illness.
- Delivery of our **Global Digital Exemplar Programme** – and maximising the use of technology to improve safety and help us manage demand and capacity.
- Further exploration of measurement of **patient experience and outcomes** across our mental health services.
- Continuing to refine and implement our **Workforce Plan** for mental health – this includes focus on both inpatient and community services with the establishment of our CMHT Function and Workforce initiative.
- **Progressing mental health initiatives within our ICSs**. This will include work with partners to reduce out of area placements, achievement of FYFV MH targets and ensuring mental health is effectively represented in all work streams. The completion of five year system plans during the summer will require a significant focus on mental health.
- Working with commissioners to ensure that the **Mental Health Investment Standard** is met, and that Mental Health Investment Strategies reflect funding provided to commissioners to achieve LTP targets: the investment standard is being met currently, but progress on reducing OAPs will enable investment in local, prevention-focussed initiatives.
- **Forward planning for the refresh of our Three Year Strategy in April 2020,** informed by the NHS Long Term Plan and implementation guidance.

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

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

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

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

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

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

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

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

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

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

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

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

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

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READING HEALTH AND WELLBEING BOARD

DATE OF MEETING:	**13 March 2020**		
REPORT TITLE:	**Update on Joint Strategic Needs Assessment Model**		
REPORT AUTHOR:	**Poppy Barnard**	**TEL:**	**0118 937 4332**
JOB TITLE:	**National Management Trainee**	**E-MAIL:**	**poppy.barnard@reading.gov.uk**
ORGANISATION:	**Reading Borough Council**		

1. PURPOSE OF REPORT AND EXECUTIVE SUMMARY

1.1 This report has been written to provide the Health and Wellbeing Board with an update on each of the three strands of the Joint Strategic Needs Assessment (JSNA) model, as agreed in Health and Wellbeing Board in October 2018.

1.2 Appendix 1 outlines the main functionality of the Berkshire Observatory data tool.

1.3 Appendix 2 contains an example of a detailed needs analysis carried out by a partner organisation that has been included as part of the JSNA (to follow).

1.4 Appendix 3 shows the process for including local research on the RBC JSNA webpages.

2. RECOMMENDED ACTION

2.1 For the Health and Wellbeing Board to note the progress made by each strand of the new JSNA model.

3. POLICY CONTEXT

3.1 In October 2018, the Health and Wellbeing Board agreed to progress the JSNA in line with a new model which provided a more cohesive and efficient approach to assessing the needs of the local population. The new JSNA model has been developed to contain three strands:

1. A digital resource of data to describe the demography and wider determinants of health of the Reading population in a way that is user-friendly and configurable;

2. A repository for detailed, service specific needs assessments carried out by internal and external partners with support from Public Health and Wellbeing officers;

3. Improved engagement with local research groups, focusing on qualitative and participatory research.

4. CURRENT POSITION

4.1 Strand 1: Online Data Tool

4.1.1 The Shared Public Health for Berkshire Team successfully procured a digital data resource, Instant Atlas, which is provided by Geowise. This tool has been localised to the six Berkshire Local Authorities and is called the Berkshire Observatory, available at https://berkshireobservatory.co.uk.

4.1.2 The Berkshire Observatory holds over 9,000 data indicators on the local population in Berkshire, pulled from a variety of public sources and automatically updated when new

data is released. The website offers detailed analysis of data, with tools that let users make comparisons at a council, ward and neighbourhood level across Berkshire, the South East and England. The mapping functionality of this data onto a Berkshire-wide footprint allows staff at all levels to access and interpret the data.

4.1.3 The Berkshire Observatory was soft launched on 2 September 2019 and the Public Health and Wellbeing Team in Reading have since been raising awareness of the website internally to staff at all levels, including specific workshops for teams that would benefit from using this tool as part of their service planning, such as Commissioning in Adult Social Care. The tool has also been promoted externally to local partners such as the voluntary and community sector, Older People's Working Group, Physical Disability and Sensory Needs Network and Berkshire West CCG.

4.1.4 The outcome of this work is that the Berkshire Observatory has started to become well-recognised and used as a data resource on the local population, informing strategic service planning and decision-making at Reading Borough Council and the wider community. It has also encouraged its users to work in health-oriented ways whilst promoting a prevention approach.

4.1.5 Appendix 1 illustrates the main functionality of each of the tools on the Berkshire Observatory.

4.2 Strand 2: Focussed Needs Assessments

4.2.1 The second strand of the JSNA model focuses on producing content in alignment with needs assessments that have already been undertaken or are in the process of being developed by staff in the Council and its partners as part of its strategic development and commissioning.

4.2.2 If necessary, Public Health and Wellbeing officers can support development of needs analyses that enable commissioning activity and consider vulnerabilities and inequalities. Once these are completed, they are published online as JSNA content on the RBC website. A piece of work has also taken place to update the JSNA webpages on the RBC website to reflect the new model.

4.2.3 The overall aim of this strand is to build a library of resources with partners using a more integrated and coordinated approach, accompanied by analysis of local need and evidence of effectiveness as part of the design of interventions and pathways for health and wellbeing. This is a move away from the Public Health and Wellbeing team annually creating a large number of reports and thematic chapters which can result in duplication of work already completed by other areas within the organisation.

4.2.4 An example of one of the needs analyses is included in Appendix 2 (to follow).

4.3 Strand 3: Engagement with Local Research Groups

4.3.1 The final strand of the JSNA model looks to improve engagement with local research, especially qualitative and participatory research, that captures service users' voice.

4.3.2 A working group was established with local partners to develop a Local Research and Evidence Framework to:

- Provide guidelines for what will be published as local research and evidence on the RBC JSNA web pages, as well as a process and schedule for reviewing local research through the Virtual Panel
- Create minimum expectations for setting out the context of local research
- Set expectations for the ethical treatment of individuals who contribute to local research
- Include mechanisms for review and revision to the framework when necessary

- Celebrate and publicise local research and create links between local commissioners/ strategic planners and organisations with capability to capture the voices of local people.

4.3.3. The work concluded on 27th January 2020 with agreement to hold an annual review meeting in February of each year, providing an opportunity to reflect on the panel process and agree changes where needed, and to promote and celebrate local research projects.

4.3.4 Appendix 3 contains the process for local research to be included on RBC JSNA webpages.

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 model creates a more cohesive and efficient approach to assessing those needs by:

- 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 groups.
- Improving links with local qualitative research to provide an opportunity for service user voices to be articulated and taken into account.

6. COMMUNITY & STAKEHOLDER ENGAGEMENT

6.1 Consultation and engagement has taken place between Public Health and Wellbeing officers and internal teams and external organisations to promote the usage of the Berkshire Observatory data tool within Reading.

6.2 In addition, communicating with partner organisations has assisted with planning and supporting the production of service-specific needs analyses.

6.3 The Local Research and Evidence Framework has required membership of internal teams and partner organisations that undertake qualitative or participatory research in Reading, including Policy Team, Neighbourhoods Team, Healthwatch Reading, University of Reading, Reading Voluntary Action and Berkshire West CCG.

7. EQUALITY IMPACT ASSESSMENT

7.1 An Equality Impact Assessment is not required for this report as no groups will be disproportionately affected by the new JSNA model. Through improved engagement with local research groups, the JSNA will incorporate viewpoints of under-represented groups.

8. ENVIRONMENTAL IMPLICATIONS

8.1 There are no negative environmental implications related to this report.

9. LEGAL IMPLICATIONS

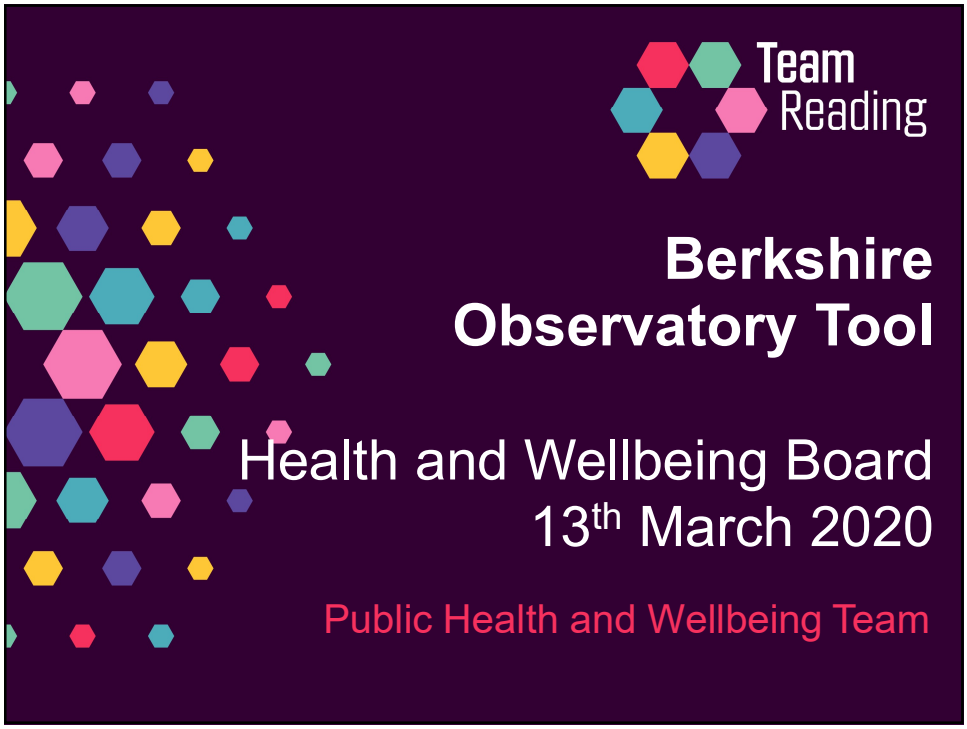
9.1 Preparing a JSNA, in partnership with local CCGs, is a legal requirement for local authorities. Under the Local Government and Public Involvement in Health Act (2007) and the Health and Social Care Act (2012), Reading Borough Council has a legal duty to prepare a JSNA and a strategy for meeting the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

10. FINANCIAL IMPLICATIONS

10.1 There are no financial implications related to this report as the procurement of the Data Observatory tool has been funded by the existing flat rate contribution Reading Borough Council make to the Public Health Shared Team in Bracknell on an annual basis.

11. BACKGROUND PAPERS

11.1 There are no background papers attached to this report.



Joint Strategic Needs Assessment

Councils and CCGs have a duty to complete a JSNA to assess the current and future health, care and wellbeing needs of the area to inform decision-making.

The Reading JSNA model contains three strands:

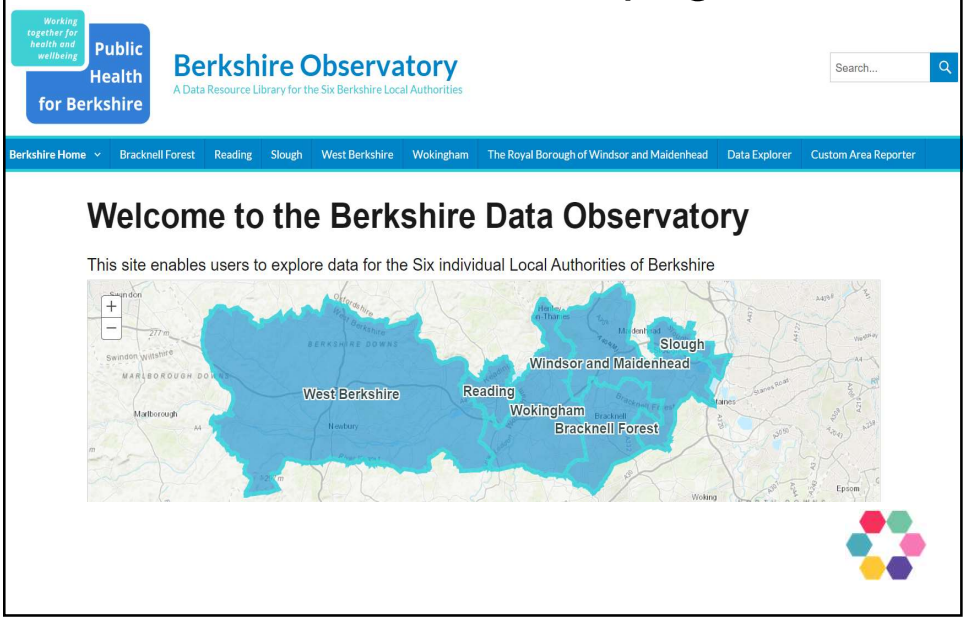
1. **A digital data tool to describe the demography and wider determinants of health of the Reading population**
2. **A repository for service-specific needs assessments carried out by internal and external partners supported by Public Health and Wellbeing**
3. **Improved engagement with local research groups, focusing on qualitative and participatory research**

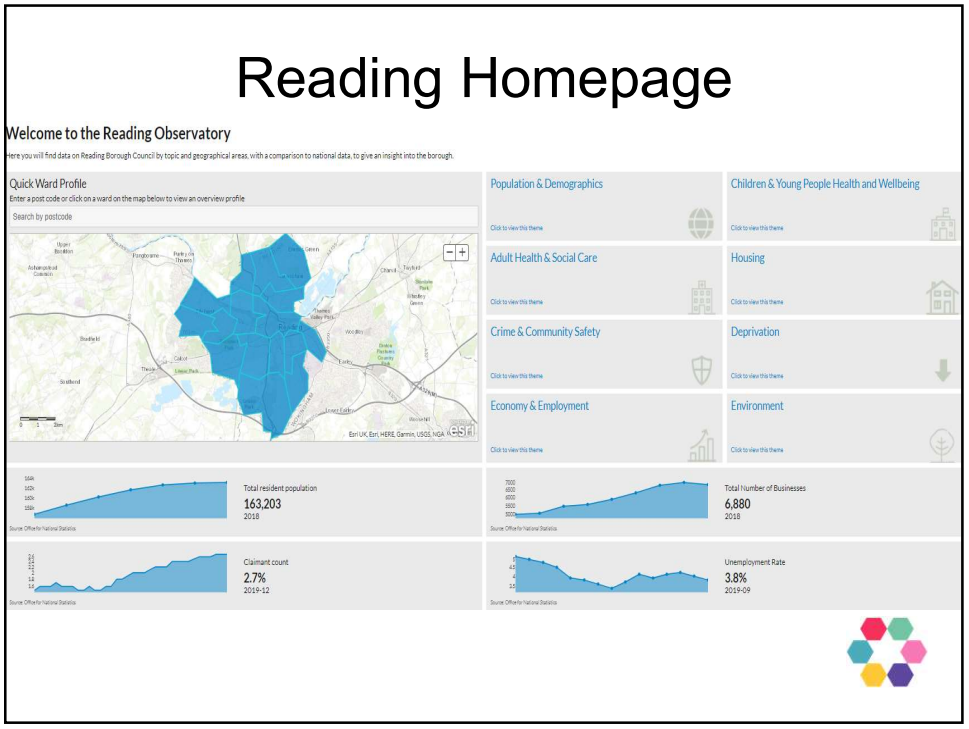
Why Use the Berkshire Observatory?

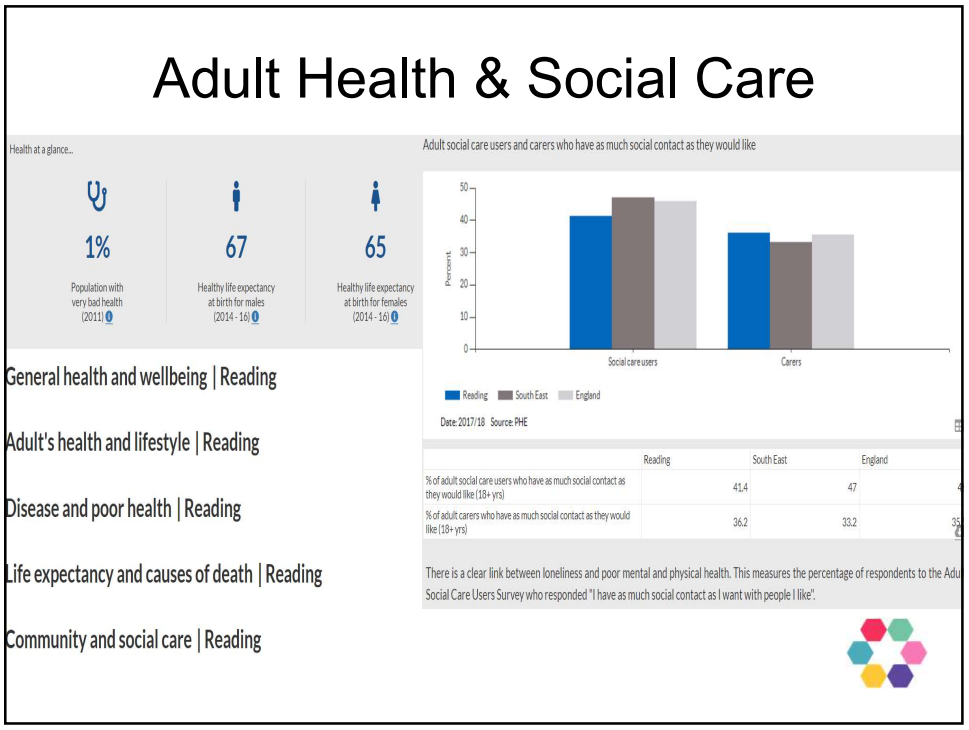
- Use local data to inform decision-making and planning in your team
- Pulls data from various public sources into one place & updates automatically
- Data available for each Berkshire council at neighbourhood, ward and council level
- Easy to navigate & has mapping tools to visualise data better

https://berkshireobservatory.co.uk

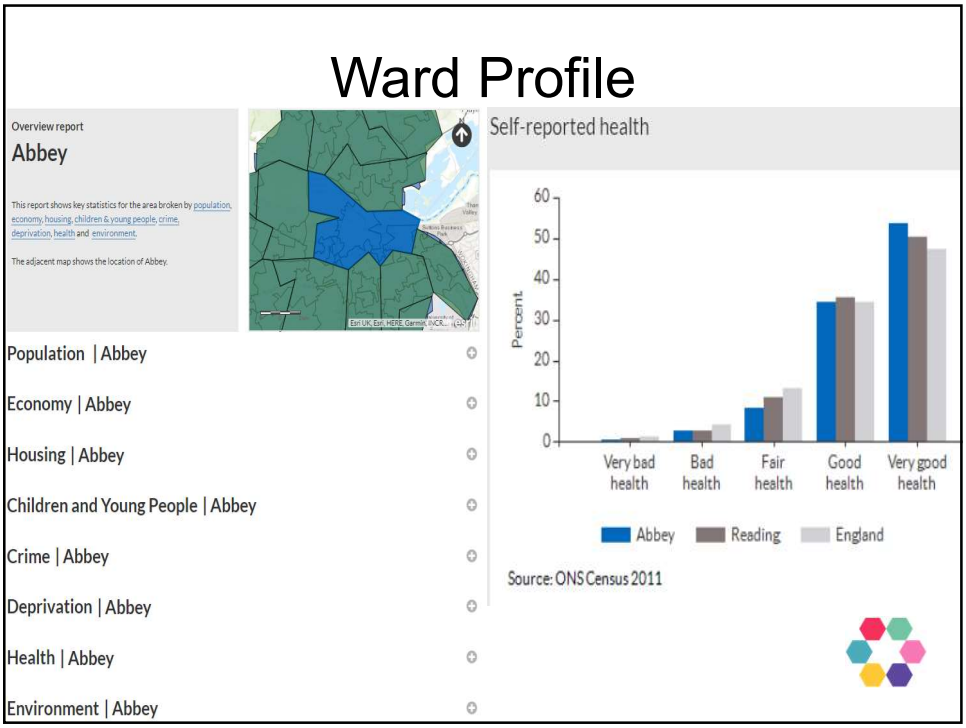
Berkshire Homepage



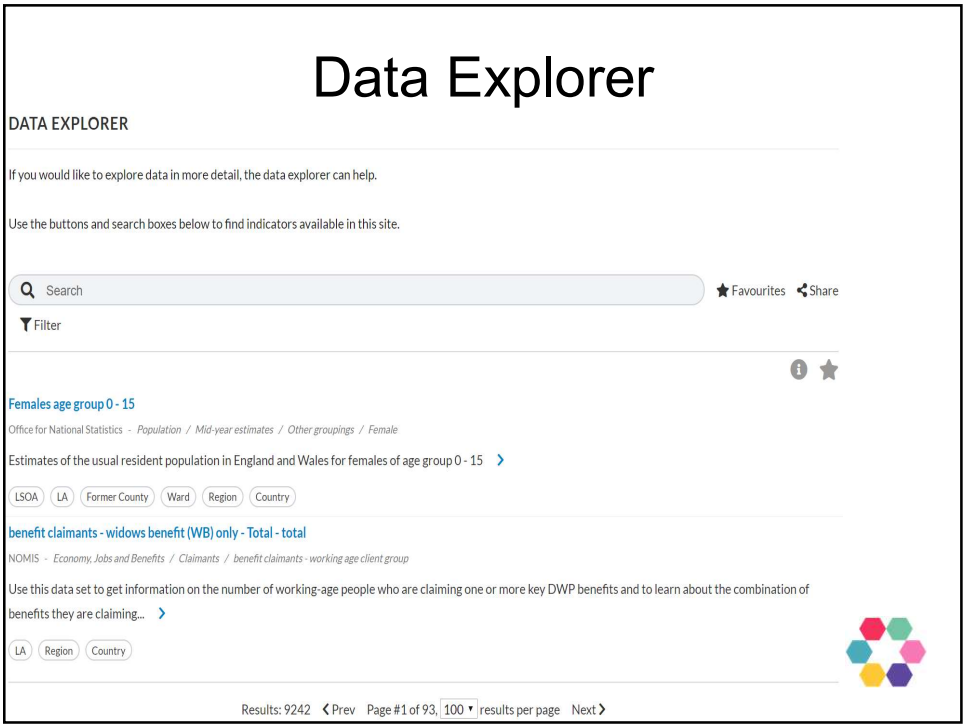

Reading Homepage
Welcome to the Reading Observatory
Here you will find data on Reading Borough Council by topic and geographical areas, with a comparison to national data, to give an insight into the borough.
Quick Ward Profile
Enter a post code or click on a ward on the map below to view an overview profile
Search by postcode
Population & Demographics
Children & Young People Health and Wellbeing
Adult Health & Social Care
Housing
Crime & Community Safety
Deprivation
Economy & Employment
Environment
Total resident population
163,203
2018
Total Number of Businesses
6,880
2018
Claimant count
2.7%
2019-12
Unemployment Rate
3.8%
2019-09


Adult Health & Social Care
Health at a glance...
1%
Population with very bad health (2011)
67
Healthy life expectancy at birth for males (2014 - 16)
65
Healthy life expectancy at birth for females (2014 - 16)
General health and wellbeing | Reading
Adult's health and lifestyle | Reading
Disease and poor health | Reading
Life expectancy and causes of death | Reading
Community and social care | Reading
Adult social care users and carers who have as much social contact as they would like
Percent
Social care users
Carers
Reading
South East
England
Date: 2017/18 Source: PHE
Reading
South East
England
% of adult social care users who have as much social contact as they would like (18+ yrs)
41.4
47
% of adult carers who have as much social contact as they would like (18+ yrs)
36.2
33.2
There is a clear link between loneliness and poor mental and physical health. This measures the percentage of respondents to the Adu
Social Care Users Survey who responded "I have as much social contact as I want with people I like".

Ward Profile



Data Explorer

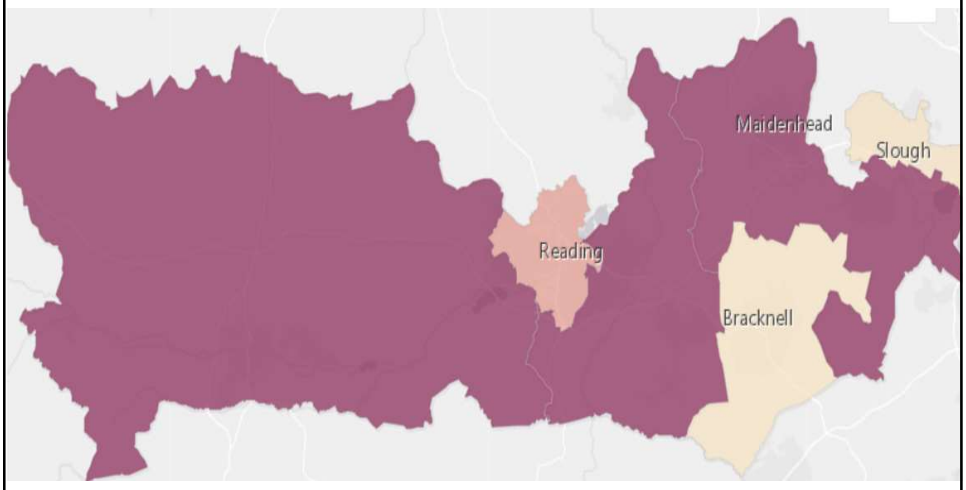


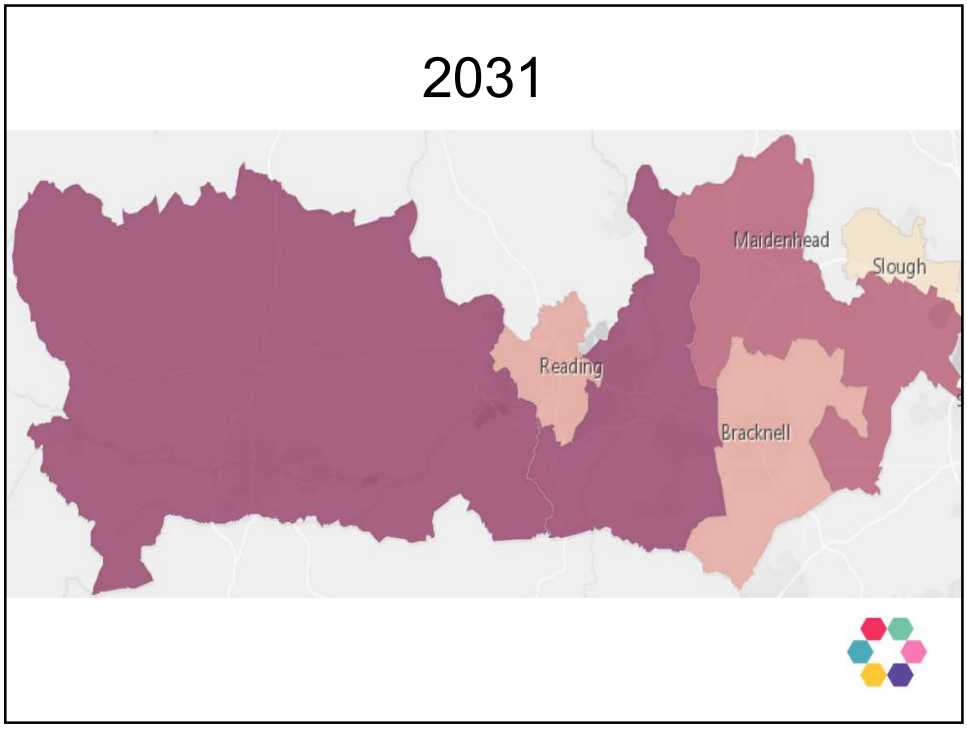
Population Projection of Over 65's

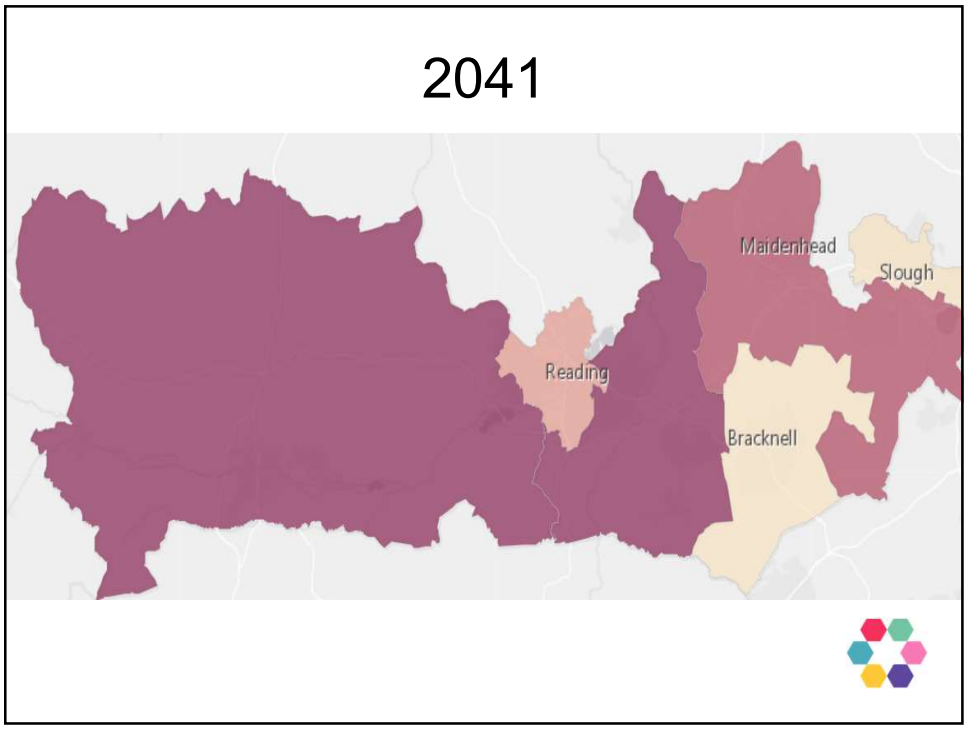
Map Download

Name	2020	2021	2026	2031	2036	2041
Bracknell Forest	18,294	18,802	21,591	24,763	27,388	29,228
West Berkshire	31,359	32,096	36,112	40,650	44,544	46,793
Reading	20,791	21,162	23,438	26,501	29,399	31,624
Slough	15,686	16,037	18,222	20,782	23,376	25,813
Windsor and Maidenhead	28,762	29,108	31,665	35,255	38,746	41,362
Wokingham	30,488	31,045	34,449	38,309	41,685	44,277

2020

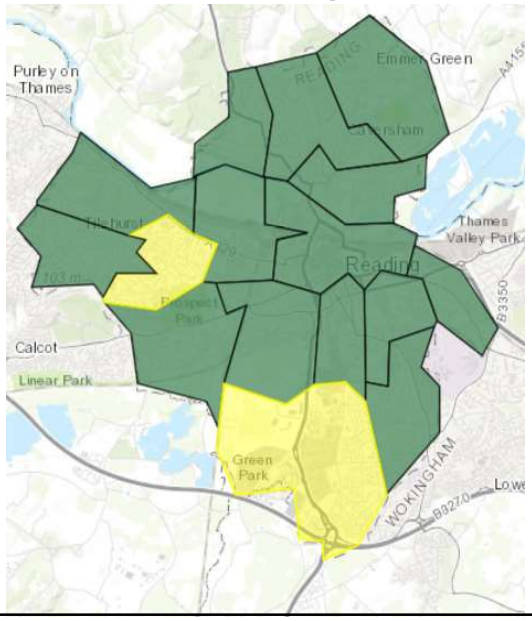



2031
Maidenhead
Slough
Reading
Bracknell

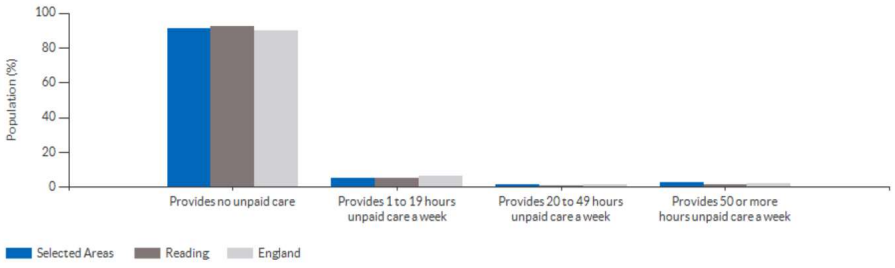

2041
Maidenhead
Slough
Reading
Bracknell

Custom Area Reporter

- Overview
- Population
- Housing
- Health
- Environment
- Economy
- Deprivation
- Crime
- Children & Young People



Provision of Unpaid Care

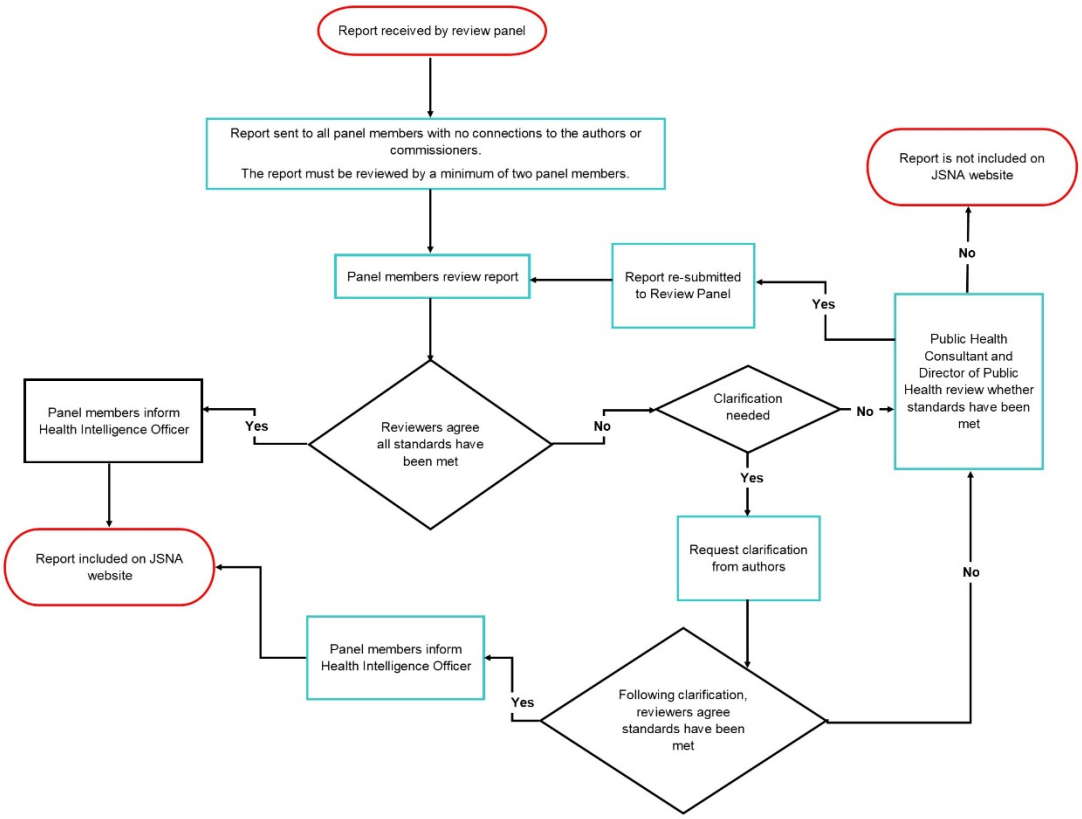


Source: ONS Census 2011

	Selected Areas		Reading		England	
	Count	%	Count	%	Count	%
Provides no unpaid care	19,557	91.1	143,383	92.1	47,582,440	89.8
Provides 1 to 19 hours unpaid care a week	1,061	4.9	8,074	5.2	3,452,636	6.5
Provides 20 to 49 hours unpaid care a week	307	1.4	1,642	1.1	721,143	1.4
Provides 50 or more hours unpaid care a week	541	2.5	2,599	1.7	1,256,237	2.4


Team
Reading
Thank you for
listening

Appendix 3 – Process for including local research on the RBC JSNA webpages



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READING HEALTH AND WELLBEING BOARD

DATE OF MEETING:	**13th MARCH 2020**		
REPORT TITLE:	**INTEGRATION PROGRAMME UPDATE**		
REPORT AUTHOR:	**LEWIS WILLING**	**TEL:**	**01189 372477**
JOB TITLE:	**INTEGRATION PROJECT MANAGER**	**E-MAIL:**	**LEWIS.WILLING@READING.GOV.UK**
ORGANISATION:	**READING BOROUGH COUNCIL / BERKSHIRE WEST CCG**		

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 for the financial year so far.

1.2 Of the 4 national BCF targets:

- Performance against one (limiting the number of new residential placements) is strong, with 51 placements made in 9 months and a projected 68 placements for the financial year (Against a target of 116 for the financial year).
- Whilst we have not met our target for reducing the number of non-elective admissions (NELs), the performance now includes some of the winter pressure period. Over the 8 recorded months, there have been 11495 NELs against a target of 10987. Work against this goal remains a focus for the Berkshire West-wide BCF schemes and the Reading Integration Board work plan.
- We have met our target DTOC for 63% of this financial year. There has been improvement in performance in 5 of the 8 months in this financial year for DTOC.
- Progress against our target for increasing the effectiveness of reablement services remains in line with previous reports, but this is due to revised guidance around the methods of measuring their impact (see section 4.9 – 4.11 for further detail) and further activities are planned to align our reablement offer with emerging national best practice.

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

DTOC

4.1 Our target for 2019/2020, we aspire to have no more than 419 bed days lost per month broken down as follows (as average monthly targets):

- 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

4.2 Our results across the last year to date are as follows:

- April 2019 = 224 (of which 160 Health, 29 ASC, 35 both)
- May 2019 = 264 (of which 182 Health, 80 ASC, 2 both)
- June 2019 = 467 (of which 205 Health, 246 ASC, 16 both)
- July 2019 = 368 (of which 140 Health, 196 ASC, 32 both)
- August 2019 = 492 (of which 260 Health, 184 ASC, 48 both)
- September 2019 = 360 (of which 206 Health, 128 ASC, 26 both)
- October 2019 = 456 (of which 162 Health, 205 ASC, 89 both)
- November 2019 = 378 (of which 214 Health, 134 ASC, 30 both)

4.3 Health have met their target in 6 of the 8 months so far, with better performance than last year in 6 of the 8 months so far. Adult Social Care have met their target in 4 of the 8 months so far, with better performance in 2 of the 8 months so far. Those attributed as both the target has been met in 5 of 8 months, with better performance than last year in 6 of 8 months. Projections show that DTOC will be below the target (fewer DTOC) at the end of the year.

4.4 In terms of our local schemes' impact on the DTOC rates:

- *Community Reablement Team (CRT)* – For this financial year so far, the service appears to have prevented 6542 delayed days in hospital, assuming a cost of £400 per NHS bed/day, this would equate to a cost avoidance of £2,616, 809.

- *Discharge to Assess (D2A)* –. For this financial year so far, the service appears to have prevented 410 delayed days in hospital, assuming a cost of £400 per NHS bed/day, this would equate to a cost avoidance of £164, 007

4.5 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 Delivery Group to implement the High Impact Model across the Berkshire West system. This is due to be reported to NHS England this month and the High Impact Change action plan has been reviewed by senior management.

- A review of the Reading Integration Board dashboard is taking place, including a refresh of metrics and a deep dive into some performance elements (including DTOC)

Residential Admissions

4.6 Our target is to have no more than 116 new residential admissions for older people.

4.7 So far for 2019/2020, a total 51 (9 months) new residential admissions have been made in this financial year. This level of performance tracks to show 68 new admissions for the financial year, which would indicate that the locality would meet the target.

4.8 In terms of our local schemes' impact on the rate of residential admissions:

- *CRT* – 196 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 196 entrances into residential care. Taking the average cost of a residential / nursing placement, this could equate to full-year effect cost avoidances of around £2,271,629. (if the average numbers of SUs staying home will stay at the current level)

- *D2A* – 24 clients were living at home prior to entering the service, and subsequently 12 returned home rather than progressing to a residential or nursing placement upon leaving the service. The service could therefore be argued to have prevented 12 entrances into residential care. Taking the average cost of a residential / nursing placement, this could equate to full-year effect cost avoidances of around £141,438 (if the average numbers of SUs staying home will stay at the current level)

Reablement

4.9 Our target is to maintain an average of 93% of people remaining at home 91 days after discharge reablement / rehabilitation services (having entered these services following a stay in hospital).

4.10 Based on our performance to date (within our CRT and D2A service), within the financial year 2019/2020 we have achieved an average of 81% of service users remaining at home 91 days after discharge from hospitals into our Community Reablement Service and Discharge to Assess service.

4.11 This is due to revised guidance being issued by NHS England. Previously, any clients who passed away following discharge from reablement services were not included in the count, as it was felt that clients with terminal conditions and/or severe ill health could not be reabled. However, NHS England have asked for these clients to be included in the count moving forward, which has decreased our performance accordingly. Please note that:

- Were the clients in question not included, performance would be much closer to target.

- Had the clients in question not been referred to reablement services, it is potentially likely that they would've remained in hospital and become DToCs and could potentially have passed away in hospital. Therefore, whilst their inclusion in the count has decreased performance against the national target, the practice that has caused this is arguably in the clients' best interest and has played a significant role in avoiding higher DToC rates.

Non-Elective Admissions (NELs)

4.12 Our BCF target is to achieve a 0.97% reduction (expressed as 161 fewer admissions) against the number of NEL admissions seen in 2018/2019. This equates to a target of no more than 16480 NELs in 2019-2020 (or no more than 1373 per month).

4.13 Based on this financial year's performance data, so far, we have achieved a total of 11495 NELs. This equates to an increase of 4.62% compared to the target.

4.14 NELs reduction features as a key part of the Reading Integration Board Programme Plan, and there is currently a review of NELs related data being conducted by the CCG Locality Manager.

4.15 In terms of our local schemes' impact on the rate of NELs:

- *CRT* - by engaging with 52 "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 52 NELs[1].

- *D2A* – Have not received any appropriate rapid referrals so far this financial year.

4.16 Further actions to improve NEL performance are detailed in section 5.1 below.

5. PROGRAMME UPDATE

5.1 Since January, the following items have been progressed:

- **Pilot of the Neighbourhood Care Planning Group,** a joint working initiative between Adult Social Care (ASC) and North/West and South Reading GP Alliances. The pilot

[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.

brings together key professionals to provide a forum for multi-disciplinary discussion, risk assessment and comprehensive care planning. 10 meetings have been held to date, with input from Adults Social Care, 6 voluntary sector organisations, 3 GP surgeries, community matrons, community nurses, and community mental health team workers. Reading Integration Board have agreed to roll the pilot out to all of the Primary Care Networks in the locality.

- **Reading Integration Board Work Plan.** This was agreed in the January Reading Integration Board and the detailed programme plan will be discussed in the March meeting**.**

- **Ageing Well,** The Berkshire West, Oxfordshire, Buckinghamshire Sustainability and Transformation Partnership have been selected to be an accelerator site. The focus of this work in the borough will be linked to access to 2-hour Rapid Health Response and 2 Day Reablement support.

6. NEXT STEPS

6.1 The planned next steps for March to May include:

- **Finish and evaluate the Neighbourhood Care Planning Group pilot**
- **Finalise the Reading Integration Board Programme Plan**
- **Carry out a review of the Reading Integration Board Dashboard**
- **Review NELs**
- **Engage with the Ageing Well programme**
- **Continue to develop joint working with Primary Care Networks**

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 workshop (see 5.1) took place to ensure that stakeholders are included in guiding integration in the locality.

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 The BCF planning template has been recommended by the local NHS England (NHSE) representative and the Association of Directors of Adult Social Services (ADASS) representative. A report covering the completed template is on the agenda to be discussed today.

READING HEALTH AND WELLBEING BOARD

DATE OF MEETING:	**13th March 2020**		
REPORT TITLE:	**Health and Wellbeing Dashboard – March 2020**		
REPORT AUTHOR:	**Kim McCall**	**TEL:**	**0118 937 3245**
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 This report presents an update on the Health and Wellbeing Dashboard (Appendix A), which sets out local trends in a format previously agreed by the Board to provide the Board with an overview of performance and progress towards achieving local goals as set out in the 2017-20 Health and Wellbeing Strategy for Reading.

1.2 The appended document gives the Board a context for determining which parts of the Health and Wellbeing Strategy it wishes to review in more depth, such as by requesting separate reports. Identifying priorities from the Health and Wellbeing Strategy to provide themes for Health and Wellbeing Board meetings is in line with the 2016 Peer Review recommendation that the Health and Wellbeing Strategy should be used to drive the agenda of the Health and Wellbeing Board.

2. RECOMMENDED ACTION

2.1 That the Health and Wellbeing Board notes the following performance updates contained in the dashboard:

- **Estimated dementia diagnosis rate (aged 65+) has been updated with monthly snapshots.**
- **The following NHS Healthcheck indicators are updated each quarter**
  - **People invited for a healthcheck**
  - **People taking up a healthcheck**
  - **People receiving a healthcheck**
- **Successful completion of alcohol treatment updated each quarter**
- **Alcohol-related hospital admissions has been updated with 2018 data**
- **Cancer screening – bowel cancer has been updated with 2019 data**
- **Cancer screening – breast cancer has been updated with 2019 data**

3. POLICY CONTEXT

3.1 The Health and Social Care Act 2012 sets out the requirement on Health and Wellbeing Boards to use a Joint Strategic Needs Assessment (JSNA) and a Joint Health and Wellbeing Strategy (JHWS) to develop plans which:

- improve the health and wellbeing of the people in their area;

- reduce health inequalities; and
- promote the integration of services.

3.2 Reading's 2017-20 Health and Wellbeing Strategy sets out local plans as required under the Health and Social Care Act, and also addresses the local authority's obligations under the Care Act 2014 to promote the wellbeing of individuals and to provide or arrange services that reduce needs for support among people and their (unpaid/family) carers in the local area.

3.3 The current strategy is founded on three 'building blocks' – issues which underpin and are expected to be considered as part of the implementation plans to achieve all of the strategic priorities. These are:

- Developing an integrated approach to recognising and supporting all carers
- High quality co-ordinated information to support wellbeing
- Safeguarding vulnerable adults and children

3.4 The Strategy then sets out eight priorities:

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

3.5 In July 2016, Reading's Health and Wellbeing Board agreed to introduce a regular Health and Wellbeing Dashboard report – at each meeting - 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. The updated Health and Wellbeing Action Plan is also presented to the Board in full twice a year.

4. CURRENT POSITION (March 2020)

Priority 1

4.1 A greater or similar proportion of Reading's population continues to make healthy lifestyle choices. There are more people than average whose weight is within the recommended range; a greater number than average who meet criteria for being physically active; and a smaller proportion of adults who smoke. Smoking amongst those in routine and maintenance professions in Reading appeared to increase slightly in 2018, but the change was too small to be considered reliable.

4.2 As in previous periods, Reading is unlikely to meet local or national targets for the delivering NHS health checks to eligible residents (those aged 40-74 without certain specified diagnoses). The NHS health check assesses people's risk of stroke, heart disease, kidney disease, diabetes and dementia, and leads to targeted advice.

Priority 2

4.3 The results from the 2018/19 Adult Social Care survey were published in November 2019 and tell us that a higher proportion of respondents to the survey than previously have reported that they have as much social contact than they would like (47.1% compared to

41.4% the previous year). Furthermore, a larger proportion of respondents in Reading reported as much social contact as they would like compared with elsewhere in England.

Priority 3

4.4 The number and proportion of primary school children with social, emotional or mental health need increased very slightly between 2017 and 2018, both in Reading and across England. The proportion in Reading continues to be very slightly higher than the national average and the average amongst local authority areas with similar levels of deprivation and above, but the difference is not large enough to be statistically different. In the same period, the proportion of secondary school children with social, emotional or mental health needs has fallen very slightly, but not significantly enough to bring it in line with the national average.

Priority 4

4.5 At the time of the latest release the mortality rate for suicide and undetermined intent for local authority areas the rate in Reading was in line with the national average and average for local authority areas with similar levels of deprivation and showed continuing improvement in line with targets. However, more current national data, which is not yet available at local level, suggests a recent increase. Local intelligence is being used to determine whether this is likely to be reflected in Reading.

Priority 5

4.6 The proportion of people receiving alcohol treatment who successfully completed treatment continues to be above the England average. The rate of hospital admissions where the primary diagnosis is an alcohol-related condition increased slightly in 2018/19, both in Reading and in England. The rate in Reading continues to be below the English average.

Priority 6

4.7 The Dementia Friendly Reading Steering Group leads on delivering Dementia Friends sessions to secure individual commitments to taking action on dementia and agreed a revised stretch target after exceeding the previous local target. There are already over 8,400 Dementia Friends, but the Group has now increased its focus on engaging local businesses - such as Broad Street Mall, The Oracle, Thames Water and Visa. The Group's successes in this area have been recognised by the achievement of the Alzheimer's Society 'dementia friendly town' award.

4.8 The rate of diagnosis of dementia amongst those aged 65 and older continues to exceed the national target for two thirds of people with dementia to have their condition diagnosed. This is in line with the England average and similar to the average for Local Authority areas with similar levels of deprivation as measured through IMD.

Priority 7

4.11 Locally set targets for breast and bowel cancer screening, which have been set at minimum coverage standards, have been met. More than 10,000 people were screened for bowel cancer and 9,773 screened for breast cancer during 2019.

Priority 8

4.10 Although incidence of TB continues to be higher in Reading than elsewhere, the latest published data confirms ongoing improvement in line with targets. As a result, incidence of TB in Reading has more than halved since reaching a peak in 2008-10 of 38.4 cases per 100,000 population (176 cases) to 17.8 cases per 100,000 in 2016-18 (87 cases).

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. ENVIRONMENTAL AND CLIMATE IMPLICATIONS

6.1 The recommended action will have no impact on the Council's ability to respond to the Climate Emergency.

7. COMMUNITY & STAKEHOLDER ENGAGEMENT

7.1 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.

8. EQUALITY IMPACT ASSESSMENT

8.1 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.

9. LEGAL IMPLICATIONS

9.1 There are no legal implications.

10. FINANCIAL IMPLICATIONS

10.1 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.

11. BACKGROUND PAPERS

APPENDIX A – Health and Wellbeing Dashboard – March 2020

Priority	Indicator	Target Met/Not Met	Direction of Travel
1. Supporting people to make healthy lifestyle choices	% adults overweight or obese	Met	Better
	% of adults physically active	Met	Better
	% 4-5 year olds classified as overweight/obese	Not Met	No change
	% 10-11 year olds classified as overweight/obese	Met	No change
	Smoking status at the time of delivery	Met	Better
	Age 15 smoking prevalence placeholder	*NA*	*NA*
	Smoking prevalence - all adults - current smokers	Met	Better
	Smoking prevalance - routine and manual - current smokers	Met	Worse
	People invited for an NHS Healthcheck	Not Met	No change
	People taking up an NHS Healthcheck invite	Met	No change
	People receiving an NHS Healthcheck	Not Met	No change
2. Reducing loneliness and social isolation	% of adult social care users with as much social contact as they would like	Met	Better
	% of adult carers with as much social contact as they would like	Not Met	Worse
	Placeholder - Loneliness and Social Isolation	*NA*	*NA*
3.Promoting positive mental health and wellbeing in children and young people	Pupils with social, emotional and mental health needs (primary school age)	Not Met	No change
	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
4. Reducing deaths by suicide	Age-standardised mortality rate from suicide and injury of undetermined intent	Met	Better
5.Reducing the amount of alcohol people drink to safer levels	Successful treatment of alcohol treatment	Met	Better
	Admission episodes for alcohol related conditions (DSR per 100,000)	Met	Worse
6.Living well with dementia	Estimated diagnosis rate for people with dementia	Met	No change
	No. Dementia Friends (Local Indicator)	Not Met	No change
	Placeholder - ASCOF measure of post-diagnosis care	*NA*	*NA*
7.Increasing take up of breast and bowel screening and prevention services	Cancer screening coverage - bowel cancer	Met	No change
	Cancer screening coverage - breast cancer	Met	No change
8.Reducing the number of people with tuberculosis	Incidence of TB (three year average)	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
% adults overweight or obese	Public Health Outcomes Framework	Active Lives Survey	Annual	Low	2017-18	55.7	63.4	Met	Better	62.0	63.5
% of adults physically active	Public Health Outcomes Framework	Active Lives Survey	Annual	High	2017-18	68.8	64	Met	Better	66.3	67.0
% 4-5 year olds classified as overweight/obese	Public Health Outcomes Framework	National Child Measurement Programme	Annual	Low	2018-19	22.5	22.0	Not Met	Better	22.6	Not available
% 10-11 year olds classified as overweight/obese	Public Health Outcomes Framework	National Child Measurement Programme	Annual	Low	2018-19	34.0	36	Met	Worse	34.3	Not available
Smoking status at the time of delivery	Public Health Outcomes Framework	Smoking Status At Time of Delivery (SSATOD) HSCIC	Annual	Low	2018-19	5.6	8.0	Met	Better	10.6	Not available
Smoking prevalence - all adults - current smokers	Public Health Outcomes Framework	Annual Population Survey	Annual	Low	2018	13.0	14.8	Met	Better	14.4	Not available
Age 15 smoking prevalence placeholder	Public Health Outcomes Framework								Better		
Smoking prevalance - routine and manual - current smokers	Public Health Outcomes Framework	Annual Population Survey	Annual	Low	2018	28.3	28.9	Met	Worse	25.4	Not available
People invited for an NHS Healthcheck	NHS Healthcheck - Fingertips dashboard	https://fingertips.phe.org	Quarterly	High	2015/16-2019/20, Q2	40.8%	90%	Not Met	No change	79.8%	81.5%
People taking up an NHS Healthcheck	NHS Healthcheck - Fingertips dashboard	https://fingertips.phe.org	Quarterly	High	2015/16-2019/20, Q2	51%	50%	Met	No change	45.9%	47.3%
People receiving an NHS Healthcheck	NHS Healthcheck - Fingertips dashboard	https://fingertips.phe.org	Quarterly	High	2015/16-2019/20, Q2	21%	43%	Not Met	No change	37.6%	39.5%

Back to HWB Dashboard

PRIORITY 2: Reducing Loneliness and Social Isolation

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
% 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	2018-19	47.1	45.4	Met	Better	45.9	NA
% 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	32.0	38.5	Not Met	Worse	32.5	
Placeholder - Loneliness and Social Isolation	NA	TBC	Annual							NA	NA

Back to HWB Dashboard

Priority 3: Promoting positive mental health and wellbeing in children and young people

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
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	Annual	Low	2018	2.4%	2.3%	Not Met	No change	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	Annual	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	Annual	Low	2018	3.0%	3.0%	Met	No change	2.4%	2.2%

Back to HWB Dashboard

Priority 4: 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
Age-standardised mortality rate from suicide and injury of undetermined intent	Public Health Outcomes Framework	Public Health England (based on ONS)	Annual	Low	2016-18	7.2	8.25	Met	Better	9.6	Not available

Back to HWB Dashboard

PRIORITY 5: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
Successful treatment of alcohol treatment	Public Health Outcomes Framework	National Drug Treatment Monitoring System	Quarterly	High	Q4 2018-19	43.2%	38.3%	Met	Better	38.2%	Not available
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	2018/19	567	599	Met	Worse	664	Not available

Back to HWB Dashboard

Priority 6: 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
Estimated diagnosis rate for people with dementia	Public Health Outcomes Framework/NHS Outcomes Framework	NHS Digital	Monthly	High	Dec-19	69.4	66.7	Met	Better	68.1	68.6
No. of Dementia friends	NA (Local only)	Local Report	Quarterly	High	Sep-19	8548	10000	Not Met	No change	Not available	Not available

PLACEHOLDER - Post diagnosis care

Back to HWB Dashboard

Priority 7: 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
Cancer screening coverage - bowel cancer	Public Health Outcomes Framework	Health and Social Care Information Centre (HSCIC)	Annual	High	2019	56.5%	52.0%	Met	No change	60.1%	61%
Cancer screening coverage - breast cancer	Public Health Outcomes Framework	Health and Social Care Information Centre (HSCIC)	Annual	High	2019	70.1%	70.0%	Met	No change	74.5%	77%

Back to HWB Dashboard

Priority 8: Reducing the number of people with tuberculosis

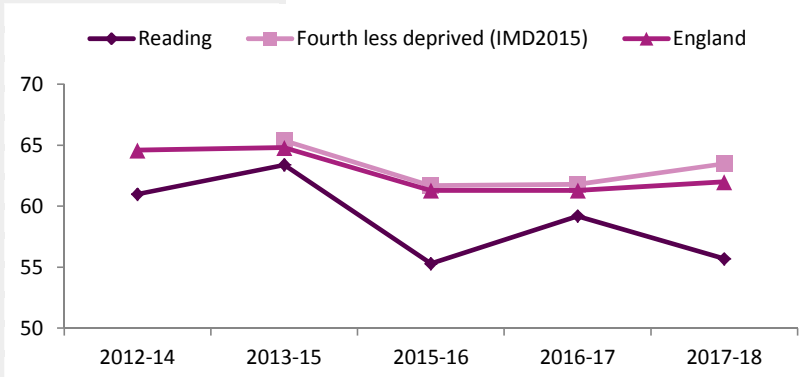
Indicator Title	Framework	Source	Frequency updated	Good performance low/high	Most recent reporting period	Most recent performance	Target	Met/Not Met	DOT	England Average	2015 Deprivation Decile Average
Incidence of TB (three year average)	Public Health Outcomes Framework	Public Health England.	Annual	Low	2016-18	17.8	30	Met	Better	9.2	6.0

Back to HWB Dashboard

Indicator number	**93088**
Outcomes Framework	**Public Health Outcomes Framework**
Indicator full name	**Excess weight in adults**
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.

[Back to Priority 1](#)
[Back to HWB Dashboard](#)

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
2017-18	55.7	*63.5*	62

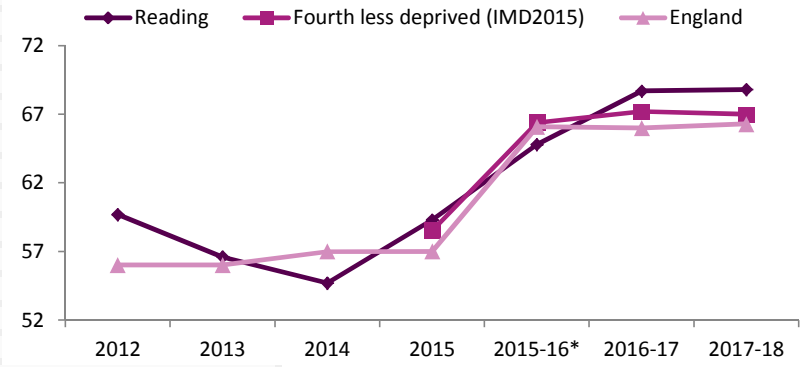


Indicator number	**93014**
Outcomes Framework	**Public Health Outcomes Framework**
Indicator full name	**% Physically Active Adults**

[Back to Priority 1](#)
[Back to HWB Dashboard](#)

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	Fourth less deprived (IMD2015)	England
2012	59.7		56
2013	56.6		56
2014	54.7		57
2015	59.3	*58.5*	57
2015-16*	64.8	*66.4*	66.1
2016-17	68.7	*67.2*	66
2017-18	68.8	*67*	66.3

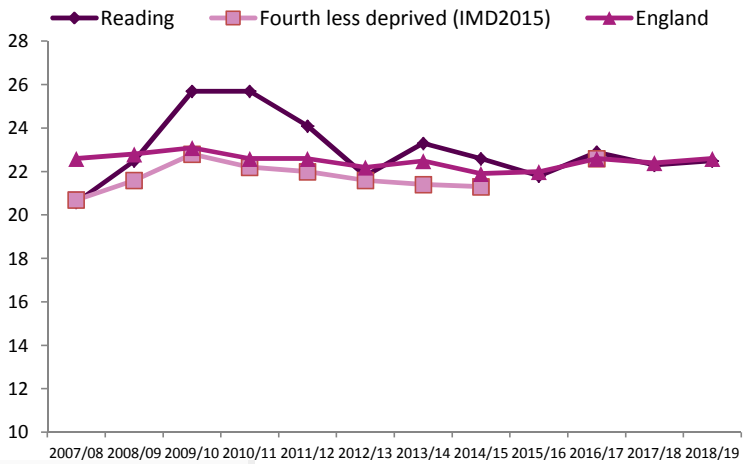


Indicator number	**20601**
Outcomes Framework	**Public Health Outcomes Framework**
Indicator full name	**Child excess weight in 4-5 year olds**

[Back to Priority 1](#)
[Back to HWB Dashboard](#)

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	Fourth less deprived (IMD2015)	England
2007/08	20.6	*20.7*	22.6
2008/09	22.5	*21.6*	22.8
2009/10	25.7	*22.8*	23.1
2010/11	25.7	*22.2*	22.6
2011/12	24.1	*22*	22.6
2012/13	21.8	*21.6*	22.2
2013/14	23.3	*21.4*	22.5
2014/15	22.6	*21.3*	21.9
2015/16	21.8		22
2016/17	22.9	*22.6*	22.6
2017/18	22.3		22.4
2018/19	22.5		22.6

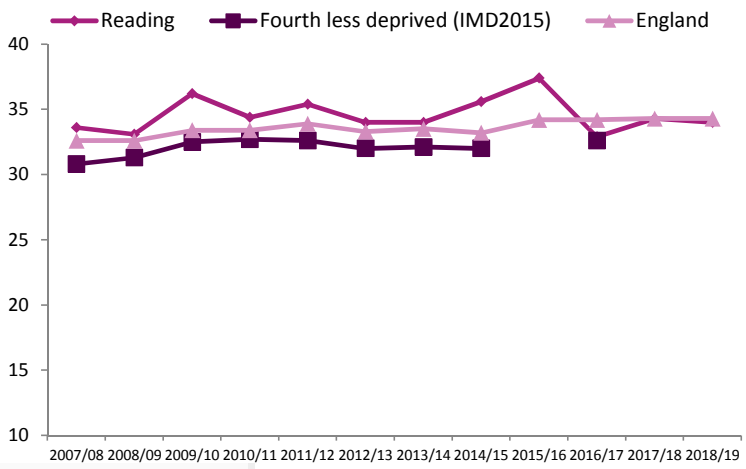


Indicator number	**20602**
Outcomes Framework	**Public Health Outcomes Framework**
Indicator full name	**Child excess weight in 10-11 year olds**

[Back to Priority 1](#)
[Back to HWB Dashboard](#)

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	Fourth less deprived (IMD2015)	England
2007/08	33.6	*30.8*	32.6
2008/09	33.1	*31.3*	32.6
2009/10	36.2	*32.5*	33.4
2010/11	34.4	*32.7*	33.4
2011/12	35.4	*32.6*	33.9
2012/13	34	*32*	33.3
2013/14	34	*32.1*	33.5
2014/15	35.6	*32*	33.2
2015/16	37.4	-	34.2
2016/17	32.9	*32.6*	34.2
2017/18	34.3		34.3
2018/19	34		34.3

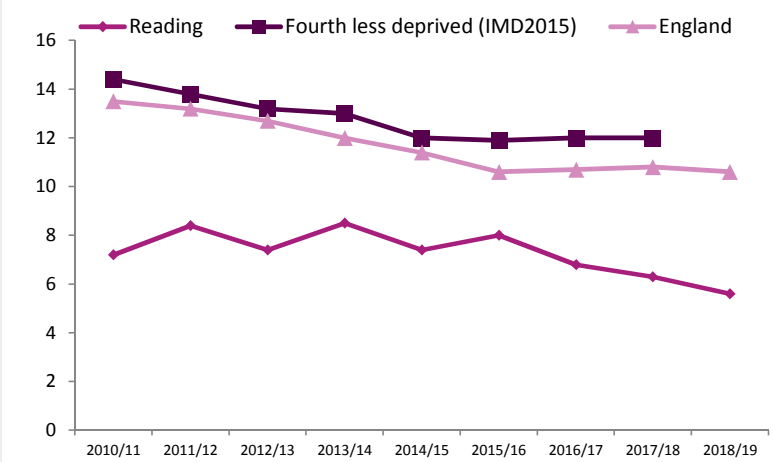


Indicator number	**93085**
Outcomes Framework	**Public Health Outcomes Framework**
Indicator full name	**% of women who smoke at the time of delivery**

[Back to Priority 1](#)
[Back to HWB Dashboard](#)

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	Fourth less deprived (IMD2015)	England
2010/11	7.2	*14.4*	13.5
2011/12	8.4	*13.8*	13.2
2012/13	7.4	*13.2*	12.7
2013/14	8.5	*13*	12
2014/15	7.4	*12*	11.4
2015/16	8	*11.9*	10.6
2016/17	6.8	*12*	10.7
2017/18	6.3	*12*	10.8
2018/19	5.6		10.6

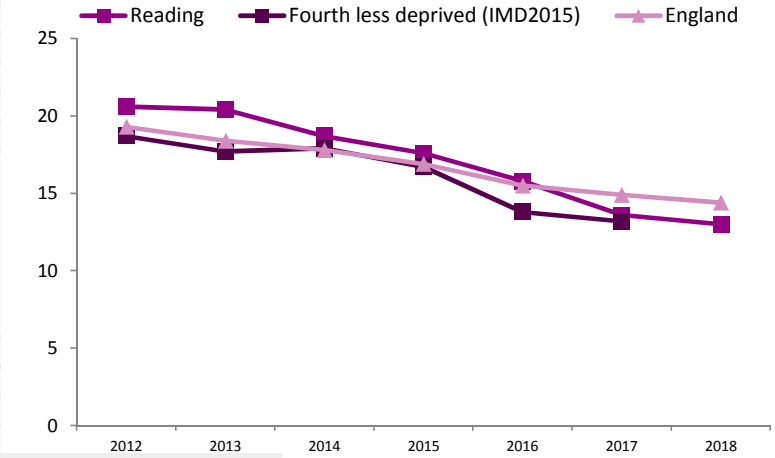


Indicator number	**92443**
Outcomes Framework	**Public Health Outcomes Framework**
Indicator full name	**Smoking Prevalence in Adults - Current Smokers**

[Back to Priority 1](#)
[Back to HWB Dashboard](#)

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	Fourth less deprived (IMD2015)	England
2012	20.6	*18.7*	19.3
2013	20.4	*17.7*	18.4
2014	18.7	*17.9*	17.8
2015	17.6	*16.7*	16.9
2016	15.8	*13.8*	15.5
2017	13.6	*13.2*	14.9
2018	13		14.4

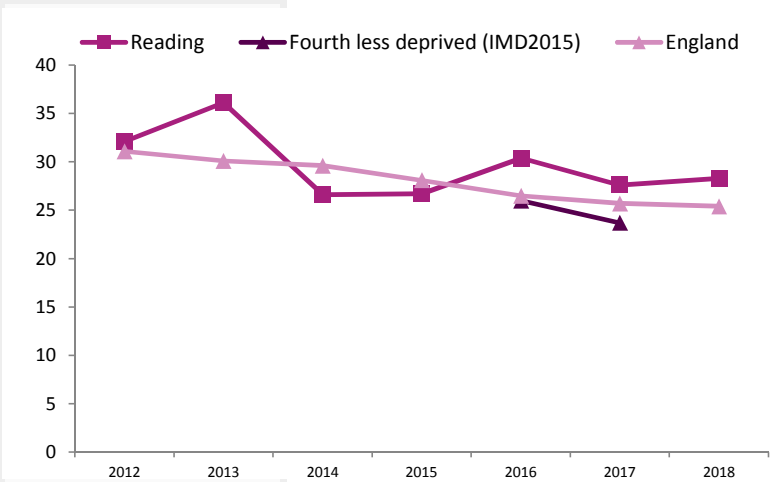


Indicator number	**92445**
Outcomes Framework	**Local Tobacco Control Profiles**
Indicator full name	**Smoking prevalence in routine and manual occupations - Current smokers**

[Back to Priority 1](#)
[Back to HWB Dashboard](#)

Period	Reading	Fourth less deprived (IMD2015)	England
2012	32.1		31.1
2013	36.1		30.1
2014	26.6		29.6
2015	26.7		28.1
2016	30.4	*26*	26.5
2017	27.6	*23.7*	25.7
2018	28.3		25.4

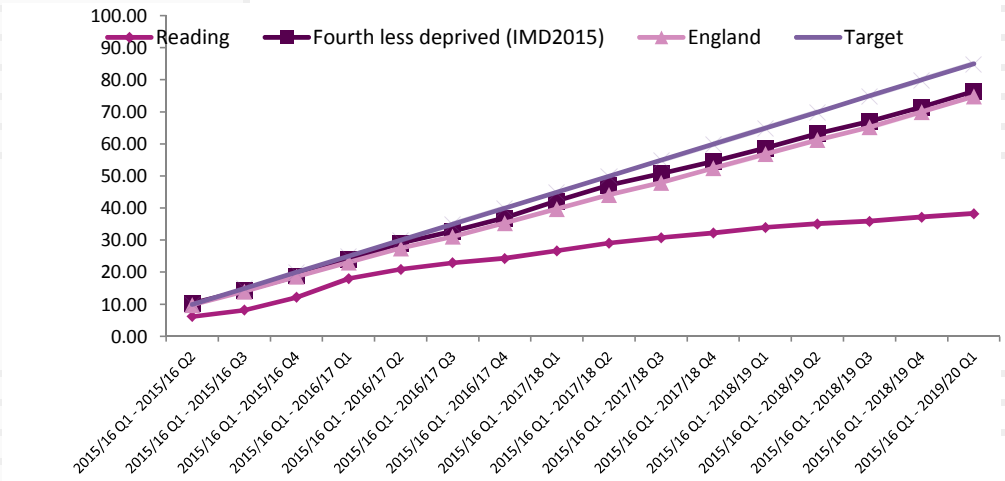
Data source	Annual Population Survey
Denominator	Total respondents with a self-reported smoking status aged 18-64 in the R&M group. Weighted to improve representativeness.
Numerator	Respondents who are self-reported smokers in the R&M group. Weighted to improve representativeness



Indicator number	**91111**
Outcomes Framework	
Indicator full name	**People invited for an NHS Healthcheck**

[Back to Priority 1](#)
[Back to HWB Dashboard](#)

Data source	PHE Fingertips - NHS Healthchecks
Denominator	Number of people aged 40-74 eligible for an NHS Health Check in the financial year.
Numerator	Number of people aged 40-74 eligible for an NHS Health Check who were offered an NHS Health Check up to the current quarter from quarter 1 2015

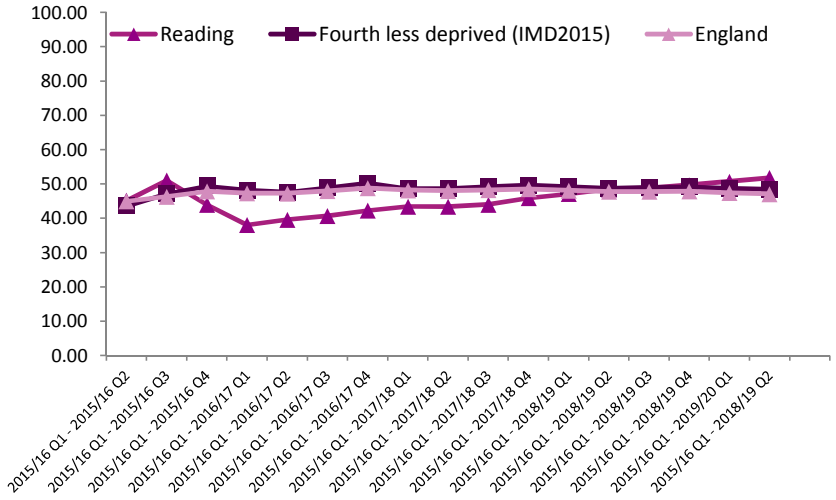


Period	Reading	Fourth less deprived (IMD2015)	England	Target
2015/16 Q1	3.80	5.30	4.90	5.00
2015/16 Q1 - 2015/16 Q2	6.22	10.39	9.89	10.00
2015/16 Q1 - 2015/16 Q3	8.22	14.38	14.08	15.00
2015/16 Q1 - 2015/16 Q4	12.20	18.76	18.70	20.00
2015/16 Q1 - 2016/17 Q1	18.07	23.87	23.15	25.00
2015/16 Q1 - 2016/17 Q2	20.93	29.11	27.50	30.00
2015/16 Q1 - 2016/17 Q3	22.99	32.82	31.17	35.00
2015/16 Q1 - 2016/17 Q4	24.30	36.98	35.43	40.00
2015/16 Q1 - 2017/18 Q1	26.73	42.28	39.83	45.00
2015/16 Q1 - 2017/18 Q2	29.14	47.18	44.21	50.00
2015/16 Q1 - 2017/18 Q3	30.81	50.82	47.99	55.00
2015/16 Q1 - 2017/18 Q4	32.27	54.57	52.53	60.00
2015/16 Q1 - 2018/19 Q1	34.00	58.74	56.91	65.00
2015/16 Q1 - 2018/19 Q2	35.12	63.26	61.31	70.00
2015/16 Q1 - 2018/19 Q3	35.90	67.03	65.29	75.00
2015/16 Q1 - 2018/19 Q4	37.17	71.56	70.02	80.00
2015/16 Q1 - 2019/20 Q1	38.30	76.43	74.87	85.00
2015/16 Q1 - 2019/20 Q2	40.80	81.50	79.80	90.00
2015/16 Q1 - 2019/20 Q3				95.00
2015/16 Q1 - 2019/20 Q4				100.00

Indicator number	**91735**
Outcomes Framework	
Indicator full name	**People taking up an NHS Healthcheck**

[Back to Priority 1](#)
[Back to HWB Dashboard](#)

Data source	PHE Fingertips - NHS Healthchecks
Denominator	Number of people aged 40-74 eligible for an NHS Health Check who were offered an NHS Health Check up to the current quarter from quarter 1 2013
Numerator	Number of people aged 40-74 eligible for an NHS Health Check who received an NHS Health Check up to the current quarter from quarter 1 2015.

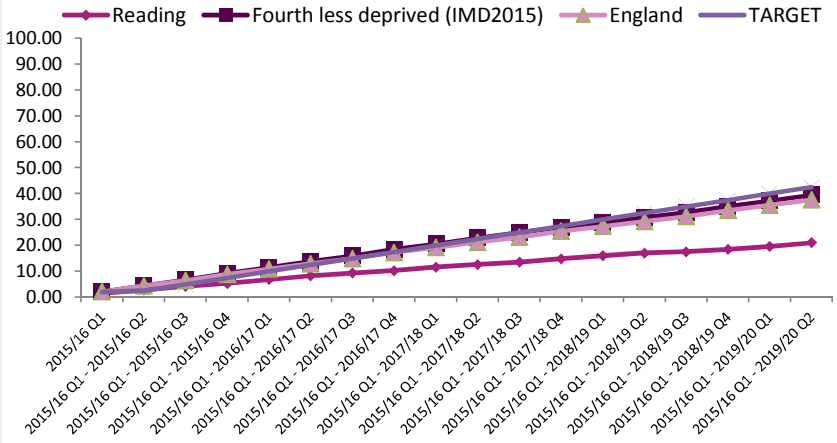


Period	Reading	Fourth less deprived (IMD2015)	England
2015/16 Q1 - 2015/16 Q2	45.21	43.61	45.01
2015/16 Q1 - 2015/16 Q3	51.09	47.13	46.38
2015/16 Q1 - 2015/16 Q4	43.98	49.38	47.90
2015/16 Q1 - 2016/17 Q1	38.10	48.24	47.35
2015/16 Q1 - 2016/17 Q2	39.64	47.57	47.31
2015/16 Q1 - 2016/17 Q3	40.72	48.86	48.01
2015/16 Q1 - 2016/17 Q4	42.31	50.25	48.85
2015/16 Q1 - 2017/18 Q1	43.48	48.64	48.24
2015/16 Q1 - 2017/18 Q2	43.42	48.61	48.04
2015/16 Q1 - 2017/18 Q3	44.05	49.15	48.29
2015/16 Q1 - 2017/18 Q4	45.93	49.64	48.55
2015/16 Q1 - 2018/19 Q1	47.14	49.17	48.11
2015/16 Q1 - 2018/19 Q2	48.53	48.72	47.80
2015/16 Q1 - 2018/19 Q3	48.84	48.99	47.81
2015/16 Q1 - 2018/19 Q4	49.70	49.10	47.90
2015/16 Q1 - 2019/20 Q1	50.76	48.73	47.45
2015/16 Q1 - 2018/19 Q2	51.80	48.40	47.10

Indicator number	**91112**
Outcomes Framework	
Indicator full name	**People receiving an NHS Healthcheck**

[Back to Priority 1](#)
[Back to HWB Dashboard](#)

Data source	PHE Fingertips - NHS Healthchecks
Denominator	Number of people aged 40-74 eligible for an NHS Health Check who were offered an NHS Health Check up to the current quarter from quarter 1 2013
Numerator	Number of people aged 40-74 eligible for an NHS Health Check who received an NHS Health Check up to the current quarter from quarter 1 2015.

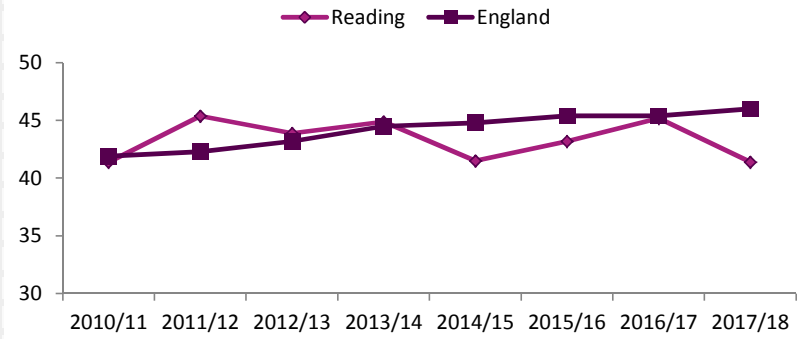


Period	Reading	Fourth less deprived (IMD2015)	England	TARGET
2015/16 Q1	1.50	2.10	2.20	2.00
2015/16 Q1 - 2015/16 Q2	2.81	4.53	4.45	2.50
2015/16 Q1 - 2015/16 Q3	4.20	6.77	6.53	5.00
2015/16 Q1 - 2015/16 Q4	5.37	9.26	8.96	7.50
2015/16 Q1 - 2016/17 Q1	6.89	11.52	10.96	10.00
2015/16 Q1 - 2016/17 Q2	8.30	13.85	13.01	12.50
2015/16 Q1 - 2016/17 Q3	9.36	16.04	14.96	15.00
2015/16 Q1 - 2016/17 Q4	10.28	18.58	17.31	17.50
2015/16 Q1 - 2017/18 Q1	11.62	20.57	19.21	20.00
2015/16 Q1 - 2017/18 Q2	12.65	22.93	21.24	22.50
2015/16 Q1 - 2017/18 Q3	13.57	24.98	23.18	25.00
2015/16 Q1 - 2017/18 Q4	14.82	27.09	25.50	27.50
2015/16 Q1 - 2018/19 Q1	16.03	28.88	27.38	30.00
2015/16 Q1 - 2018/19 Q2	17.04	30.82	29.31	32.50
2015/16 Q1 - 2018/19 Q3	17.53	32.84	31.21	35.00
2015/16 Q1 - 2018/19 Q4	18.47	35.14	33.54	37.50
2015/16 Q1 - 2019/20 Q1	19.60	37.24	35.60	40.00
2015/16 Q1 - 2019/20 Q2	21.10	39.50	37.60	42.50
2015/16 Q1 - 2019/20 Q3				45.00
2015/16 Q1 - 2019/20 Q4				50.00

Indicator number	**90280**
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**

Back to Priority 2
Back to HWB Dashboard

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



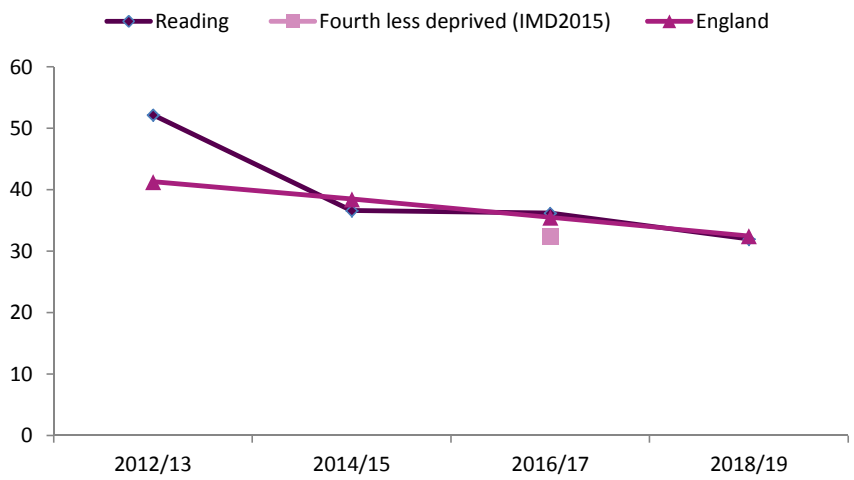
Period	Reading	Fourth less deprived (IMD2015)	England
2010/11	41.4	-	41.9
2011/12	45.4	-	42.3
2012/13	43.9	-	43.2
2013/14	44.9	-	44.5
2014/15	41.5	-	44.8
2015/16	43.2	-	45.4
2016/17	45.2	-	45.4
2017/18	41.4		46

Indicator number	**90638**
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**

[Back to Priority 2](#)
[Back to HWB Dashboard](#)

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	Fourth less deprived (IMD2015)	England
2012/13	52.2		41.3
2014/15	36.6		38.5
2016/17	36.2	*32.4*	35.5
2018/19	32		32.5

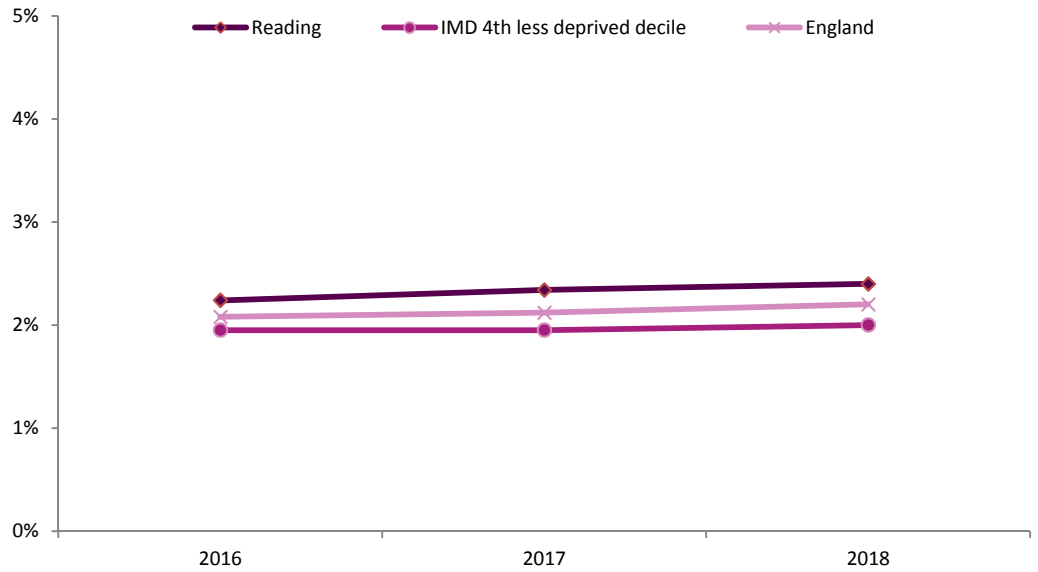


Indicator number	**91871**
Outcomes Framework	**Children and Young People's Mental Health and Wellbeing**
Indicator full name	**Pupils with social, emotional and mental health needs (primary school age)**

[Back to Priority 3](#)
[Back to HWB Dashboard](#)

Period	Reading	IMD 4th less deprived decile	England
2016	2%	2%	2%
2017	2%	2%	2%
2018	2%	2%	2%

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

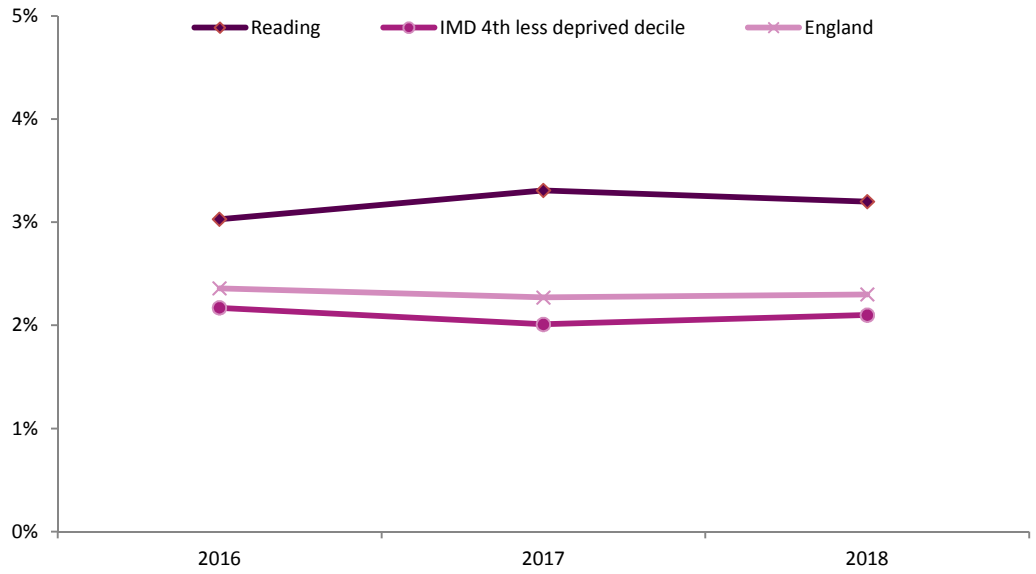


Indicator number	**91871**
Outcomes Framework	**Children and Young People's Mental Health and Wellbeing**
Indicator full name	**Pupils with social, emotional and mental health needs (secondary school age)**

[Back to Priority 3](#)
[Back to HWB Dashboard](#)

Period	Reading	IMD 4th less deprived decile	England
2016	3%	2%	2%
2017	3%	2%	2%
2018	3%	2%	2%

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

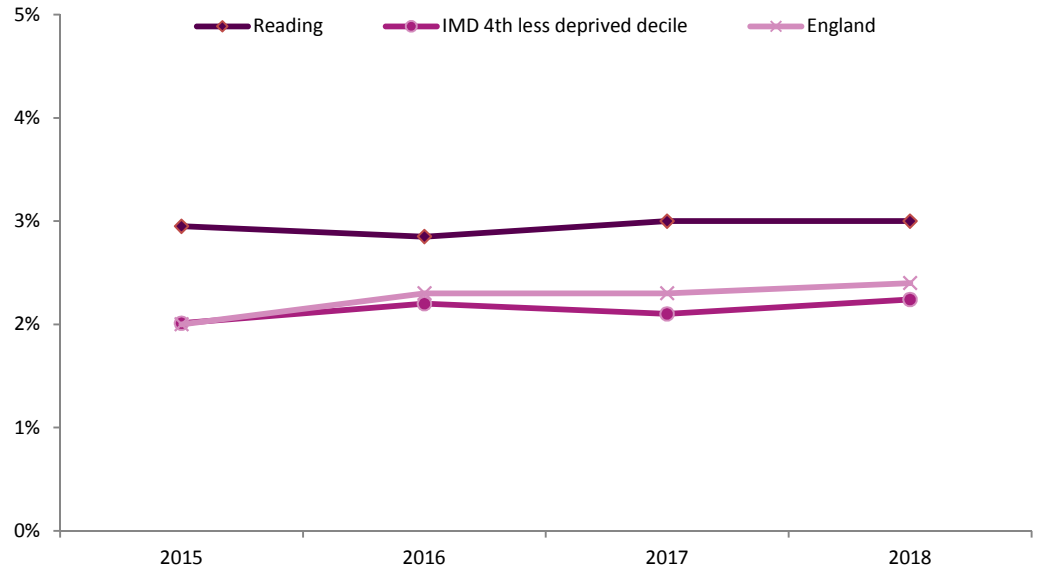


Indicator number	**91871**
Outcomes Framework	**Children and Young People's Mental Health and Wellbeing**
Indicator full name	**Pupils with social, emotional and mental health needs (all school age)**

[Back to Priority 3](#)
[Back to HWB Dashboard](#)

Period	Reading	IMD 4th less deprived decile	England
2015	3%	2%	2%
2016	3%	2%	2%
2017	3%	2%	2%
2018	3%	2%	2%

Data Source	DFE Special Needs Education Statistics
Denominator	Total pupils (LA tabulations)
Numerator	Number of pupils with statements of SEN where primary need is social, emotional and mental health https://www.gov.uk/government/collections/statistics-special-educational-needs-sen



Indicator number	**41001.00**
Outcomes Framework	**Public Health Outcomes Framework**
Indicator full name	**Age-standardised mortality rate from suicide and injury of undetermined intent per 100,000 population**

Back to Priority 4
Back to HWB Dashboard

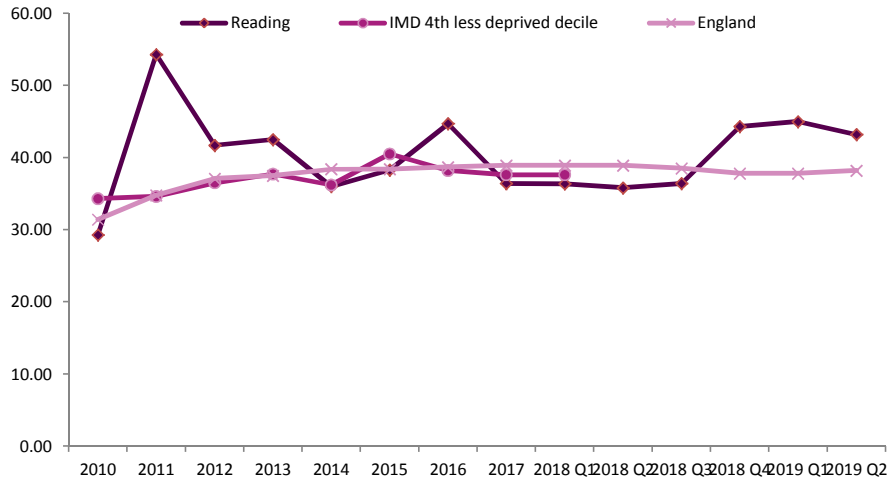
Data Source	Public Health England (based on ONS)
Denominator	ONS 2011 census based mid-year population estimates
Numerator	Number of deaths from suicide and injury from undetermined intent ICD10 codes X60-X84 (age 10+), Y10-34 (age 15+).

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
2015 - 17	8	9.6	9.6
2016 -18	7.2		9.6

Indicator number	**92447**
Outcomes Framework	**Public Health Outcomes Framework**
Indicator full name	**Successful completion of alcohol treatment**

[Back to Priority 5](#)
[Back to HWB Dashboard](#)

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
2017	36.40	37.60	38.90
2018 Q1	36.36	37.60	38.92
2018 Q2	35.80		38.90
2018 Q3	36.40		38.50
2018 Q4	44.30		37.80
2019 Q1	45.00		37.80
2019 Q2	43.20		38.20

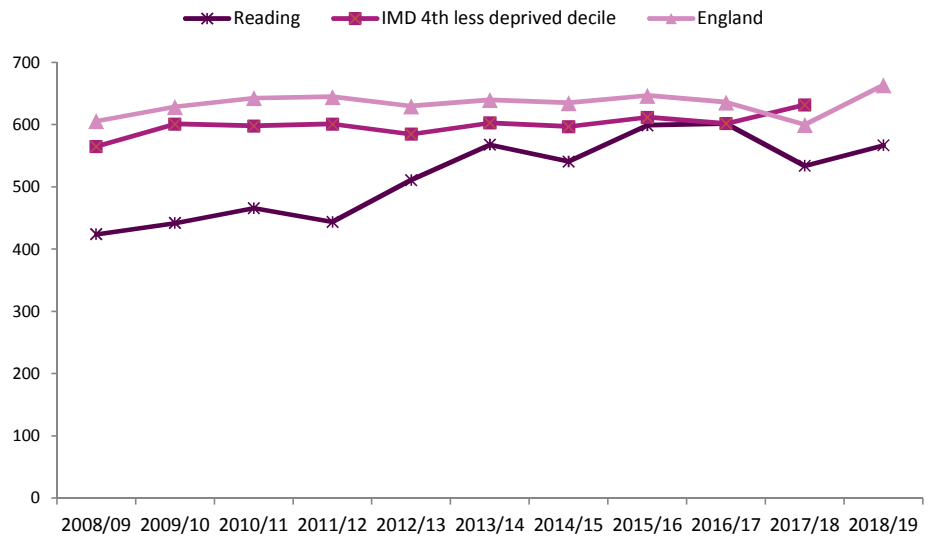
(NDTMS DOMES)

Indicator number	**91414**
Outcomes Framework	**Public Health Outcomes Framework**
Indicator full name	**Admission episodes for alcohol-related conditions per 100,000 people**

[Back to Priority 5](#)
[Back to HWB Dashboard](#)

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.

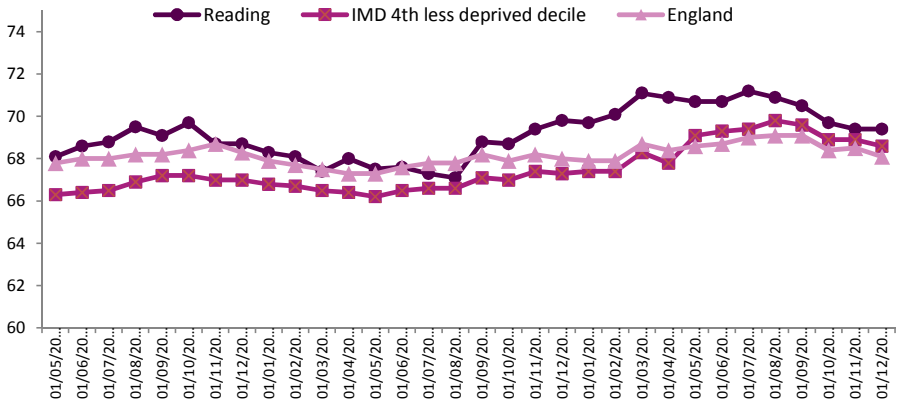
Period	Reading	IMD 4th less deprived decile	England
2008/09	424	565	606
2009/10	442	601	629
2010/11	466	598	643
2011/12	444	601	645
2012/13	511	585	630
2013/14	568	603	640
2014/15	541	597	635
2015/16	599	612	647
2016/17	602	602	636
2017/18	534	632	600
2018/19	567		664



Indicator number	**92949**
Outcomes Framework	**Public Health Outcomes Framework / NHS Outcomes Framework**
Indicator full name	**Estimated diagnosis rate for people with dementia**

[Back to Priority 6](#)
[Back to HWB Dashboard](#)

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.

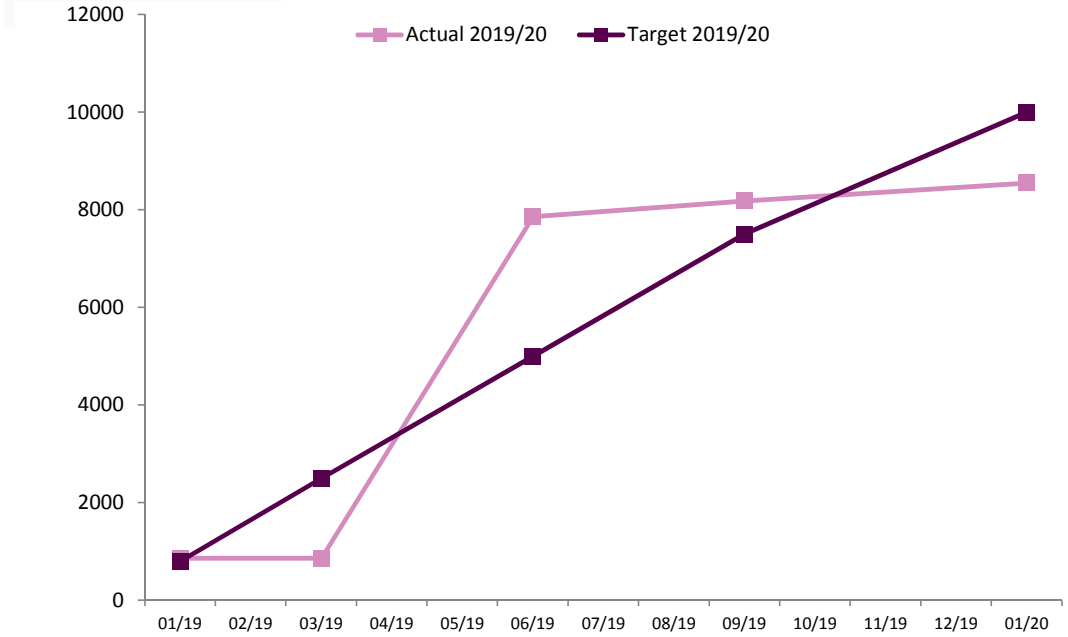


Period	Reading	IMD 4th less deprived decile	England
31/05/2017	68.1	66.3	67.8
30/06/2017	68.6	66.4	68
31/07/2017	68.8	66.5	68
31/08/2017	69.5	66.9	68.2
30/09/2017	69.1	67.2	68.2
31/10/2017	69.7	67.2	68.4
30/11/2017	68.7	67	68.7
31/12/2017	68.7	67	68.3
31/01/2018	68.3	66.8	67.9
28/02/2018	68.1	66.7	67.7
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
30/09/2018	68.8	67.1	68.2
31/10/2018	68.7	67	67.9
30/11/2018	69.4	67.4	68.2
31/12/2018	69.8	67.3	68
31/01/2019	69.7	67.4	67.9
28/02/2019	70.1	67.4	67.9
31/03/2019	71.1	68.3	68.7
30/04/2019	70.9	67.8	68.4
31/05/2019	70.7	69.1	68.6
30/06/2019	70.7	69.3	68.7
31/07/2019	71.2	69.4	69
31/08/2019	70.9	69.8	69.1
30/09/2019	70.5	69.6	69.1
31/10/2019	69.7	68.9	68.4
30/11/2019	69.4	68.9	68.5
31/12/2019	69.4	68.6	68.1

Indicator number	**NA**
Outcomes Framework	**NA**
Indicator full name	**No. of Dementia Friends**

[Back to Priority 6](#)
[Back to HWB Dashboard](#)

Data Source	Locally Recorded
Definition	No. of people who have completed a 45 minute training session and agreed to be a dementia friend



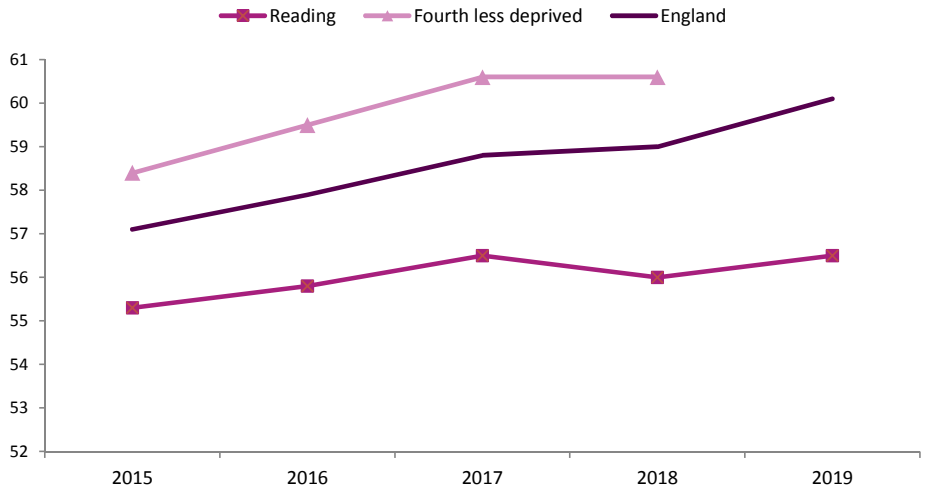
Period	Actual 2019/20	Target 2019/20
Jan-19	857	800
Mar-19	857	2,500
Jun-19	7859	5,000
Sep-19	8,182	7500
Jan-20	8,548	10,000

Indicator number	**91720.00**
Outcomes Framework	**Public Health Outcomes Framework**
Indicator full name	**Cancer screening coverage - bowel cancer**

[Back to Priority 7](#)
[Back to HWB Dashboard](#)

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

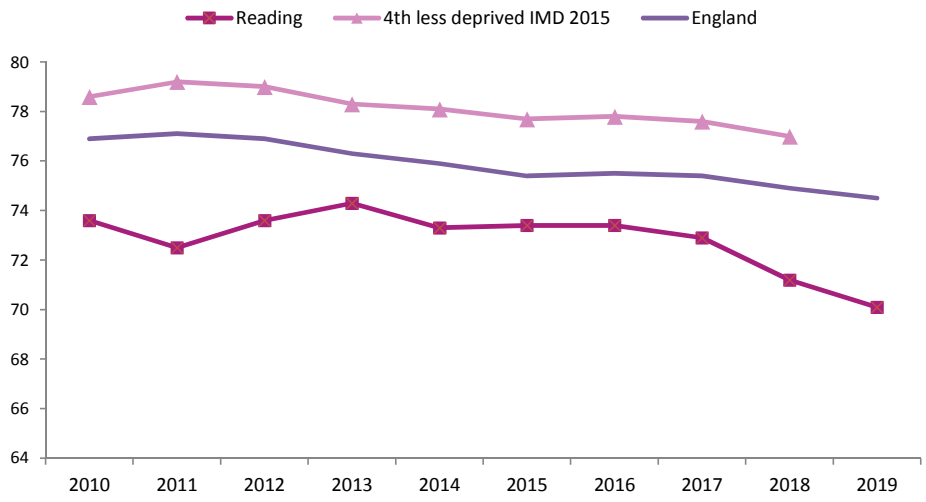
Period	Reading	Fourth less deprived	England
2015	55.3	58.4	57.1
2016	55.8	59.5	57.9
2017	56.5	60.6	58.8
2018	56	60.6	59
2019	56.5		60.1



Indicator number	**22001**
Outcomes Framework	**Public Health Outcomes Framework**
Indicator full name	**Cancer screening coverage - breast cancer**

[Back to Priority 7](#)
[Back to HWB Dashboard](#)

Data Source	Health and Social Care Information Centre (Open Exeter)/Public Health England
Denominator	Number of women aged 53-70 resident in the area (determined by postcode of residence) who are eligible for breast screening at a given point in time.
Numerator	Number of women aged 53-70 resident in the area (determined by postcode of residence) with a screening test result recorded in the previous three years Target is the NHS England minimum coverage standard https://www.england.nhs.uk/wp-content/uploads/2017/04/service-spec-24.pdf

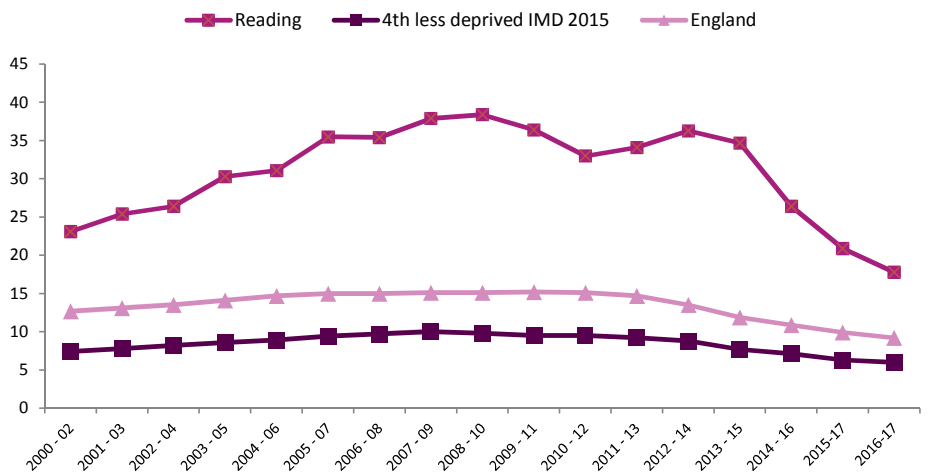


Period	Reading	4th less deprived IMD 2015	England
2010	73.6	78.6	76.9
2011	72.5	79.2	77.1
2012	73.6	79	76.9
2013	74.3	78.3	76.3
2014	73.3	78.1	75.9
2015	73.4	77.7	75.4
2016	73.4	77.8	75.5
2017	72.9	77.6	75.4
2018	71.2	77	74.9
2019	70.1		74.5

Indicator number	**34**
Outcomes Framework	**Public Health Outcomes Framework**
Indicator full name	**Incidence of TB (three year average)**

[Back to Priority 8](#)
[Back to HWB Dashboard](#)

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
2015-17	20.9	*6.3*	9.9
2016-17	17.8	*6*	9.2

HEALTH AND WELLBEING BOARD

EXECUTIVE DIRECTOR OF SOCIAL CARE AND HEALTH

DATE OF MEETING:	**13th March 2020**		
REPORT TITLE:	**Care Quality Commission (CQC) Reading Local System Review – Action Plan Quarterly Update**		
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 an update of the Action Plan as a result of the Care Quality Commission (CQC) led Local System Review that the Reading system across Health and Social Care was subject to during October 2018. The focus of the Review was on older people 65 and over.

1.2 The Reading Health and Social Care System comprises of Reading Borough Council, 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, Healthwatch, the Voluntary and Community-Sector organisations have been fully engaged.

1.3 The requirement of the Health and Social Care system is to devise an Action Plan in response to the recommendations of the Report. (Appendix A) .

2. RECOMMENDED ACTION

2.1 To note the quarterly update of that action plan.

3. POLICY CONTEXT

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

3.2 The Review was carried out under Section 48 of the Health and Social Care Act 2008. This gives CQC the ability to explore issues wider than their usual regulatory work.

3.3 The Reading Review followed on from 20 System Reviews carried out between August 2017 and July 2018. The findings from these were published in a report called "Beyond Barriers: How older people move between health and social care in England."

3.4 The review process consisted of analysis of the local area performance data, an analysis of a range of information available from National Data collections, as well as CQC's own data.

3.5 The Reading System was also asked to provide a System Overview Information Return. (SOIR) The SOIR was submitted prior to on the on-site fieldwork and provided and enabled system leaders to give their own perspective on the challenges faced in their local area, as well as an opportunity to share the value of the positive outcomes for service users.

3.6 The Local System Reviews explored how people moved between health and social care organisations, and the mechanisms that are in place to achieve a timely response to the health and social care needs.

3.7 The final report was published by CQC on their website on 17th January 2019.

4. THE PROPOSAL AND KEY DEVELOPMENTS

4.1 The Action Plan combines several agreed tasks and outcomes that were either in the planning stages at the time of the Review or were a response to suggestions and findings of the Review inspection team.

4.2 The Report suggested areas for improvement, and these are addressed and prioritised in the action plan. (Appendix A)

4.3 The action plan for this quarter has been updated to show the progress against each of the actions in the period since it was agreed. The update has been provided by the named action owner as nominated by their organisation.

4.4 The progress column details the work to date and the relationship between the actions and who is responsible. The RAG rating column details the progress. Where an action remains rated as Red then this is due to the agreed timescale for completion being someway in the distance and the remaining work.

4.5 Key achievements since this report was last presented:

- A Population Health Management approach pilot has been launched in Reading
- Integrated Health and Social Care triage is in place for discharge planning
- Agreement has been reached to develop a joint Health & Wellbeing Board strategy across the West of Berkshire (Reading, Wokingham and West Berkshire Councils)

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

5.1 The Reading Health and Wellbeing Strategy priorities that relate to the Reading Review:

1. Supporting people to make healthy lifestyle choices
2. Reducing loneliness and social isolation
3. Making Reading a place where people can live well with dementia

5.2 Strategic Aim 6. Making Reading a place where people can live well with dementia. The system overview return that the 5 key organisations submitted to CQC referred to the strategy and policy context that is relevant to both the individual organisations involved along with joint working initiatives. However, it specifically focussed on those over 65 and with Dementia and so provided a useful reflection for the system, highlighting what works well and where there are opportunities for improving how the system works for people using services.

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 used a variety of methods to ensure full engagement was undertaken across the area. Areas of the community were involved in specially arranged focus groups. One of these was with the local voluntary sector partners and another with groups of carers. The Reviewers visited services such as lunch clubs and sheltered housing and day centres that are accessed by Reading's older population and so will have direct contact with individuals who use these services. The case tracking evidenced an individual's interactions with all of the organisations involved in the review. The Review also included a relational audit which was a questionnaire sent out to a wide range of partners and users of services to establish how relationships were working between the partner organisations. Healthwatch, Voluntary, Community and Social Enterprise partners (VCSE) were involved in the interviews and focus groups.

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; however this was not required in this instance CQC and the Review Team were 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 were involved in the visits and focus groups. There was also a Relational Audit send out by CQC across a wide range of user groups to ensure a wider proportion of people were given an opportunity to express their opinions and share their experiences.

8. LEGAL IMPLICATIONS

8.1 Care Quality Commission (CQC) were 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 The potential for any increased costs of any proposals and recommendations are minimal as this Action Plan's main focus is about strengthening the strategic development of joint working, and improvements in services already in situ. Consideration will need to be given to any changes alongside each organisation's financial envelope.

10. BACKGROUND PAPERS

10.1 CQC Local System Review - Reading

10.2 Action Plan

10.3 The findings from the 20 previous 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

Reading Action Plan

Care Quality Commission Local System Review of Reading

January 2019

Background to the review and development of this Action Plan

The Local System Review in Reading looked at the services provided by the following organisations:

- Reading Borough Council
- Berkshire West Clinical Commissioning Group
- Royal Berkshire Hospital
- Berkshire Healthcare Foundation Trust
- South Central Ambulance Service

Local System Reviews are carried out following a request by the Secretary of State for Health and Social Care and the Secretary of State for Housing, Communities and Local Government.

The Care Quality Commission were asked to carry out a programme of targeted reviews of local authority areas, of which Reading was one.

The main purpose of this review was to understand how people move through the Health and Social Care System in Reading with a focus on the interface between services. The Local System Review considered system performance along a number of pressure points on a typical pathway of care with a focus on people aged 65 and over.

This action plan is a response to the findings of the Reading System CQC review carried out between 6th September and 2nd November 2018 and in the report published by CQC on the 16th January in CQC'S published report dated January 2019.

This Action Plan will be monitored and progressed via a pre-existing multi-agency Reading Integration Board, this is made up of key senior representatives of all of the above organisations and led and chaired by the Director of Adult Care and Health Services at Reading Borough. .

NB. Mostly the CQC report makes reference to the Berkshire West 10 (BW10) this was a name used to describe the number of organisations involved in the joint working programme and Integrated Care System. However due to the amalgamation of the 4 CCG's into 1 and forming of the new GP Alliances this action plan for clarity now makes reference to the renamed BW7.

Action Owner	Role	Organisation
Seona Douglas	Director of Adult Care and Health Services	Reading Borough Council
Jon Dickinson	Deputy Director Adult Care and Health Services	Reading Borough Council
Peter Sloman	Chief Executive	Reading Borough Council
Cathy Winfield	Berkshire West CCG	Berkshire West CCG's
Cllr Graeme Hoskins	Chair of Health and Wellbeing Board	Reading Borough Council
Cllr David Absolom	Chair of ACE Committee	Reading Borough Council
Debbie Simmons	Director of Nursing	Berkshire West CCG
Maggie Neale	Integrated Care System Workforce Manager	Berkshire West CCG
Maureen McCartney	Director of Operations, CCG Urgent Care Lead	Berkshire West CCG
Melissa Wise	Assistant Director for Transformation and Performance – Adult Care & Health Services	Reading Borough Council
Katrina Anderson	Director of Joint Commissioning	Berkshire West CCG's
Liz Rushton	Assistant Director for Berkshire NHS Continuing Healthcare (Adults and Children)	Berkshire West CCG's
Tessa Lindfield	Strategic Director of Public Health	Public Health Services for Berkshire
Steve McManus	Chief Executive	Royal Berkshire Hospital Foundation Trust
Janette Searle	Preventative Services Development Manager, Wellbeing Team	Reading Borough Council
Reva Stewart	Divisional Director, Adult Community Health Services West	Berkshire Healthcare Foundation Trust
Eiliis McCarthy	Reading Locality Manager	Berkshire West CCG

Key for RAG priority rating:

RED	RED	Not started or priority to complete
AMBER	AMBER	Work in progress to deadline
GREEN	GREEN	Work Complete

Group 1 - Strategic Development Governance and System Alignment						
CQC Findings / Suggested Area for Improvement	**Action Required**	**Action Owner**	**RAG Rating**	**Timescale for Completion**	**Identified Risks and Mitigating Actions**	**Progress and Recommendations**
1a) The vision for the delivery of health and care services in Reading was set out in the Health and Wellbeing Strategy however we did not find this to have strong engagement and agreement by all system partners. The Health and Well Being Strategy had a strong public health focus but was not driving the future direction of health and care for the city. The delivery of health and care services in Reading was influenced by the work of a collaboration of organisations, known as the Berkshire West 7 (BW7).	1. Review of Governance across: Berks West Integrated Care System , Berkshire West 7, Health and Well Being Board across 3 West Berkshire Local Authorities to ensure stronger engagement across the system. 2. Agree the Strategic Principles and statement across Berkshire West 7 through the Chief Officers Group. 3. Agree with Chairs of the 3 Berkshires West Health and Well Being Board's political commitment to the Strategic Vison and table at Health and well Being Boards to inform the public.	Seona Douglas	GREEN	1st July 2019	**Risks** • National driver's e.g. Integrated Care System/Strategic Transformation Partnership change. Chief Executive Priorities change. E.g. national and local issues e.g. Brexit/local critical incident. **Mitigations** • Programme Management Office needs strong leadership. • Partnership accountability via the Health and Well Being Boards in the Berkshire West 7	This action plan will be presented to Reading Health and Well Being Board meetings to monitor progress. <u>November 2019</u> Buckinghamshire, Oxfordshire and Berkshire Integrated Care System future arrangements have been presented to the current three system areas. Underpinning these strategy proposals in the Berkshire West Integrated Partnership which focuses on place at BW7 level with a chief executive leadership team with a number of integrated work streams reporting through the CE to HWBB A new chair has been elected to Adult, Children and Education committee and the scrutiny function has been developed and is supported fully by all stakeholders. A joint Health and Wellbeing Strategy will be agreed jointly across the BW7. The Reading Integration Board is drafting a work plan is being drafted into an action plan which plans to ensure the BW7 vision is realised through local service delivery groups, involving all partners. **<u>This action is complete</u>**

Group 1 - Strategic Development Governance and System Alignment						
CQC Findings / Suggested Area for Improvement	**Action Required**	**Action Owner**	**RAG Rating**	**Timescale for Completion**	**Identified Risks and Mitigating Actions**	**Progress and Recommendations**
1b) The strategic direction of the Berkshire West 7 was set out by Chief Officers representing the member organisations. There were strong relationships between the Chief Officers, however	1. Co-design Strategy at Stakeholder events in the Reading Locality to inform the Integrated Care Strategy.	Seona Douglas	AMBER	31st October 2019	**Risks** • Lack of engagement of partner agencies in terms of Communication assistance.	Progress detailed in 1A At operational level the Reading Integration Board will set a whole plan that delivers to the

the strategic vision for the Berkshire West area, including Reading, had not yet been articulated into a credible strategy that was agreed by and understood by all partners. As a result, it was not clear to people who use services and staff, how the strategy for the delivery of health and care services in Reading was aligned to the vision for the Berkshire West area.	2. Multi System Staff Awareness events to be held across all agencies to deliver the agreed strategy as part of the sign up to fully integrate health and social care. 3. Publicise the Strategy in local areas such as Primary Care Hubs organisations internet, local forums and each organisations to use social media to spread the understanding of the commitments of Berkshire West linked with Reading.		AMBER		• Unable to release staff due to day to day demands. • Impact on other public interest issues as a result of an incident or changing priorities. • Local Adult Social Care strategies need to be linked. **Mitigation** Chief Officers driving priorities	strategic pointer in relation to integration and reduction of duplication and effective us eof resources. The PCN work continues to develop at the front line.

Group 1 - Strategic Development Governance and System Alignment (cont.)						
CQC Findings / Suggested Area for Improvement	**Action Required**	**Action Owner**	**RAG Rating**	**Timescale for Completion**	**Identified Risks and Mitigating Actions**	**Progress and Recommendations**
1c) Health partners had led the development of the Berkshire West Integrated Care System in 2016 and were in support of merging the work of the BW7 into the INTEGRATED CARE SYSTEM. Historically there had been reluctance from some local authority partners for this direction of travel; however opportunities for alignment were being explored, supported through recent meetings between the Chairs of the Health and Wellbeing Boards in the three unitary authorities.	1. Meetings and engagement with Chairs of the Health and Well Being Boards with Local Authority and Health representatives to agreed strategy across Berkshire West 7. 2. Chief Executive Group to clarify and agree joint strategy alignment	Seona Douglas	GREEN	31st May 2019		See response to 1A above **<u>This action is complete</u>**
1d) System leaders should evaluate governance boards and processes to ensure that there is not duplication. System leaders should also ensure that people working in the system are clear on where decisions are taken, and where accountability lies for system performance.	1. Map all Governance systems, meetings and projects to decide upon cohesive agreement regarding streamlining and averting duplication of priorities. 2. Create / update diagram of current decision making to understand the link within and across the System. 3. Make decisions on duplication across BW7 in consultation with other LA's to affect 1D (2).	Seona Douglas	GREEN	30th June 2019	**Risks** • Loss of organisations autonomy. • Sufficient time allocated to complete tasks • Organisational cooperation • Production of accurate data **Mitigation** • Changes are appropriately communicated. • Chief Officer Commitment and scheme of delegation.	Work detailed in response 1a determines the direction of travel. Berkshire West 7 group details the proposed Governance in relation to the whole system **<u>This action is complete</u>**

1e) The Health and Wellbeing Board should play a greater role in scrutinising health and care decisions taken at an Integrated Care System (ICS) and BW7 level to ensure that plans are aligned with Reading's Health and Wellbeing Strategy. The Health and Wellbeing Board should also review its membership and ensure greater representation of health and social care providers, including independent providers.	1. Review Health and Wellbeing Board Membership in line with the Health and Social Care Act 2012 – Chapter2 section's 194 – 199 to ensure representative membership for scrutiny and challenge. 2. Decisions of the boards mapped out at 1d need to be reported at Health and Wellbeing Board	Seona Douglas	GREEN	30th October 2019	**Risks** • Failure to comply with the legislation and benefits from the wider membership and what this has to offer to progress outcomes for residents of Reading **Mitigation** • Support from the LGA Health and Wellbeing Board Support Team/Social Care Institute for Excellence to engage with relevant organisations with us if required to gain sign up	Following the agreement to 1abc and d above a review will need to be completed for submission to the Autumn Health and Wellbeing Board meeting. Original June target date amended accordingly to reflect that. **<u>This action is complete</u>**

<u>Group 1</u> - Strategic Development Governance and System Alignment (cont.)						
CQC Findings / Suggested Area for Improvement	**Action Required**	**Action Owner**	**RAG Rating**	**Timescale for Completion**	**Identified Risks and Mitigating Actions**	**Progress and Recommendations**
1f) The Adults, Children and Education (ACE) Committee should better embed its scrutiny function and play a more significant role in holding partners to account for common goals and scrutinising future strategic plans. The ACE Committee should call health leaders to account for decisions that impact on the delivery of health and care services to people in Reading.	1. Chair of Adults, Children and Education Committee (ACE) has arranged visits with partners NHS Chief Executives to open communications and set out expectations for the scrutiny programme and future agenda setting. 2. Meeting held to determine respective roles of Health and Wellbeing Board (HWBB) and Adult Children and Education (ACE) Committee 3. Consider other Reading needs and support for a Health Scrutiny function to consider the role of Healthwatch in that task.	Seona Douglas	GREEN	31st May 2019	**Risks** • Visits do not take place in a timely way. • Lack of sign up from the Partner organisation to presentation and attendance at Adults Children's and Education Committee. **Mitigation** • Director of Adults Care and Health Services to facilitate meetings to support Elected Member.	**6/2/2019:** Cllr Hoskin and Cllr Absolom along with Director of Adult Care and Health Services have agree roles of Adult Children and Education Committee (ACE) and Health and Wellbeing Board (HWBB) to assist with agenda setting **10/2/2019:** Chief Executives and Adults Children's and Education Committee chair are arranged for dates over the next 6 weeks **22/5/19** The Reading Children's services are now in a company arrangement "Brighter Futures for Children" Therefore new arrangements are now in place for member reporting from them as an organisation. Meetings have taken place with Cathy Winfield CCG, Will Hancock SCAS, and Julian Emms BHFT and Steve McManus to engage in co-operating with scrutiny. This is now evidenced. **<u>This action is complete</u>**

Group 2 - Operational Delivery and Workforce						
CQC Findings / Suggested Area for Improvement	**Action Required**	**Action Owner**	**RAG Rating**	**Timescale for Completion**	**Identified Risks and Mitigating Actions**	**Progress and Recommendations**
2a) The modelling work undertaken by Integrated Care System workforce leads should be developed into a system workforce strategy and they should ensure that the local authority and the VCSE sector are involved in its development as partners and not just as providers.	1. Develop a Workforce strategy for Social and Health Care across Reading and secure the future staffing requirements to meet the needs of the system. 2. Revise Terms of reference to include all system partners alongside current workforce leads so that there is clarity of the task required. 3. Engagement event of the relevant system partners to ensure all have contributed to the strategy to ensure meets need of area and looks at integration. 4. Reports form the Workforce group need to be included in updates to Reading Integration Board	Debbie Simmonds	AMBER	30th April 2020	**Risks** • Social care partners may not engage or understand the relevance of the Integrated Care System Workforce Group to their workforce so need to be informed. • Engagement with senior's managers who are able to contribute and participate in the work. • Day to day priorities and/or emergency situations occur • Individual organisations workforce priorities and strategy need to be aligned with core principles. • Previous Workforce planning undertaken by Health Education England was not fully engaged with or embedded in Berkshire West. **Mitigation** • Escalation to the Chief Officers Group to direct as required	Since CQC met with Workforce Focus Group leaders Integrated Care System Workforce Group has put into the March Meeting a 'Deep Dive' of social care workforce issues. This has led to higher engagement which will hopefully embed the social care issues within Integrated Care System Workforce Structure. Berkshire West Integrated Care System Workforce Group has agreed across the Integrated Care System, a workforce methodology, Skills for Health '6 Step'. Social Care alongside all health providers and has been offered support in engaging with this model. Workshops to facilitate this are currently in development. .

Group 2 - Operational Delivery and Workforce (cont.)						
CQC Findings / Suggested Area for Improvement	**Action Required**	**Action Owner**	**RAG Rating**	**Timescale for Completion**	**Identified Risks and Mitigating Actions**	**Progress and Recommendations**
2b) Although people received high-quality care and support in hospital, people aged 65+ were more likely to attend hospital in an emergency when compared to the national average, there was also a higher chance than the England average that that they would be admitted.	1. Ensure that the Optum Population Health Management work programme provides the intelligence we need to identify the underlying reasons for the higher number of non-elective admissions for patients aged 65 plus. 2. Working with clinical leads and other partners, including Primary Care Networks and service users, use this intelligence to develop an action plan to help address the issues contributing to this higher than average number. 3. Reading Integration Board to oversee the implementation of the actions in this plan and to provide reassurance of progress to the Health and Wellbeing Board.	Maureen McCartney	AMBER	Ongoing in 20/21 and a key workstream in Reading Integration Board work plan.	**Risks** • A focus on patients aged 65 plus may detract from work needed to address NEL's in other age groups • Need to ensure alignment with priorities of system partners • Commitment from all partners to delivery of the action plan • Resources to implement all actions identified **Mitigation** • RIB to ensure the Optum findings are used to support .an overall reduction in NELS's across all age groups and timescales for this agreed action • RIB membership to ensure joined up working and commitment across partner agencies • RIB to prioritise actions	Health and Social Care Partners actively engaged with the Optum Population Health Management Programme and an in depth analysis of the Optum and CCG data in relation to Non Elective Admissions was completed. The key findings from this analysis was that people living in the 3 most deprived wards in South Reading have more Non Elective Admissions, and high % prevalence of CHD, COPD, Diabetes Hypertension , obesity and CKD. RIB considered recommendations from this work in July 2019 and noted that a pilot was planned for South Reading testing out a virtual wrap around approach for COPD patients; initial focus on patients living in the 3 most deprived wards in South Reading (Whitley, Minster and Church wards) to improve health and wellbeing Virtual MDTs have now been completed in 3 out 5 practices. A Respiratory Consultant is working in an integrated way with each practice to identify suitable COPD patients for review and to then sign post/review/refer patients as appropriate) e.g. if there are any patients that would benefit from social support e.g. housing, language/cultural barrier, finance, loneliness etc who could be flagged to the in-house Social Prescriber Link Worker/or referral to Social Services, smoking cessation etc . This pilot will run for 6 months, due to finish in March 2020 and is being evaluated as it is rolled out. It is being overseen by the ICP Long Term Conditions Programme Board. In addition one of the large GP Practices in Whitley PCN is reviewing a cohort of 50 patients who are high users of healthcare services and most at risk of a non-elective admission. Patients will be invited to attend a review of their care plan needs and the clinician will ensure they are on the optimum care pathway .

						Further action to reduce Non Elective Admissions is a key priority for the Reading Integration Board work plan for 20/21. This will include a review of the prevention and early intervention support services in the community. The NCPG pilot finishes on 31 March. The pilot will then be reviewed to review patient outcomes and other successes and this will be presented to RIB on 29 April. The main success to date has been bringing together professionals across health and social care organisations to discuss holistic plans for patients. The next steps are to develop recommendations for PCNs and to work with BHFT, Social Care and PCNs to develop MDTs as described in the NHS Long Term Plan and the Primary Care Network Directed Enhanced Service. **This action is ongoing and included in the Reading Integration Board work plan.** **Lewis please check Seona is happy with this.**
2c) While there was extensive support for people living in care homes, the support offer in the wider community was less well developed. Schemes such as the Falls and Frailty Service and the Rapid Response Service were in place to meet people's needs at a point of crisis, however there was not an effective system risk stratification to identify people at high risk of deterioration in their condition which meant that early targeted interventions could not be put in place.	1. Address the gap identified in the work in 2B above 2. Develop an action plan to address the gaps in support to reduce risk of non-elective admissions from a community setting. 3. Include the external providers of domiciliary care and identify support for early supported discharge planning	Reva Stewart	AMBER	31st December 2019	**Risks** • Funding priorities • Sufficient allocated resource to undertake the task. • Lack of System/partner engagement **Mitigation** • Chief Officer group mandate	**September 2019** Project group in place to pilot Neighbourhood Care Planning Group as a MDT approach. Gaining access to Integrated Population Analytics (IPA) tool is underway, as the risk stratification tool will contribute to identifying patients at risk of admission and support proactive interventions such as a MDT. Reading Integration Board will review outputs from 2b to inform the development of an action plan. **November 2019** **See above for progress in 2b)** Review of Rapid Response pathway across Berkshire West commenced in November and includes all system partners.

						February 2020 **See above progress in 2b)** Development of the Urgent Community Response model will support the aspiration of supporting residents in their home setting when clinically safe to do so. Locally there is a project board and associated task and finish groups in place to support: • Specification & Referral Criteria Task & Finish Group • Care Provision Task & Finish Group • Data Task & Finish Group we have an integrated health and social care triage for discharge planning which identifies and arranges support from therapists when care is provided by external providers.
<u>Group 2</u> - Operational Delivery and Workforce (cont.)						
CQC Findings / Suggested Area for Improvement	**Action Required**	**Action Owner**	**RAG Rating**	**Timescale for Completion**	**Identified Risks and Mitigating Actions**	**Progress and Recommendations**
2b) Two primary care alliances had recently formed the Reading Primary Care Alliance and the North & West Reading Primary Care Alliance. The formation of the two alliances covered 25 GP practices in Reading and would allow for a more cohesive and collaborative approach to workforce planning and would represent and contribute towards a strategy for primary care within the Integrated Care System. It was expected that through the alliances, GP practices would work closer together in the development of a system risk stratification tool that would identify people at the highest risk of hospital admission.	1. Ensure the GP Workforce Group is linked in to wider system workforce strategy **<u>THIS ACTION IS COMPLETE</u>** 2. CCG to work with GP providers to use outputs from Optum public health management work to further develop risk stratification and MDT care planning for patients at risk of deterioration in their health, linking to care navigators as appropriate.	Helen Clark	AMBER	Ongoing in 20/21 and a key workstream in Reading Integration Board work plan.	A key risk would be around engagement and funding for PHM, however the BOB Primary Care Programme Board has agreed in principle for some of the PCN OD funding to be used to support PHM roll-out and in particular continuing to fund clinical ambassadors. These clinical leads will support PCNs in the use of PHM to inform MDT care planning as well as the identification of further opportunities for redesign projects along the lines of those referred to in our previous updates.	We have an agreed structure for work on the primary care workforce which links in both with BOB colleagues through the BOB Primary Care Workforce Group and with the ICP workforce workstream which is looking to take a collaborative approach to recruitment and retention for example through rotational posts. We are also working to embed the role of the Berkshire West Training Hub in supporting future workforce development and continued training and development for existing staff. The further roll-out of PHM will consider how it can be used to support risk stratification and underpin MDT working e.g. to identify people who will most benefit from a care planning approach. This now forms part of the RIB workplan.

Group 2 - Operational Delivery and Workforce (cont.)						
CQC Findings / Suggested Area for Improvement	**Action Required**	**Action Owner**	**RAG Rating**	**Timescale for Completion**	**Identified Risks and Mitigating Actions**	**Progress and Recommendations**
2e) Connected Care, an information sharing platform was already improving connectivity between services, with ambulance and A&E staff accessing GP summary care records, enabling them to make more informed decisions about a person's care. Connected Care had been rolled out within the acute and community trusts but was yet to be established in social care – plans were in place for a phased roll out in December 2018. Social care staff told us that this will make a big difference for them as they will be able see the conversations that have taken place with a person before the point that they make contact, saving time and informing better assessments	1. Deliver the currently agreed implementation plan.	Melissa Wise	GREEN	31st June 2019	**Risk** • There is a risk that these projects will not Go Live as planned due to technical challenges. This risk will be robustly monitored through the Connected Care Implementation Board to ensure the project delivers to plan. **Mitigation** • To maintain reporting through the Connected Care Implementation Board.	Portal access was launched as planned. Initially we offered a limited number of logins to staff to manage the administration however this has since been broadened with now 100 staff that have access **This action is complete** .

roup 2 - Operational Delivery and Workforce (cont.)						
CQC Findings / Suggested Area for Improvement	**Action Required**	**Action Owner**	**RAG Rating**	**Timescale for Completion**	**Identified Risks and Mitigating Actions**	**Progress and Recommendations**
2f) System leaders told us that processes for CHC had been reviewed and extra training had been provided for frontline staff. Despite this frontline staff still did not feel processes were still clear and consequently this was continuing to cause delays. We heard how this was impacting on people being able to die in their preferred place and were given examples of people dying in hospital before the funding was approved. A progress report given to the BW7 on the CHC Quality Premium in March 2018 showed that the CCG was still not reaching the terms of the Quality Premium.	1. Evidence of dissemination through the System of the Interim funding paper agreed by the CCG. This will enable agreement for interim funding so that someone can be placed while assessment and decision regarding Continuing Heath Care are completed to prevent delay in a hospital. 2. Process redesign of the Continuing Heath Care Discharge to assess pathway and process. 3. Interim funding paper – wider communication needed of desired outcomes when the process is redesigned to ensure achieving the outcome.	Katrina Anderson	GREEN	31st July 2019	**Risks** • People wait unnecessarily for a Continuing Health Care determination. • Potentially Health Care needs are not identified early enough and may impact upon resident if they fund their own care. • Adult Social Care potentially provide for Health care needs inappropriately. • Need to review training needs against the framework agreements **Mitigation**	These communication plan and these tasks will be allocated across all the organisations by Reading Integration Board when the pathway and process are signed off. A proposed CHC Discharge to Assess pilot was discussed and agreed at BW7 in January 2019. The CCG and LA's have met twice to discuss and agree the proposed CHC Discharge to Assess protocol (signed off by BW7 in Jan 2019). A further revised protocol was circulated to all 3 LA's in June 2019 and comments/agreement has not yet been received. Therefore the pilot has remained at amber and funding is due to finish in September 2019.

	4. A focus on more assessments happening in the community.				• Multidisciplinary Team Meeting need terms of reference sharing • CHC senior manager now attending DASC Wednesday 8 am meetings to • Discuss/agree DTOC issues. • Adult Social Care have received training and support from Michael Mandelstam in relation to Continuing Health Care	**January 2020** Following the re-circulation of the revised protocol to the L.A.'s no further comments or agreements were received. Funding for the pilot ceased at the end of September2019. **This action is complete**

Group 3 - Commissioning and Market Management						
CQC Findings / Suggested Area for Improvement	**Action Required**	**Action Owner**	**RAG Rating**	**Timescale for Completion**	**Identified Risks and Mitigating Actions**	**Progress and Recommendations**
3a) Health and care commissioners should work together to develop the new Joint Strategic Needs Assessment and ensure that in its development it is aligned with the Integrated Care System's Population Health Management approach.	1. Engage partners and service users to join existing boards to influence and contribute to meeting the needs in the Joint Strategic Needs Assessment (JSNA). 2. Ensure all partners are involved in decisions regarding Joint Strategic Needs Assessment (JSNA and Public Health Monies 9PHM). 3. Make best use of IT to present and share the information across the various organisations and staff groups.	Tessa Lindfield for Joint Strategic Needs Assessment Eiliis McCarthy for Population Health Management	GREEN	31st December 2019	**Risk** • There is a continued risk that organisations will continue to use the outputs of the Joint Strategic Needs Assessment and Public Health Monies work separately given the differing timescales of delivery. **Mitigation** • This is mitigated by both TL and MM being part of both working groups	PH now a member of the PHM & Digital Board. JSNA model has been agreed at all HWBs to include development of on line Berkshire Observatory tool as part of the JSNA which went live with a "soft launch" in September 2019 with a "hard launch" planned for early 2020. Agreement in place to develop joint commissioning for 0-19s in Berkshire West BCEG have agreed measured to strengthen governance of PH system and are reviewing set up across Berks. PH Board continues to meet to review use of PH Grant. A paper will be brought to the Health and Wellbeing Board in March 2020 to show the implementation of the JSNA model, including the Berkshire Observatory data tool and local research framework with an example of a deep-dive thematic needs analysis **This action is complete**

3b) Health and care commissioners should develop a joint commissioning strategy. Health and care commissioners should agree on commissioning intentions across health and social care and work together to develop a joint market position statement.	1. Directors across Berkshire West set high level commissioning priorities for a joint commissioning strategy across Berkshire West and this will now be progressed to agree joint commissioning programme. 2. Develop and agree Joint Market Position statement across the 3 Local Authority's and Clinical Commissioning Group for areas that are common to all partners	Seona Douglas	**RED**	31st December 2019	**Risks** • Commissioning capacity in all partner organisations remains a risk to this work. **Mitigation** • Additional capacity is being explored through the Better Care Fund to expedite this work.	Work in this area is slow. This is being reported to the Chief Executives in Dee20. A way forward is necessary to deliver in this area, as the 3 Local Authorities do not have completed Market Position Statements. This has meant that Seona has reconsidering how a Berkshire West pricing range can be agreed.

Group 3 - Commissioning and Market Management (cont.)						
CQC Findings / Suggested Area for Improvement	**Action Required**	**Action Owner**	**RAG Rating**	**Timescale for Completion**	**Identified Risks and Mitigating Actions**	**Progress and Recommendations**
3c) System leaders should focus on developing prevention and early intervention services that increase the support offer in the community. A system approach to risk stratification and active case management should be developed to identify people at the highest risk of hospital admission.	1. MDT Risk stratification progressing as part of care planning, but will be accelerated and broadened in order for partners and other projects to benefit from understanding this risk profiling approach. 2. The Neighbourhood Care Planning Group (NCPG) pilot project needs to be reviewed to ensure the outcomes are aligned with the CQC outcomes. Consider if the information GP's hold in their GP frailty register could link into the pilot.	Maureen McCartney	**AMBER**	Ongoing in 20/21 and a key work stream in Reading Integration Board work plan.	**Risks** • There is a risk that the Neighbourhood Care Planning Group work is completed in isolation of the planned system wide neighbourhood work. **Mitigation** • All planned work related to Neighbourhoods is cited through the Reading Integration Board	Health and Social Care Partners have actively engaged with the Optum Population Health Management Programme and the outputs from this and the analysis and recommendations in the Paper referred to in Action 2b) support the action referred to in 3C . Public Health Managements data packs have been produced for each PCN in Reading by the CCG Chief Information Officer. In addition the Public Health lead at RBC is leading a work stream with partners from Reading Integration Board to develop a Population Health Management Process for Reading. This will help ensure that health and social care work together to support those Reading Residents most at risk of hospital admission. **This action is ongoing and included in the Reading Integration Board work plan.** **Lewis please check Seona is happy with this.**
3d) The role of the Reading Integration Board	1. Review Terms of Reference and	Melissa Wise	GREEN	31st March	**Risks**	Further to discussion with RIB Chair a 5 minute

should be further developed to enable joint commissioning outside of the Better Care Fund and be more closely aligned to the Health and Wellbeing Board	membership. 2. RIB chair and PMO to engage with HWBB Chair to identify options for better alignment. 3. As Joint Commissioning develops utilise the Reading Integration Board as the appropriate Governance vehicle for monitoring			2020	• Lack of sufficiently experienced Programme Management capacity. • Joint commissioning develops at a slower pace than expected. **Mitigation** • Identify internal resources if required to undertake required work.	recurring item will be added to the Reading Integration Board (RIB) agenda for May 2019 onwards to discuss and monitor progress made / opportunities arising at the Berkshire West 7 Joint commissioning board and consider ongoing conversations re joint commissioning opportunities. Meeting to be planned for late June to allow Director and Chairs of both boards to discuss better alignment of Reading Integration Board (RIB) and Health and Wellbeing Board (HWBB). To also agree any necessary changes to terms of reference and membership. **<u>This action is complete</u>**
3e) Market management was undertaken by the local authority and the CCG separately although system leaders stated an intention to move towards a more joined up approach. The local authority had a robust market position statement and was undertaking work to update this.	See 3b above	Seona Douglas pending appointment of new Asst. Director Commissioning	AMBER	30th September 2019	**Risks** • Commissioning capacity in all partner organisations remains a risk to this work **Mitigation** • Additional capacity is being explored through the Better Care Fund to expedite this work.	**22/5/2019** A Joint Commissioning Group as a part of the new Governance arrangements described above in 1A has been set up across the Berkshire West 7 group to address the commissioning issues more widely than Reading BC and the CCG. The group will be informed by the JSNA work, the Optum project and the 3 LA's (Reading Wokingham and West Berkshire) Market Position Statements. **4/12/2019** Please see the update in 3b for further detail

<u>Group 4</u> - Communication & Engagement						
CQC Findings / Suggested Area for Improvement	**Action Required**	**Action Owner**	**RAG Rating**	**Timescale for Completion**	**Identified Risks and Mitigating Actions**	**Progress and Recommendations**
4a) In developing the next Health and Wellbeing Strategy, due for publication in 2020, the local authority should engage system partners and ensure greater alignment with the wider Berkshire West Integrated Care System strategic intentions and those of the Buckinghamshire, Oxford and Berkshire West STP	1. Using the Health & Wellbeing Board as the vehicle for discussion undertakes early scoping with partners to develop the strategic intentions for the strategy. 2. Ensure System Leaders are engaged in approving the strategy and associated action plan. Ensuring alignment to the Integrated Care System (ICS) strategic intentions as appropriate. Joint	Tessa Lindfield	AMBER	30th September 2019	**Risks** • As the Integrated Care System work evolves there is a risk that developments will not be included in the Health & Wellbeing Strategy as it has a finite publish date. • Ensure sufficient time is allowed to capture service	The chairs of the Wokingham, Reading and West Berks Health and Wellbeing Boards agreed in April 2019 to pursue having a Berkshire West shared joint health and wellbeing strategy. Post-election, Wokingham wanted to revisit this commitment. Discussions continue to agree how this can best include the Wokingham LA area. Reading and West Berks remain committed to developing this jointly.

	ownership of the Action Plan is secured.				user voice through partnership groups	A bid for programme support to develop the strategy made to the ICP delivery group has been successful. An interim project worker has been appointed The timeline for the production of the strategy is dependent on the recruitment of project management support for the work. Recruitment will take place in early 2020. The ambition for a shared joint HWBS with joint strategic ambitions and local priorities remains.
4b) While relationships between system leaders are strong, improvements in relationships between health and local authority partners could be improved. As the system moves towards greater integration at a Berkshire West level, system leaders should ensure that staff are engaged in the process and that health partners and working with colleagues in the local authority to progress plans.	1. Public Health Consultants are working at a Berkshire West level to create the Framework needed to coordinate and bring groups together on a more formal basis. 2. Action plan to decide how we really engage with each other and the wider stakeholders and public. 3. Staff from all organisations are involved in the further development of the Integrated Care System work to ensure alignment and a joined up approach.	Cathy Winfield	GREEN	31st August 2019	**Risks** • Potential changes to elected members and senior leaders with a subsequent reduction in commitment to joint working • Lack of capacity to deliver the ICP work programme • Lack of resource to support the development of the joint strategy **Mitigation** • Secure full organisational support for joint working and embed robust governance at locality and system level to reduce the impact of loss of specific individuals • Review the resource associated with the current BW10 so that this can be deployed on agreed priorities and makes more efficient use of current capacity by doing things once and sharing. Each ICP partner to agree how the development of the new strategy will be resourced.	1. Reading Borough Council and the Health and Well Being Board have agreed to implement the ICP governance. This creates the framework needed to coordinate the joint working and engage staff. The first meeting of the ICP Unified Executive will take place on 12th September and the first meeting of the ICP Leadership group will take place on 30th September. 2. All ICP partners have undertaken a strategic prioritisation process which will be signed off via the ICP governance and have agreed to develop a joint strategy for Berkshire West by July 2020, coordinated by public health, with clear identification of specific priorities for each local authority area (see 4a). RAG rating is now Green as the ICP has been implemented and joint strategy proposals are agreed. **<u>This action is complete</u>**

Group 4 - Communication & Engagement						
CQC Findings / Suggested Area for Improvement	**Action Required**	**Action Owner**	**RAG Rating**	**Timescale for Completion**	**Identified Risks and Mitigating Actions**	**Progress and Recommendations**
4c) There were opportunities to make better use of the VCSE sector services market. Health and care commissioners should work with VCSE sector providers to support in the development joined up service offers.	1. Linked to 3B above 2. Refresh mapping exercises previously undertaken across the Clinical Commissioning Group and Reading Borough Council to align existing Voluntary Sector and Social Enterprise Commissioning and ensure Voluntary sector groups included across board.	Seona Douglas pending appointment of new Asst. Director Commissioning	GREEN	30th September 2019	**Risks** • Capacity in commissioning teams across partner organisations is proving challenging. **Mitigation** • A realistic approach to be adopted to what can be achieved and maximise the resources available.	The Joint Commissioning Board described in 3e has a sub group focussed on Voluntary Sector commissioning led by the Public Health Consultant in West Berkshire and will report to the Joint Commissioning Board. This is built into Joint Commissioning Board work and a group led by the West Berkshire for all three Local Authorities and the CCG. **<u>This action is complete</u>**
4d) Carers had varying experiences of accessing support in Reading. Statutory services were not always well linked to VCSE sector services that could provide support to carers. The Reading Carers Hub provided information and advice for unpaid carers however carers felt that they were not always well supported to access services and many felt they had to reach crisis point before they were offered support.	1. Raise awareness of third sector support for carers amongst all organisations across the system 2. Promote Carers Week (June) and Carers Rights Day (November) activities to create network opportunities	Jon Dickinson	GREEN	30th September 2019	**Risks** • Lack of understanding legislation and local services **Mitigation** • Utilise local HUB's GP surgery's and on-line solutions to inform as widely as possible	Awareness has been raised over the last few months, with the following activities taking place: - Speed Dating events to link ASC and the 3rd Sector. - Spotlight on the voluntary sector – regular item in GP e-newsletter. Refresh of Caring in Reading information pack. Carers Rights day was promoted on twitter and the carers forum in Reading was held in November **<u>This action is complete</u>**

Group 4 - Communication & Engagement (cont)						
CQC Findings / Suggested Area for Improvement	**Action Required**	**Action Owner**	**RAG Rating**	**Timescale for Completion**	**Identified Risks and Mitigating Actions**	**Progress and Recommendations**
4e) Carers we spoke with were concerned about the availability of respite care and that those who did not fund their own care had limited choice and control over what respite services were available. Carers felt that carers issues are not well understood and more could be done to join services together and promote common issues	1. Carers needs to be incorporated in to the roll out of the new strength based model work – Conversations Count within Reading Borough Council see in 2 c above Further training to be rolled out across the department and partners re identifying carers who may have significant caring role.	Jon Dickinson	GREEN	31st March 2020	**Risks** • Further analysis and identification work if needed. **Mitigation** • Explore involvement from Healthwatch and Carers	1. Speed dating events have happened between ASC & 3rd Sector to raise awareness of community support / focus on carers. 2. The Multi-Agency carers steering group continues to promote good practice and information sharing across partners. 3. 'Caring in Reading' information pack has been refreshed to strengthen information about

	2. System partners to understand the joined up carers strategy – and to align in the future. 3. Develop the 'getting a break' section of the 'Caring in Reading' information pack which is disseminated online within Reading Services Guide) and in hard copy so as to improve awareness of respite services				Hubs	respite services. **<u>This action is complete</u>**
4f) Strategic provider forums which bring together staff from across health and social care providers should be established to enable staff to discuss operational processes and overcome barriers to joint working.	1. RBC will facilitate provider forums across all service areas ensuring representatives from partner organisations are represented.	Melissa Wise	**AMBER**	31st October 2020	**Risks** • Attendance at the sessions • Partaking and absorbing the messages to champion in the workplace. • Day to day priorities **Mitigation** • Inclusive workshop style to encourage understanding. • Commitment of Managers to release staff to participate.	This is a wider matter in relation to response for 1a above therefore the timescale has been adjusted from the original July date to enable this to be considered further and established across the wider footprint. For further detail, please take a look at 3b. A date for the Executive Director of Adults is arranged at the end of April 2020 to meet the Home Care Supported Living and Residential and Nursing Providers.

<u>Group 4</u> - Communication & Engagement (cont.)						
CQC Findings / Suggested Area for Improvement	**Action Required**	**Action Owner**	**RAG Rating**	**Timescale for Completion**	**Identified Risks and Mitigating Actions**	**Progress and Recommendations**
4g) In the establishment of pathways care, operational leads should ensure they are understood and signed up to by staff across the system and that they are clearly communicated to people so that they understand what options are available to them when they are discharged from hospital	1. To Review all the care pathways to provide a clear understanding of the hospital discharge journey for residents. 2. To provide public information in relation the pathway so that there is clarity in relation to a range of options.	Mark Robson	**GREEN**	30th September 2019	**Risks** • Allocated time • Day to day priorities. **Mitigation** • Commitment to improve the resident experience of hospital discharge.	The Royal Berkshire Foundation Trust along with its partners, RBC and BHFT have in place agreed pathways to all destinations for onward care. We have been reviewing these pathways (as per action plan) particularly the Community Reablement and Community Hospital ones. The systems has also agreed the "Choice Policy" which sets the expectation framework for discharging from RBFT and community beds to onward care. The RBFT has initiated a patient Discharge Envelope (A4) which contains all

						relevant information to patients and their relatives. We are also about to launch a new 1st stage letter from the Patient Choice Policy, which will be in line with the revised pathways, setting out details and expectations of the different pathways. This will be issued to all patients that may require onward care, for instance, home reablement, community hospital, residential care, domiciliary care and self-funded care. **<u>This action is complete</u>**