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Notice of Meeting

Health and Wellbeing Board

Thursday, 22nd January 2015 at 9.00am

in Council Chamber Council Offices
Market Street Newbury

Date of despatch of Agenda: Wednesday, 14 January 2015

For further information about this Agenda, or to inspect any background documents referred to in Part I reports, please contact Jessica Bailiss on (01635) 503124
e-mail: jbailiss@westberks.gov.uk

Further information and Minutes are also available on the Council's website at www.westberks.gov.uk

West Berkshire COUNCIL

To: Dr Bal Bahia (Newbury and District CCG), Adrian Barker (Healthwatch), Dr Barbara Barrie (North and West Reading CCG), Leila Ferguson (Empowering West Berkshire), Councillor Marcus Franks (Portfolio Holder for Health and Well Being), Dr Lise Llewellyn (Public Health), Councillor Gordon Lundie (Leader of Council & Conservative Group Leader), Councillor Gwen Mason (Shadow Health and Wellbeing Portfolio Holder), Councillor Irene Neill (Portfolio Holder for Children and Young People), Matthew Tait (NHS Commissioning Board), Rachael Wardell (WBC - Community Services), Cathy Winfield (Berkshire West CCGs), Nikki Luffingham (NHS England Thames Valley) and Councillor Keith Chopping (Portfolio Holder for Community Care)

Also to: Jessica Bailiss (WBC - Executive Support), Nick Carter (WBC - Chief Executive), Andy Day (WBC - Strategic Support), Councillor Quentin Webb, Councillor Graham Pask, Tandra Forster (WBC - Adult Social Care), Shairoz Claridge (Newbury and District CCG), Councillor Roger Hunneman (Deputy Liberal Democrat Group Leader), Mark Evans (Head of Children's Services), Dr Abid Irfan (Newbury and District Clinical Commissioning Group), Councillor Peter Argyle, Councillor Adrian Edwards, Tony Quinn (Empowering West Berkshire) and Dr Rupert Woolley (North and West Reading CCG)

Agenda

Part I

			Page No.
9.00 am	1	**Apologies for Absence** To receive apologies for inability to attend the meeting (if any).	
9.01 am	2	**Minutes** To approve as a correct record the Minutes of the meeting of the Board held on 27th November 2014 and 8th January 2015.	7 - 20
9.05 am	3	**Health and Wellbeing Board Forward Plan** For information.	21 - 24
9.07 am	4	**Actions arising from previous meeting(s)** For information.	25 - 26

9.10 am	5	**Declarations of Interest** To remind Members of the need to record the existence and nature of any Personal, Disclosable Pecuniary or other interests in items on the agenda, in accordance with the Members' Code of Conduct.	
	6	**Public Questions** Members of the Health and Wellbeing Board to answer questions submitted by members of the public in accordance with the Executive Procedure Rules contained in the Council's Constitution. *(Note: There were no questions submitted relating to items not included on this Agenda.)*	
	7	**Petitions** Councillors or Members of the public may present any petition which they have received. These will normally be referred to the appropriate Committee without discussion.	

Items for discussion

Systems Resilience

9.15 am	8	**Health and Social Care Dashboard (Tandra Forster/Shairoz Claridge/Jessica Bailiss)** Purpose: To present the Dashboard and highlight any emerging issues.	27 - 30

Integration Programme

9.25 am	9	**Update report on the Better Care Fund (Tandra Forster)** Purpose: To update the Health and Wellbeing Board of progress on the Better Care Fund plans and projects.	31 - 44
9.40 am	10	**Alignment of Commissioning Plans (Tandra Forster/Shairoz Claridge)** Purpose: To give an brief update and presentation detailing progress with this area of work.	45 - 50

Health and Wellbeing Strategy/Joint Strategic Needs Assessment

9.50 am	11	**Finalisation and Agreement of the Health and Wellbeing Strategy (Lesley Wyman)** Purpose: To finalise and agree the Health and Wellbeing Strategy post the consultation period.	To follow

Governance and Performance

10.10 am	12	**Health and Wellbeing Performance Report (Lesley Wyman)** Purpose: To give a report to the Board on performance against the current Health and Wellbeing Strategy.	51 - 106

Other issues for discussion

10.20 am	13	**Draft Business Plan for the Local Safeguarding Children's Safeguarding Board (Fran Gosling-Thomas)** Purpose: To present the LSCB Business Plan to the Board.	107 - 118
10.30 am	14	**Mental Health Crises Concordat (Angus Tallini)** Purpose: To introduce the Mental Health Crises Concordat and to give consideration to implications for the Health and Wellbeing Board.	119 - 128
10.40 am	15	**Post Implementation Reflection - Special Educational Needs Reform (Jane Seymour)** Purpose: To report on the new way of working with Children with Educational Needs.	129 - 156
10.50 am	16	**Dementia Alliance (Alison Love)** Purpose: To inform the Board about this national programme of work, which has time limited funding.	157 - 176
	17	**Member's Questions** Members of the Health and Wellbeing Board to answer questions submitted by Councillors in accordance with the Executive Procedure Rules contained in the Council's Constitution.	
11.00 am	18	**Future meeting dates**	

26 March 2015	26 November 2015
4 June 2015	28 January 2016
30 July 2015	24 March 2016
24 September 2015	26 May 2016

Andy Day
Head of Strategic Support

If you require this information in a different format or translation, please contact Moira Fraser on telephone (01635) 519045.

DRAFT

Note: These Minutes will remain DRAFT until approved at the next meeting of the Committee

HEALTH AND WELLBEING BOARD

MINUTES OF THE MEETING HELD ON THURSDAY, 27 NOVEMBER 2014

Present: Dr Bal Bahia (Newbury and District CCG), Adrian Barker (Healthwatch), Leila Ferguson (Empowering West Berkshire), Councillor Marcus Franks (Portfolio Holder for Health and Well Being), Dr Lise Llewellyn (Public Health), Councillor Gwen Mason (Shadow Health and Wellbeing Portfolio Holder), Councillor Irene Neill (Portfolio Holder for Children and Young People), Rachael Wardell (WBC - Community Services), Cathy Winfield (Berkshire West CCGs), Nikki Luffingham (NHS England Thames Valley) and Councillor Keith Chopping (Portfolio Holder for Community Care)

Also Present: Jessica Bailiss (WBC - Executive Support), Nick Carter (WBC - Chief Executive), Lesley Wyman (WBC - Public Health & Wellbeing), Heather Hunter (Healthwatch), Tandra Forster (WBC - Adult Social Care), Shairoz Claridge (Newbury and District CCG), Fatima Ndanusa (Public Health), Steve Bedser (Local Government Association), Susan Powell and Barrie Prentice (Boots and Berkshire LPC)

Apologies for inability to attend the meeting: Dr Barbara Barrie and Councillor Gordon Lundie

PART I

50. Minutes

The Minutes of the meeting held on 18th and 25th September were approved as a true and correct record and signed by the Chairman.

51. Health and Wellbeing Board Forward Plan

The Health and Wellbeing Board noted the Forward Plan.

52. Actions arising from previous meeting(s)

The Health and Wellbeing Board noted the actions arising from the previous meeting.

53. Declarations of Interest

Dr Bal Bahia declared an interest in all matters pertaining to Primary Care, by virtue of the fact that he was a General Practitioner, but reported that, as his interest was not personal, prejudicial or a disclosable pecuniary interest, he determined to remain to take part in the debate and vote on the matters where appropriate.

54. Public Questions

There were no public questions.

55. Petitions

There were no petitions presented to the Board.

56. Health and Social Care Dashboard (Tandra Forster/Shairoz Claridge/Jessica Bailiss)

Tandra Forster introduced the item to the Health and Wellbeing Board and referred to the Adult Social Care section. It was noted that ASC1 was currently red regarding the average number of delayed transfers of care which were attributable to social care per 100,000. She reported that the figure of 6.1 per 100,000 population had now improved to 5.3 and therefore the direction of travel was improving.

ASC2 was also red regarding the proportion of older people who were still at home 91 days after discharge from hospital to reablement/rehabilitation services. Tandra Forster reported that this area in particular was under a lot of pressure as they were working with people with critical needs.

Shairoz Claridge referred to the section of the dashboard on the Acute Sector. There had been a good degree of improvement around the four hour accident and emergency target. The Royal Berkshire Hospital in particular had seen a significant improvement. Ongoing work would continue to alleviate pressures within this area. Cathy Winfield added that this particular target had been achieved for seven of the last eight weeks and therefore was on track to be on target at the end of the quarter.

Shairoz Claridge asked if there were any further comments on the Acute Sector section of the dashboard. Councillor Marcus Franks queried when missing target information would be added to the Dashboard. Shairoz Claridge reported that some new information would be added as related areas of work progressed. In the mean time it was suggested that baseline information be provided where there were no targets/benchmarks.

RESOLVED that Shairoz Claridge would provide baseline data for the Dashboard where necessary.

Cathy Winfield reported that 10% was the target for the 111 Service nationally and therefore this could be used on the Dashboard. Berkshire was currently green (9.7%) against the national target. Cathy Winfield reported that there was also activity information that could be added.

Dr Lise Llewellyn referred to the Primary Care Section of the dashboard and suggested that the extension of hours be used as a metric. This would gauge how surgeries were responding. Dr Bal Bahia reported that there were a number of initiatives taking place across Primary Care and the limiting factor was currently the workforce. Many practices already opened on a Saturday morning. There was also an additional fund available for winter resilience.

Dr Llewellyn felt that Dashboards often focused on negatives issue. The expansion of Primary Care was extremely positive and should be included. Dr Bahia agreed in principle however felt that it would be difficult to define a measure.

RESOLVED that metrics to reflect the expansion of Primary Care to be explored as a possibility for the Health and Social Care Dashboard.

Rachael Wardell drew the Board's attention to the Children's Social Care section on the Dashboard. She referred to the number of Looked After Children and reported that the decision to take a child into care was always taken for the right reasons. Ways to bring this figure down were being explored and involved early intervention and family work. Regarding Child Protection Cases, although red (91%), they were not too far from the 99% target however, there was still a lot of work to be done to get them to where they wanted to be. The number of Section 47 enquiries carried out was within the normal range expected however, was at the higher end of the range. This was also the picture

nationally and in turn created work load pressures, which impacted upon review timescales.

Adrian Barker commented on the format of the Dashboard and suggested that it could show trends over a period of time.

RESOLVED that the format of the dashboard and whether it should include longer term trend data would be discussed at the Management Group.

Cathy Winfield reported that Monitor had recently been called in to carry out an investigation at the Royal Berkshire Hospital. She suggested that this could be included on the Dashboard.

RESOLVED that a metric to reflect Monitor's investigation at the Royal Berkshire Hospital would be included on the dashboard.

57. JSNA Ward Profiles (Lesley Wyman)

Lesley Wyman introduced the item to Members of the Board, which aimed to inform them on how ward profiles could be used to identify links between deprivation and health.

Lesley Wyman gave a presentation to the Board. In summary:

- The ward profiles included information on demographics; deprivation, poverty and access to services; economy and enterprise; education; health; housing; community safety and the environment.
- Summary spine charts showed the areas where each ward was performing more or less positively compared to the West Berkshire average.
- Regarding deprivation, each ward was ranked out of the 30 wards in West Berkshire.
- School children receiving free school meals was a measure used when calculating deprivation. Recently however, this measure had changed as all children in reception received schools meals. The coding would need to be changed accordingly to ensure it was still apparent, which families were on lower incomes.
- A caveat was highlighted regarding health data because data at ward level was often very small numbers and therefore should not be used to make strong conclusions, especially forecasting trends etc.
- Regarding mortality rates, levels were higher in wards which were more deprived.
- There were also ward profiles featured on the Local Government Associations (LGAs) website. Although these profiles used the same data as that used for West Berkshire's own profiles, it was set out in a different way that some might find useful.
- Lifestyle data indicated that 65% of people in West Berkshire were overweight or obese. This was similar to the national average but still very high.
- Census data used for the ward profiles was from the year 2011 and therefore was reasonably up to date.
- Central heating information was an important measure of fuel poverty.
- Regarding how the ward profiles would be used, there were many factors that affected someone's health and wellbeing. The aim was to achieve positive outcomes for the population, address inequalities in health and understanding where to target resources and services.

- There were two overarching Public Health Outcome Framework Indicators (PHOF): increased healthy life expectancy and reduced difference in life expectancy and healthy life expectancy between communities

Lesley Wyman concluded her presentation on ward profiles by exploring the possible ways forward. There was the potential to link to the parish planning process; use the new Communities Sub-group to guide the process; explore other ward based work that could be linked to and increase involvement of elected Members. Lesley Wyman explained that although the Public Health Team wanted to do more around this work, capacity was a limiting factor. Community asset mapping was a possibility for the future however; this would require resourcing and a partnership approach.

Asset Mapping was a possibility for the future however, this would require resourcing and a partnership approach.

Cathy Winfield was interested to see how community asset mapping could be linked to the Adult Social Care hub work. Tandra Forster felt that this was an area that needed building on and that more could be done at ward level through working with the parishes/communities.

Councillor Marcus Franks noted a similarity to the Pharmaceutical Needs Assessment (PNA) paper. Cathy Winfield highlighted that pharmacies were excluded from the work of the Clinical Commissioning Groups (CCG). Cathy Winfield added that risk mapping was taking place across surgeries. It was important that housing development and planning were also taken into account.

Councillor Franks pointed out that none of the three most deprived wards in West Berkshire had a GP surgery located within them.

Rachael Wardell stated that Lesley Wyman was working closely with the Communities Directorate Leadership Team, who were having active conversations regarding what could be done collaboratively. A programme of work was unfolding with a focus on community resilience. Community assets needed to be drawn on to a greater degree and assurance was given that a piece of work was taking place.

Dr Bal Bahia thanked Lesley Wyman for her presentation, which he felt highlighted areas that were often overlooked. Dr Bahia felt that focusing on community asset mapping and empowering communities was moving things in the right direction however, consideration was now required as to how these things would be made to happen.

Dr Lise Llewellyn reiterated that the ward profile data often consisted of small numbers however, it did initiate useful conversations. The work linked to care groups including both children and older people. Links to community development was something that needed exploring further.

Rachael Wardell stated that conversations did not necessarily need to be led from the Health and Wellbeing Board and alternatively could be given to the community to lead on. Ward Members worked at grass root level within communities. Councillor Gwen Mason felt that caution needed to be taken when going out to the community, as it was vital that they fully understood what was trying to be achieved.

Councillor Franks suggested that the link to the ward profiles be emailed to all Members. Lesley Wyman suggested that there be a short session aimed at supporting Members to interpret the data accurately.

RESOLVED that the link to ward profile would be emailed out to all elected Members.

58. Themes for Health and Wellbeing Board meetings (Lesley Wyman)

Lesley Wyman introduced her report to the Health and Wellbeing Board, which proposed three priority areas that would be brought to the Board for update, discussion and development. It was suggested within the report that each priority areas be called a Hot Focus..

Lesley Wyman reported that the Management Group for the Board had discussed and agreed with the three proposed hot focuses, as follows:

1. We will improve the health and educational outcomes of looked after children through high quality health and social care support.
2. We will promote mental health and wellbeing in adults through prevention, early identification and provision of appropriate services.
3. We will maximise independence in older people by preventing falls, reducing preventable hospital admissions due to falls and improving rehabilitation services.

The three hot focuses had been lifted from the Health and Wellbeing Strategy, which was currently being consulted on and therefore a degree of flexibility would be required depending on the outcome of the consultation.

The plan was to have a three month period focused on each Hot Focus, which would give an opportunity to explore successes and areas where joint working could take place. For each Hot Focus a task and finish group would be set up, which would feedback to the Board at the end of the three month period.

It was acknowledged that issues could change over the period of a year due to different areas of work taking place across the district and therefore the Hot Focuses would need to remain flexible.

Councillor Marcus Franks felt that thought needed to be given to the format of each meeting and that each theme would require an adequate slot on the agenda to ensure it was given the level of attention necessary.

Rachael Wardell supported the chosen three hot focuses. These were also the areas identified through the West of Berkshire Pioneer Bid. Regarding the format, Rachael Wardell reported that she had recently attended a very useful half day session on domestic abuse, aimed at creating a better collated response to the issue. It was suggested a similar format could be applied to each of the Hot Focus sessions.

Adrian Barker was satisfied with the hot focuses however felt that the one around Looked After Children was a little narrow and could be broadened out to include other vulnerable groups of children. He also felt that the hot focus on falls prevention could also be broadened out.

Dr Lise Llewellyn commented that the area of Looked After Children drew together a whole host of services. She disagreed that the topics should be broadened out and was of the view that it was important to stay focused. With this approach there was more likeliness that there would be a positive impact that could then be rolled out in the future. Dr Llewellyn noted that the Looked After Children and Falls Prevention work linked to the Care Group work referred to by Tandra Forster.

Cathy Winfield stressed that it was important to look at what work was already underway when assessing what work was required. They also needed to remain realistic about capacity.

Rachael Wardell stated that she was not resistant to broadening out the Hot Focus on Looked after because work within her directorate covered a wider area. However she felt

that keeping it focused would help to get the work started. She reassured all that work with other vulnerable groups would continue despite the Board choosing to focus on a specific area.

Lesley Wyman noted that a half day session for each hot focus had been suggested. She concurred with Cathy Winfield that they needed to be smart when assessing areas where work was required.

RESOLVED that three half day sessions would be set up in addition to the six Health and Wellbeing Board meetings.

59. Health and Wellbeing Strategy Performance Report (Lesley Wyman)

Lesley Wyman introduced her report to Members of the Board, which reported on performance against the current Health and Wellbeing Strategy, which would be in place until the end of March 2015. The Strategy had a huge range or priorities, which made performance reporting particularly onerous and had led to the subsequent Strategy for 2015 onwards consisting of a much smaller number of priorities.

Consultation on the new Strategy had recently been undertaken and there would be a performance framework in place from the adoption of the new Strategy.

Lesley Wyman drew Board Members' attention to appendices 1a to e, which were the performance framework for 2013/14. Data for smoking prevalence in adults had slightly increased according to this however, Lesley Wyman reported that more recent data showed a significant decrease. The weight management service had recently been commissioned and therefore it was anticipated that this would bring obesity levels down.

Lesley Wyman reported that the figure for the number of Health Checks carried out was slightly below the 10% target. A lot of effort was going into raising this figure.

Councillor Marcus Franks queried why less people were opting to have Health Checks. Dr Bal Bahia explained that they had been contacting people regarding these checks for a few years now. He reported that there had been an ongoing debate concerning the effectiveness of the Health Checks as a screening programme.

Dr Lise Llewellyn assured all that the Health Checks would continue. Two areas of focus for West Berkshire included blood pressure and atrial fibrillation. Work needed to be carried out on raising the profile of the Health Checks. Dr Llewellyn reported that it did not necessarily have to be a medic who carried out the Health Checks, for example four individuals within the Fire service had recently been trained

60. Health and Wellbeing Board Governance (Councillor Marcus Franks)

Councillor Marcus Franks introduced the item to the Board, which aimed to give clarification on the constitution for the Health and Wellbeing Board. He reported that the paper in particular clarified the situation around voting and nominated deputies.

The report also set out that when a situation occurred where a decision of the Board would impact on the finances or general operation of the Council, the recommendation made by the Board must be referred up to the Executive for final determination and decision.

Dr Bal Bahia stated that a similar process would need to be followed for the Clinical Commissioning Groups (CCGs), in that the Governing Body would have to be advised. Cathy Winfield stated that they would need to look at the CCGs constitution and give those on the Board delegated responsibilities.

Councillor Franks informed the Board that going forward, they needed to ensure that from a public perspective the deliberations of the Board were more transparent to ensure that accountability was clear. He proposed that only the thirteen Members of the Health and Wellbeing Board or their nominated deputies sit around the Committee tables. This would mean that it would be apparent to those attending who the members of the Board were. Only Board Members, or their nominated deputies, would be permitted to vote on issues or take part in discussions.

Councillor Franks reported that he had asked that there be a designated table for those presenting items and presenters would be expected to return back to the public seating area before the Board voted on a specific issue.

Officers and Guests who could provide clarity or answer questions on certain issues would only be able to speak if and when invited to do so by the Chairman. It would not be permissible for non Board Members to become involved in a debate or vote on an item being considered by the Board.

RESOLVED that all Members of the Board would send details of their nominated deputy to Jess Bailiss.

RESOLVED that all Members of the Board and their nominated deputies would complete a Declaration of Interest form in line with the Council's Code of Conduct.

61. Health and Wellbeing Board Development Session (Nick Carter)

Nick Carter referred to the session outline for the Health and Wellbeing Development Session on page 59 of the agenda.

It was agreed at the first Development Session in April 2014, that another would take place six months later to review the progress that had been made. The session would be led on and facilitated by the Local Government Association (LGA).

Councillor Marcus Franks felt that it would be helpful to explore the Hot Focus Sessions in more detail at the event.

62. Update report on the Better Care Fund (Tandra Forster)

Tandra Forster introduced the item, which aimed to update the Board on progress with the Better Care Fund Plans (BCF).

Tandra Foster reported that they were still awaiting a more detailed proposal on the BCF funding from the Department of Health (DH). Rachael Wardell added that the DH had stated that they were expecting no further work from West Berkshire Council.

The Department of Health had confirmed that West Berkshire was among 90 other areas that had BCF plans approved subject to conditions.

Cathy Winfield reported that dialogue was taking place with the DH and they had stated that were hoping to let West Berkshire have the necessary information during the week leading up to the 12th December. The final deadline date was 9th January 2015, so there was more time if required.

Tandra Forster added that they had entered a period of clarification and were awaiting a proposal from DH. West Berkshire was one of three authorities, that would be changing its criteria eligibility and all would be facing similar pressures.

Adrian Barker asked if the voluntary sector or members of the public had been involved in the Project Board. Tandra Forster highlighted that there had been Call to Action events

held in public. Evaluation of feedback was ongoing. The establishment of a public Care Steering Group was a possible option.

Cathy Winfield reported that there was a BCF tracker that ensured work was targeted and measured impacts and outcomes. Tandra Forster commented that metrics had been agreed for all projects and the metric start date was 1st April 2015, which was when impacts would begin to become apparent.

Adrian Barker queried the hub. Tandra Forster reported that this created consistency and avoided duplications in the system. Currently it was just a professionally based hub. Cathy Winfield added that the hub enabled consistency in response and closely linked to the obligations set out in the Care Act. Nikki Luffington reported that this sat with the national team.

Regarding the offer from the DH Councillor Franks reported that a deadline of the end of October 2014 had originally been agreed. Due to continued negotiations this deadline was extended until the end of November however, an offer had still not been received from the DH.

Councillor Franks proposed that a letter be drafted from Wokingham and West Berkshire Council, referencing local Members of Parliament, asking the DH to provide an offer by midday on 5th December. If the DH failed to meet this deadline, Members of Parliament would be asked to escalate the issue.

Cathy Winfield queried if it was a Local Authority action or Health and Wellbeing Board action. Councillor Franks stated that it was important that the Care Act was not decoupled from the BCF. Nick Carter added that the letter would come from the Local Authority with the intention of confirming timescales.

Councillor Franks proposed that the revised deadline date of 5th December be submitted to the DH. If the Board approved this date the Local Authority would draft the letter as detailed above. The proposal was seconded by Councillor Keith Chopping.

RESOLVED that the Health and Wellbeing Board supported the revised DH offer deadline date of 5th December 2014.

63. Better Care Fund Project Management Report (Tandra Forster)

Tandra Forster drew the Board's attention to the project highlight reports for each of the Better Care Fund Projects.

The Health and Social Care Hub Project was currently green and on target. The Hospital at Home Project had been through the proof of concept stage and the outcome had been evaluated. As a result of the evaluation there would be a change in the way this project was delivered.

Councillor Marcus Franks requested that the original highlight report template be retained for the West Berkshire based projects.

Cathy Winfield commented that the status report circulated was just an overview and there were more detailed reports that sat beneath it.

RESOLVED that the original highlight report templates would be retained for the West Berkshire based BCF projects. The Berkshire projects would be presented in a different format, using the reports that sat beneath the Programme Status Report.

64. Safeguarding Adults Partnership Board Annual Report (Sylvia Stone)

Rachael Wardell introduced the item and reported that she would be covering the item as Sylvia Stone was unfortunately unable to attend the meeting. Any questions on the Annual Report would be forwarded to Sylvia Stone after the meeting if required.

Rachael Wardell reported that the Safeguarding Adults Partnership Board was a single partnership board that covered the whole of Berkshire.

Dr Lise Llewellyn referred to page 193 of the annual report regarding the location of abuse. She was aware that the recent way of thinking was to encourage people to stay at home and therefore she questioned if work was taking place to account for this with regards to domestic abuse. Rachael Wardell reported that under the Care Act Regulations there was a requirement for increased focus and attention in this area however, at this stage there was not a dedicated piece of work being undertaken. Assessments of carers or those being cared for were always used as a means for giving out important information.

65. Pharmaceutical Needs Assessment Briefing (Lise Llewellyn)

Lise Llewellyn drew attention to her report, which was a summary of neighbouring areas' Pharmaceutical Needs Assessments (PNA). Generally areas across Berkshire had similar requirements to West Berkshire. Reading and Wokingham were both satisfied with their pharmaceutical services. Hampshire had also stated that they were happy with the pharmaceutical services. One issue raised was that people were often not taking their medication correctly.

Wiltshire had carried out their PNA at a district level and overall felt that they had sufficient pharmaceutical services. They were looking to increase services in the same areas as West Berkshire. Oxford also felt that they had sufficient pharmaceutical services however wanted to see more enhanced services.

In essence all were looking to expand the role of pharmacies. Dr Llewellyn proposed that if the Board were happy with the report then she would write to each neighbouring authority on behalf of the Health and Wellbeing Board, responding to their PNA, stating that it was in support of their recommendations.

Councillor Marcus Franks proposed that Dr Llewellyn be given the delegated role of responding to each area's PNA. This proposal was seconded by Rachael Wardell.

RESOLVED that Dr Llewellyn would write a letter to each neighbouring authority on behalf of the Health and Wellbeing Board, responding to their PNA.

66. NHS Five Year Forward View (Cathy Winfield)

Cathy Winfield drew the Board's attention to the NHS Five Year Forward View on page 213 of the agenda. She explained that the paper was very welcomed and was an easy read.

The paper took a view of the radical reframing of Public Health and how this should be approached. Both the importance and impact of this needed to be recognised.

There was a new model of care delivery and Cathy Winfield expressed that she was slightly disappointed that this was largely health focused.

There had been a lot of local thinking, as well as by Chief Officers on what process model would be suitable. In parallel with thinking about suitable models, work was taking place with practices to develop a Strategy for Primary Care. Once this had this had been established, thought would be needed around what was being asked of Primary Care and how the chosen model could fit with the local system. There would be a strong element of community engagement in decisions. Innovation technology was also a large

factor to be considered as all would have to get used to receiving health and social care support in a different way.

Regarding the next steps, Cathy Winfield reported that the delivery element would follow behind the Five Year Forward View. It was anticipated that this might be released around spring time 2015. It was possible that that more detailed would be provided in the National Guidance due to come out in December 2014.

67. Members' Questions

There were no questions from Members.

68. Local Safeguarding Children's Board Annual Report

The Board noted the report.

69. Mental Health Crisis Concordat

The Board noted the Mental Health Crises Concordat, which would be reported on in more detail at the meeting in January.

70. Future meeting dates

It was confirmed that the next Health and Wellbeing Board meeting would take place on 22nd January 2015.

(The meeting commenced at 9.00 am and closed at 11.30 am)

CHAIRMAN …….

Date of Signature …….

DRAFT

Note: These Minutes will remain DRAFT until approved at the next meeting of the Committee

HEALTH AND WELLBEING BOARD

MINUTES OF THE MEETING HELD ON THURSDAY, 8 JANUARY 2015

Present: Dr Bal Bahia (Newbury and District CCG), Adrian Barker (Healthwatch), Dr Barbara Barrie (North and West Reading CCG), Councillor Marcus Franks (Portfolio Holder for Health and Well Being), Dr Lise Llewellyn (Public Health), Councillor Gwen Mason (Shadow Health and Wellbeing Portfolio Holder), Councillor Irene Neill (Portfolio Holder for Children and Young People), Rachael Wardell (WBC - Community Services), Cathy Winfield (Berkshire West CCGs) and Councillor Keith Chopping (Portfolio Holder for Community Care)

Also Present: Jessica Bailiss (WBC - Executive Support), Nick Carter (WBC - Chief Executive), Councillor Quentin Webb, Tandra Forster (WBC - Adult Social Care) and Councillor Roger Hunneman (Deputy Liberal Democrat Group Leader), Steve Bedser (Local Government Association) and Jessica Bailiss (WBC - Executive Support),

Apologies for inability to attend the meeting: Leila Ferguson, Councillor Gordon Lundie and Nikki Luffingham

PART I

71. Declarations of Interest

Dr Bal Bahia and Dr Barbara Barrie declared an interest in all matters pertaining to Primary Care, by virtue of the fact that he was a General Practitioner, but reported that, as his interest was not personal, prejudicial or a disclosable pecuniary interest, he determined to remain to take part in the debate and vote on the matters where appropriate.

72. Better Care Fund

Rachael Wardell introduced the item to Members of the Health and Wellbeing Board. The Better Care Fund (BCF) was money designated to supporting priorities within the health and social care system. It involved collaborative working across the West of Berkshire and consisted of seven schemes which had been grouped into five projects. It was a year since the BCF had first been presented to the Health and Wellbeing Board.

Submission of the BCF plans was currently pending, in anticipation of a decision from the Department of Health (DH) regarding funding for the implementation of the Care Act. Local Members of Parliament were lobbying the DH on behalf of West Berkshire Council on this matter. Recently the DH had asked for further information from West Berkshire Council. Whilst the decision from the DH was awaited, West Berkshire Council were not in a position to sign off the BCF plans.

Councillor Marcus Franks added that continuing pressure was being placed on the Secretary of State and that until a decision was confirmed, it was suggested that the submission of the BCF plans should be deferred.

Cathy Winfield reported that although the Clinical Commissioning Group (CCG) supported the Local Authority in its negotiations over funding for the Care Act, she was disappointed that West Berkshire Council were not in a position to meet the national

deadline set by central Government. There would be implications for not signing the BCF within the given timescale and therefore Cathy Winfield stressed the need to set a time limit for deferral and suggested that ten days from the Special Meeting would be reasonable. The CCG were sympathetic to the negotiations the Council was having to undertake however, it saw the Care Act as more decoupled from the BCF. The CCG were of the view that discussions concerning the Care Act were between the Local Authority and Central Government. The CCG was happy to support the Local Authority however, was keen for deadlines for deferment to be agreed.

Councillor Graham Pask stated that the fact that West Berkshire had been unable to sign off its BCF plans was due to no fault of its own. It was hoped that accumulative action would be the result of not meeting the deadline set by Central Government. Various pressures had been placed on the relevant people and a rapid response was required. Councillor Pask supported deferring the submission of the BCF plans however, felt that they could not agree to a timescale that there was no control over.

Cathy Winfield stressed by not submitting the plans, West Berkshire would supersede control of almost £9 million. The BCF process would need concluding.

Councillor Marcus Franks asked that Standing Orders be suspended in order to allow Steve Bedser (an associate of the Local Government Association) to speak to the Board, Steve Bedser explained that he formed part of a team, employed by the BCF taskforce at DH, which worked with areas who had submitted their BCF plans with conditions. He had worked with four areas in total over a three month period and played a key role in the communication process with the DH. He championed the voice of both the Local Authority and the BCF taskforce.

Steve Bedser was confident that a decision from the DH was imminent. He felt that the timescale suggested by Cathy Winfield had significant merit and showed clear intent to sign the BCF plans. Steve Bedser stated that he would feel comfortable communicating this position back to the BCF taskforce. The official deadline for signing and submitting BCF plans was 2pm on 9th January however, he felt that the explanation for delay in the case of West Berkshire was justifiable.

Steve Bedser continued by emphasising the importance of the joint working that would take place as part of the BCF plans. Once a decision had been given by the DH it was anticipated that West Berkshire would be in a position to submit their plans. Steve Bedser stated that he would be expected to report back to the BCF taskforce after the meeting. He was confident that they would support the notion he anticipated from the discussions he had heard and would relax the deadline in this circumstance. Steve Bedser sought clarification regarding how the plans would be signed off once a decision had been made by the DH. He asked if another Special Health and Wellbeing Board would be set up or if there would be delegated powers.

Dr Lise Llewellyn was conscious that the BCF plans included projects that were crucial to the delivery of high quality support for patients. Therefore she asked if holding back from submitting the BCF plans was detrimental to these patients. Cathy Winfield assured all that the work included under the BCF plans was continuing despite the delay.

Cathy Winfield highlighted that there were three potential scenarios at the end of the ten day period (a) the Local Authority would receive a favourable decision over funding for the Care Act, (b) no further funding would be offered or (c) the DH would make an offer that was not acceptable to the Local Authority. Cathy Winfield felt it would be helpful to know the outcome concerning the BCF plans, for each of these scenarios.

Councillor Keith Chopping felt that it was not appropriate to discuss the action that would be taken given the current negotiations. Cathy Winfield was concerned regarding the impact upon services.

Rachael Wardell referred to Cathy Winfield's point regarding the impact on the system. She reported that the £3 million gap would have to be covered off in another way and this would require further discussion. West Berkshire's submission had stood well against the initial assessment undertaken by the DH. Savings would have to be made in the next financial year within the Communities Directorate. This would involve a reduction in services and every effort would be made to reduce the impact on service users. Any changes in the services provided would be subject to a compulsory consultation process.

Cathy Winfield further queried what the result would be for the BCF if the DH did not make an acceptable offer. Councillor Franks reported that if an acceptable offer was made within the timescale by DH, then the BCF plans would be submitted. Once an offer was received this would have to be discussed by Members of West Berkshire Council. It was possible that the matter would be taken to Judicial Review.

Cathy Winfield anticipated that NHS England would intervene if the BCF plans were not signed and submitted within the discussed timeframe. She was confident that NHS England would agree the ten day deferral however, would be keen to put an end to the situation.

Steve Bedser explained that an escalation plan was in place for West Berkshire, however, this would have a light touch approach given the circumstances. If the situation was not sorted in time for the next Health and Wellbeing Board on 22nd January, then the delay would become viewed as unreasonable and the escalation process would become less light touch. .

Councillor Franks reminded all that this was the third deadline West Berkshire Council had set for the DH to respond by.

Councillor Irene Neill stated that during a period when lobbying was taking place, it was appropriate for the Local Authority to reserve its position and the action that would be taken if its expectation were not met.

Rachael Wardell highlighted that if information from the DH was negative, then a decision would be required collectively on how the system challenge would be met. The key question in ten days time would be whether it was more helpful to address system pressures with NHS escalation measures in place, or alternatively to remain in control at a local level.

Dr Bal Bahia was concerned that if the BCF plans were not signed they could potentially be faced with a larger gap. Dr Llewellyn was concerned that if control was lost to NHS England that this could affect the discretionary £1.5 million from the CCG, which could potentially be directed into the NHS rather than Social Care. Cathy Winfield confirmed that this was a risk and hoped that Nikki Luffington from NHS England, would be able to give a clearer view of consequences from the escalation process.

Councillor Franks summarised the position of the Health and Wellbeing Board regarding the sign off of the Better Care Fund (BCF) plans as a result of the discussion that had taken place. It was resolved that a decision on the submission of the BCF plans would be deferred until the next Health and Wellbeing Board meeting at 9am on 22nd January 2015.

The awaited decision from the Department of Health regarding the shortfall of funding faced by West Berkshire Council due to the enforced eligibility criteria change in the Care

Act, would be required in time for this meeting. Adequate time would need to be provided to allow consideration to be given to any information from DH, in advance of the meeting.

If a decision on the shortfall of funding, that was acceptable to West Berkshire Council, was received prior to the next Health and Wellbeing Board meeting the BCF would be signed and submitted in consultation with Board Members as soon as possible.

73. Health and Wellbeing Board Representation at Commissioning Committee Meetings

Councillor Marcus Franks invited Cathy Winfield to elaborate on the item, which involved the Clinical Commissioning Group (CCG) inviting a Member of the Health and Wellbeing Board to sit on its Commissioning Meetings.

Cathy Winfield reported that the item related to new responsibilities designated to CCGs for the commissioning of primary care services. Primary Care was currently commissioned by NHS England.

CCGs could either apply to receive responsibly for the whole of the primary care budget or alternatively for shared responsibility with NHS England. Cathy Winfield reported that shared responsibility had been sought for the West of Berkshire. The Commissioning Group for supporting this was currently in shadow form and the guidance was vague as to whether the Health and Wellbeing representative should be at Member or Officer level.

Councillor Franks felt that it would be useful for a Member of West Berkshire Council to take up this position. This would form part of the Council's formal Outside Bodies process, which was dealt with after each district election. With this in mind Councillor Franks suggested that a temporary nomination be made until the official process took place in May/June time.

Councillor Franks asked Board Members for any nominations regarding a representative to attend the CCG Commissioning meetings. Councillor Irene Neill proposed Councillor Marcus Franks. This was seconded by Councillor Gwen Mason. Members of the Board voted in favour of this proposal.

Resolved that Councillor Marcus Franks was appointed as representative to attend CCG Commissioning Meetings until May 2015.

(The meeting commenced at 2.00 pm and closed at 3.00 pm)

CHAIRMAN …….

Date of Signature …….

Health and Wellbeing Board Forward Plan 2015/16

Ref.	Item	Purpose	Action required by the H&WB	Deadline date for reports	Lead Officer/s	Those consulted	Is the item Part I or Part II?	Comments
22nd January 2015								
	Items for Discussion							
	System Resilience							
H&WB6.1	Health and Social Care Dashboard	To present the Dashboard and highlight any emerging issues	For information and discussion	11th December	Tandra Forster/Shairoz Claridge/Jessica Bailiss	Health and Wellbeing Management Group	Part I	
	Integration Programme							
H&WB6.2	Update report on the Better Care Fund	To update the Health and Wellbeing Board of progress on the Better Care Fund plans.	For Information and discussion	11th December	Tandra Forster	Health and Wellbeing Management Group	Part I	
H&WB6.3	Better Care Fund Project Management Report	To update the Board on progression with the Better Care Fund projects.	For Information	11th December	Tandra Forster/Shairoz Claridge	Health and Wellbeing Management Group	Part I	
H&WB6.4	Alignment of Commissioning Plans	To give an brief update and presentation detailing progress with this area of work.	For Information and discussion	11th December	Tandra Forster/Shairoz Claridge	Health and Wellbeing Management Group	Part I	
	Health and Wellbeing Strategy / Joint Strategic Needs Assessment							
H&WB6.5	Finalisation and agreement of the new Health and Wellbeing Strategy	The Board to finalise and agree the Strategy post the consultation period.	For Agreement	11th December	Lesley Wyman	Health and Wellbeing Board, key stakeholders and the public	Part I	
	Governance and Performance							
H&WB6.6	Health and Wellbeing Performance Report	To give a report to the Board on performance against the current Health and Wellbeing Strategy.	For Information and discussion	11th December	Lesley Wyman	Health and Wellbeing Management Group	Part I	
	Other Issues for discussion							
H&WB6.7	Dementia Alliance	To inform the Board about this national programme of work, which has time limited funding	For information and discussion	11th December	Alison Love	Health and Wellbeing Management Group	Part I	
H&WB6.8	LSCB Business Plan	To present the LSCB Business Plan to the Board and seek support in numerous actions outlined in the covering report.	For Information and discussion	11th December	Fran Gosling-Thomas	LSCB	Part I	
H&WB6.9	Post Implementation Reflection on Special Education Needs Reforming	To report on the new way of working with Children with Educational Needs	Progress report for information	11th December	Jane Seymour	Health and Wellbeing Board Communities Directorate Leadership Team	Part I	
H&WB6.10	Mental Health Crisis Concordat	To introduce the Mental Health Crises Concordate and to give consideration to implications for the Health and Wellbeing Board.	For information and discussiong	11th December	Dr Bal Bahia /Angus Tallini	Health and Wellbeing Management Group	Part I	
26th March 2015								
	Items for Discussion							
	System Resilience							
	Health and Social Care Dashboard	To present the Dashboard and highlight any emerging issues	For information and discussion	26th February	Tandra Forster/Shairoz Claridge/Jessica Bailiss	Health and Wellbeing Management Group	Part I	
	Winter Resilience Programme	To give feedback on the Winter Resilience Programme.	For Information and discussion	26th February	Tandra Forster/Shairoz Claridge	Health and Wellbeing Management Group		
	Integration Programme							
	An update report on the Better Care Fund and wider integration programme	To keep the Board up to date on progression with the BCF and wider integration programme.	For information and discussion	26th February	Tandra Forster	Health and Wellbeing Management Group	Part I	
	Health and Wellbeing Strategy / Joint Strategic Needs Assessment							
	The Health and Wellbeing Annual Conference	To discuss ideas for the conference, which will help shape the refresh of the Health and Wellbeing Strategy.	For information and discussion	26th February	Lesley Wyman	Health and Wellbeing Board, key stakeholders and the public	Part I	
	Commissioning Plans							
	Alignment of Commissioning Plans	To timetable/forward plan the alignment of commissioning plans	For Information and discussion	26th February	Tandra Forster/Shairoz Claridge	Health and Wellbeing Management Group	Part I	
	Public Engagement							
	Draft Strategy for community engagement	To present the draft strategy to the Board for comment.	For discussion	26th February	Adrian Barker	Health and Wellbeing Management Group	Part I	
	Development Plan							
	Development Plan for the Health and Wellbeing Board	To keep an overview of the Boards progression	For Information and discussion	26th February	Nick Carter/Marcus Franks	Health and Wellbeing Management Group	Part I	
	Other Issues for discussion							
	Joint Self Assessment for Learning Disabilities	To present the feedback on this piece of work to the Board.	For Information and discussion	26th February	Tandra Forster/Alison Love	Health and Wellbeing Management Group	Part I	This includes evidence plans across the three localities for Learning Disabilities. The submission date for this work is 31st January 2015.
23rd April 2015 - half day session								
	Health and Wellbeing Hot Topic: Mental Health and Wellbeing in Adults	**To introduce the hot topic to the Board followed by a briefing on activity planned for the next three months.**			**Lesley Wyman/Rachel Johnson**			

Health and Wellbeing Board Forward Plan 2015/16

Ref.	Item	Purpose	Action required by the H&WB	Deadline date for reports	Lead Officer/s	Those consulted	Is the item Part I or Part II?	Comments
4th June 2015								
	Items for Discussion							
	System Resilience							
	Health and Social Care Dashboard	To present the Dashboard and highlight any emerging issues	For information and discussion	7th May	Tandra Forster/Shairoz Claridge/Jessica Bailiss	Health and Wellbeing Management Group	Part I	
	Integration Programme							
	An update report on the Better Care Fund and wider integration programme	To keep the Board up to date on progression with the BCF and wider integration programme.	For information and discussion	7th May	Tandra Forster/Shairoz Claridge	Health and Wellbeing Management Group	Part I	
	Health and Wellbeing Strategy / Joint Strategic Needs Assessment							
	Joint Strategic Needs Assessment	To present the JSNA to Health and Wellbeing Board	For information	7th May	Lesley Wyman	Health and Wellbeing Management Group	Part I	
	Governance and Performance							
	Community Sub-Partnership Terms of Reference	To present the Terms of Reference for this group to the Health and Wellbeing Board.	For discussion and comment	7th May	Andy Day/Nick Carter	Health and Wellbeing Management Group	Part I	
	Other Issues for discussion							
	Child Sexual Exploitation	To advise on the extent of the issues in West Berkshire.	For information	7th May	Mark Evans	Health and Wellbeing Management Group	Part I	
	Other information not for discussion							
11th June 2015 - half day session								
	Health and Wellbeing Strategy Hot Focus: Looked After Children and those at risk	**To introduce the hot topic to the Board followed by a briefing on activity planned for the next three months.**			**Lesley Wyman/TBC**			
30th July 2015								
	Items for Discussion							
	System Resilience							
	Health and Social Care Dashboard	To present the Dashboard and highlight any emerging issues	For information and discussion	2nd July	Tandra Forster/Shairoz Claridge/Jessica Bailiss	Health and Wellbeing Management Group	Part I	
	Integration Programme							
	An update report on the Better Care Fund and wider integration programme	To keep the Board up to date on progression with the BCF and wider integration programme.	For information and discussion	2nd July	Tandra Forster/Shairoz Claridge	Health and Wellbeing Management Group	Part I	
24th September 2015								
	Items for Discussion							
	System Resilience							
	Health and Social Care Dashboard	To present the Dashboard and highlight any emerging issues	For information and discussion	27th August	Tandra Forster/Shairoz Claridge/Jessica Bailiss	Health and Wellbeing Management Group	Part I	
	Integration Programme							
	An update report on the Better Care Fund and wider integration programme	To keep the Board up to date on progression with the BCF and wider integration programme.	For information and discussion	27th August	Tandra Forster/Shairoz Claridge	Health and Wellbeing Management Group	Part I	
	Health and Wellbeing Strategy / Joint Strategic Needs Assessment							
	Feedback on the Health and Wellbeing Strategy Hot Focus: Looked After Children	To feedback on activity that has taken place over the last three months.	For information and discussion	27th August	Lesley Wyman/Mark Evans	Health and Wellbeing Management Group	Part I	
	Governance and Performance							
	Health and Wellbeing Strategy Performance Reporting	To present a performance report against the performance framework for the Health and Wellbeing Strategy.	For Information and discussion	27th August	Lesley Wyman	Health and Wellbeing Management Group	Part I	
	Development Plan							
	Development Plan for the Health and Wellbeing Board	To keep an overview of the Boards progression	For Information and discussion	27th August	Nick Carter/Marcus Franks	Health and Wellbeing Management Group	Part I	
	Other Issues for discussion							
	Other information not for discussion							
22nd October 2015 - half day session								
	Health and Wellbeing Hot Topic: Falls Prevention	**To introduce the hot topic to the Board followed by a briefing on activity planned for the next three months.**			**Lesley Wyman/April Peberdy**			
26th November 2015								
	Items for Discussion							
	System Resilience							
	Health and Social Care Dashboard	To present the Dashboard and highlight any emerging issues	For information and discussion	29th October	Tandra Forster/Shairoz Claridge/Jessica Bailiss	Health and Wellbeing Management Group	Part I	
	Integration Programme							

Health and Wellbeing Board Forward Plan 2015/16

Ref.	Item	Purpose	Action required by the H&WB	Deadline date for reports	Lead Officer/s	Those consulted	Is the item Part I or Part II?	Comments
	An update report on the Better Care Fund and wider integration programme	To keep the Board up to date on progression with the BCF and wider integration programme.	For information and discussion	29th October	Tandra Forster/Shairoz Claridge	Health and Wellbeing Management Group	Part I	
	Health and Wellbeing Strategy / Joint Strategic Needs Assessment							
	Feedback on the Health and Wellbeing Strategy Hot Focus: Mental Health and Wellbeing in Adults.	To feedback on activity that has taken place over the last three months.	For information and discussion	29th October	Lesley Wyman/TBC	Health and Wellbeing Management Group	Part I	

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RefNo	Meeting	Action	Action Lead	Agency	Agenda item	Comment
31	27-Nov-14	Shairoz Claridge to provide baseline data for the Dashboard where there was no target or benchmark data available	Shairoz Claridge	CCG	Health and Social Care Dashboard	This will be provided for the Board meeting in March.
32		Metrics to reflect the expansion of primary care to be explored as a possibility for the Health and Social Care Dashboard.	Jessica Bailiss/Bal Bahia/Shairoz Claridge/Tandra Forster	WBC/CCG	Health and Social Care Dashboard	This will be provided for the Board meeting in March.
33		Regarding the format of the dashboard, Adrian Barker suggested that it could show trends over a period of time e.g. for the previous year.	Jessica Bailiss/Tandra Forster/Shairoz Claridge	WBC/CCG	Health and Social Care Dashboard	This trend information will be included under the new Performance Framework.
34		Metric to reflect Monitor's investigation at the Royal Berkshire Hospital to be included on the dashboard.	Jessica Bailiss/Shairoz Claridge	WBC/CCG	Health and Social Care Dashboard	This will be provided for the Board meeting in March.
35		Link to Ward Profiles to be emailed to all Elected Members.	Lesley Wyman/Jessica Bailiss	WBC	JSNA Ward Profiles	Link emailed to all Members
36		Three half day sessions/Board meetings to be set up to discuss each of the three identified hot focuses.	Lesley Wyman/Jessica Bailiss	WBC	Themes for Health and Wellbeing Board Meetings	three dates confirmed.
37		All Board Members to nominate a deputy and send their name/details to Jessica Bailiss.	All Board Members	All agencies on the Board	Health and Wellbeing Board Governance	Underway
38		All Board Members to fill out the Declarations of Interest Form in line with the Council's Code of Conduct.	All Board Members	All agencies on the Board	Health and Wellbeing Board Governance	Underway
39		It was proposed and agreed that Dr Lise Llewellyn would write a letter to each neighbouring authority on behalf of the Health and Wellbeing Board, responding to their PNA.	Lise Llewellyn	Public Health	Pharmaceutical Needs Assessment Briefing	Response letter sent.
40		The Health and Wellbeing Board agreed that they were in support of the revised deadline of 5th December for the BCF. Wokingham and West Berkshire Council would write a letter to the Department of Health asking them to provide an offer by this deadline.	Councillor Marcus Franks/Tandra Forster	WBC	Update Report of the Better Care Fund	The letter has been sent to the DH.
41		Councillor Marcus Franks was keen that the former BCF project highlight report template be retained for the West Berkshire based BCF projects.	Tandra Forster/Shairoz Claridge	WBC/CCG	Better Care Fund Project Management Report	The previous template will be used at the next Board meeting for the West Berkshire based projects.

Actions carried over from previous meeting

RefNo	Meeting	Action	Action Lead	Agency	Agenda item	Comment
20	25-Sep-14	NHS England/the CCG to carry out a baseline assessment to show the impact on Primary Care Services over the winter.	Shairoz Claridge/Nikki Luffington	CCG	Health and Social Care Dashboard	The work to map this data and assessment on the impact on A&E is underway. It is anticipated that the information will be ready early January. An update will be provided under the dashboard item at the HWBB on 22nd January 2015.

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System Resilience - Health and Social Care Dashboard

Adult Social Care							
Ref.	**Indicator**	**Basis**	**Frequency**	**2014/15 Benchmark**	**2014/15 Target**	**Positive or negative trend (see key)**	**Latest data**
ASC1	Proportion of older people (65+) who were still at home 91 days after discharge from hospital to reablement/rehabilitation service	West Berkshire Council Adult Social Care	Quarterly		90%	↓	**87.7% Q2**
ASC2	Number of assessments completed in last 12 months leading to a provision of a Long term service (excludes Carers)	West Berkshire Council Adult Social Care	Quarterly		Target data not yet available		
ASC3	Proportion of clients with Long Term Service receiving a review in the past 12 months	West Berkshire Council Adult Social Care	Quarterly		Target data not yet available	↑	**63.0% Q2**

Arrow key	
↑	Latest data is positive compared to the last quarter
↓	Latest data is negative compared to the last quarter
←→	Latest data is the same as the last quarter

Children's Social Care							
Ref.	**Indicator**	**Basis**	**Frequency**	**Normal Range**	**2014/15 Target**	**Positive or negative trend (see key)**	**Latest data**
CSC1	The number of looked after children per 10,000 population	West Berkshire Children's Services	Quarterly	Between 38 and 46 per 10,000		↑	**48 Q2**
CSC2	The number of child protection plans per 10,000 population	West Berkshire Children's Services	Quarterly	Between 28 and 34 per 10,000		↑	**33 Q2**
CSC3	The number of Section 47 enquiries per 10,000 population	West Berkshire Children's Services	Quarterly	Between 20 and 25 per 10,000.		↑	**24 Q2**
CSC4	To maintain a high percentage of (single) assessments being completed within 45 working days	West Berkshire Children's Services	Quarterly		70%	↓	**73% Q2**
CSC5	Looked after children cases which were reviewed within required timescales	West Berkshire Children's Services	Quarterly		99%	↑	**99% Q2**
CSC6	Child Protection cases which were reviewed within required timescales	West Berkshire Children's Services	Quarterly		99%	↓	**95% Q2**

Acute Sector							
Ref.	**Indicator**	**Basis**	**Frequency**	**Baseline data**	**2014/15 Target**	**Positive or negative trend (see key)**	**Latest data**
AS1	**4-hour A&E target - total time spent in the A&E Department** (% is less than 4 hours) [standard is 95% of patients seen within 4 hours]	Royal Berks NHS Foundation Trust	Monthly		95%	↑	**97.2% October**
		Hampshire Hospitals NHS Foundation Trust				↑	**94.8% October**
		Great Western Hospitals NHS Foundation Trust				↓	**92.4% October**
AS2	Average number of Delayed Transfers of Care (all delays) per 100,000 population (18+)	Berkshire Healthcare NHS Foundation Trust	Monthly			↑	**0.8 October**
		Great Western Hospitals NHS Foundation Trust				↓	**0.8 October**
		Hampshire Hospitals NHS Foundation Trust				↑	**0.8 October**
		Oxford University Hospitals NHS Trust				↓	**1.6 October**
		Royal Berks NHS Foundation Trust				↓	**4.9 October**
		Total West Berkshire		14.7 (2012/2013 data)		↓	**8.9 October**
AS3	Average number of Delayed Transfers of Care which area attributable to social care per 100,000 population (18+)	Berkshire Healthcare NHS Foundation Trust	Monthly			↑	**1.0 October**
		Great Western Hospitals NHS Foundation Trust				←→	**0.0 October**
		Hampshire Hospitals NHS Foundation Trust				↑	**2.0 October**
		Oxford University Hospitals NHS Trust				←→	**0.1 October**
		Royal Berks NHS Foundation Trust				↑	**1.1 October**
		Total West Berkshire			4	↑	**4.7 October**
AS4	**Community Services** Average number of Delayed Transfers of Care (all delays by patients	Berkshire Healthcare Trust as a provider	Monthly		No Target	↓	**10.3 October**
AS5	**Ambulance Clinical Quality - Category A 8 Minute Response Time - Red 2** [Category A Red 2 incidents: presenting conditions that maybe life threatening but less time critical than Red1 and receive an emergency responses irrespective of location in 75% of cases]	Berkshire West	Monthly		75%	↓	**73.2% October**

Acute Sector (continued)							
Ref.	**Indicator**	**Basis**	**Frequency**	**Baseline data**	**2014/15 Target**	**Positive or negative trend (see**	**Latest data**
AS6	A&E Attendances	Royal Berkshire Foundation Trust for Berkshire West		1256 average monthly figure from 13/14		↓	**1,289 October**
		Hampshire Hospital Foundation Trust for Berkshire West		300 average monthly figure from 13/14		↓	**373 October**
		Great Western Hospital for Berkshire West		168 average monthly figure from 13/14		↑	**186 October**
AS7	Number of non elective admissions	Royal Berkshire Foundation Trust for Berkshire West	Monthly	547 average monthly figure from 13/14		↓	**550 October**
		Hampshire Hospital Foundation Trust for Berkshire West		157 average monthly figure from 13/14		↓	**170 October**
		Great Western Hospital for Berkshire West		84 average monthly figure from 13/14		↑	**86 October**
AS8	Total number of 111 calls (Answered in 60 seconds)	Berkshire wide	Monthly			↓	**15,755 October**

Primary Care							
Ref.	**Indicator**	**Basis**	**Frequency**	**2014/15 Benchmark**	**2014/15 Target**	**Positive or negative trend (see key)**	**Latest data**
PC1(a)	GP referrals to secondary Care	Newbury & District CCG	Quarterly		N/A	N/A	**1,132 October**
PC1(b)	GP referrals to secondary Care	North & West Reading CCG	Quarterly		N/A	N/A	**1,232 October**
PC2	Friends and Family Test	TBC	TBC		TBC	TBC	TBC
PC3	Access metric to be defined	TBC	TBC		TBC	TBC	TBC

Community Services							
Ref.	**Indicator**	**Basis**	**Frequency**	**2014/15 Benchmark**	**2014/15 Target**	**Positive or negative trend (see key)**	**Latest data**
CS1	Mental Health - Crisis response % of responses witih 4 hours	Berkshire West	quarterly from Q2		85% Q2, 90% Q3 and 95% Q4	N/A	Data not available
CS2	Rapid access to Community Services: 2 hour crisis reponse by Community Nursing and Rapid Response	Berkshire West	quarterly from Q2		90%	↑	**92.21% Q2**

Appendices

Appendix 1 - Indicator/Target Narrative

Appendix 1

Adult Social Care		
Ref.	**Target/Data Narrative**	**Further explanation on indicator**
ASC1	**(Adult Social Care Framework 2B Part 1)** Small cohort that may fluctuate quarter to quarter due to unexpected deaths, health alerts or severe weather i.e. extremely cold winter - events which are outside of our control. In Q2, 8 clients started placements in res/nursing care rather than remaining at home. Data based on 3 monthly reporting of hospital discharges to rehabilitation/enablement and outcome at 91 days after discharge.	The proportion of older people aged 65 and over discharged from hospital to their own home or to a residential or nursing care home or extra care housing for rehabilitation, with a clear intention that they will move on/back to their own home (including a place in extra care housing or an adult placement scheme setting), who are at home or in extra care housing or an adult placement scheme setting 91 days after the date of their discharge from hospital. This measures the effectiveness of reablement services.
ASC2	**(Service Plan Performance Indicator)** The data will be available for the board in January 2015. The use of data from the previous year is not appropriate for setting a baseline due to the new statutory reporting framework (SALT). The reports to extract relevant data aligned to statutory reporting are still to be completed. Therefore there is no national data or comparator group data or England average to measure against at this point.	
ASC3	Figures are expected to increase for this indicator in Q3 due to data recording issues that are being addressed. In previous years, the denominator included clients with electrical equipment services, respite and short term services but excluded professional support. The denominator is now based on Long Term Service clients in the year so now includes Community Mental Health Team, professional support but excludes all short term services and low level support. The use of data from the previous year is not appropriate for setting a baseline due to the new statutory reporting framework (SALT). The reports to extract relevant data aligned to statutory reporting are still to be completed. Therefore there is no national data or comparator group data or England average to measure against at this point.	

Children's Social Care		
Ref.	**Target/Data Narrative**	**Further explanation on indicator**
CSC1	Target numbers for CSC 1, 2 and 3 have been set by Children's Services and are set on the basis of the level that the service aspire to get the figures back to. Target numbers are what are considered as more manageable for the service. Trend data is based on the last quarter.	Looked after child: These are children who are looked after by the authority
CSC2		Child Protection Plan: A detailed inter-agency plan setting out what must be done to protect a child from further harm, to promote the child's health and development and if it is in the best interests of the child, to support the family to promote the child's welfare.
CSC3		Section 47 Enquiry: Where there is reasonable cause to suspect that a child is suffering, or likely to suffer, significant harm, the local authority is required under s47 of the Children Act 1989 to make enquiries, to enable it to decide whether it should take any action to safeguard and promote the welfare of the child.
CSC4	Target Numbers come from those set in Children's Services' Service Plan. Trend data is based on the last quarter.	Single Assessments: The single assessment is a new assessment document. It is gradually replacing the initial and core assessments by combining both within one document.
CSC5		
CSC6		There are ongoing recording issues in relation to Child Protection Conferences on RAISE and therefore the true performance is likely to be higher that that presented.

(Appendix 1 continued)

Acute Sector		
Ref.	**Target/Data Narrative**	**Further explanation on indicator**
AS1	Data is based on provider as a whole	
AS2	**(Adult Social Care Framework 2C Part 1 See ASC1)** Data is based on Provider figures for West Berkshire residents only.	See ASC1
AS3	**(Adult Social Care Framework 2C Part 2)** This data is sourced from NHS England and is a monthly snapshot of delays taken on the last Thursday of the month at midnight. The Total West Berkshire figure is reported on	This measures the impact of hospital services (acute, mental health and non-acute) and community-based care in facilitating timely and appropriate transfer from all hospitals for all adults. This indicates the ability of the whole system to ensure appropriate transfer from hospital for the entire adult population. It is an important marker of the effective joint working of local partners, and is a
AS4		
AS5	Data is based on Berkshire West as a whole.	Category A Red 1 incidents: Presenting conditions that may be immediately life threatening and the most time critical and should receive an emergency response irrespective of location in 75% of cases. Category A Red 2 incidents: Presenting conditions that may be life threatening but less time critical than Red1 and receive an emergency response irrespective of location in 75% of cases.
AS6	Date is based on Provider figures for Berkshire West	An elective admission is one that has been arranged in advance. It is a non emergency admission, a maternity admission or a transfer from a hospital bed in another healthcare provider
AS7	Data is based on Provider figures for Berkshire West.	An elective admission is one that has been arranged in advance. It is a non emergency admission, a maternity admission or a transfer from a hospital bed
AS8	Data is based on Berkshire as a whole	NHS 111 is a new service that was introduced to mae it easier for people to access local NHS Services in England. 111 can be called when medical help is required quickly however, it's not a 999 emergency.

Primary Care		
Ref.	**Target/Data Narrative**	**Further explanation on indicator**
PC1(a)	No target can be provided because an increase or decrease in appropriate referrals is neither good or bad.	Secondary (or 'acute') care is the healthcare that people receive in hospital. It may be unplanned emergency care or surgery, or planned specialist medical care or surgery
PC1(b)	No target can be provided because an increase or decrease in appropriate referral is neither good or bad.	
PC2		
PC3		

Community Services		
Ref.	**Target/Data Narrative**	**Further explanation on indicator**
CS1		
CS4		

Title of Report:	**Better Care Fund – Progress Report**
Report to be considered by:	Health and Wellbeing Board
Date of Meeting:	22 January 2015
Forward Plan Ref:	N/a

Purpose of Report: To inform the Health and Wellbeing Board on the current position regarding the Better Care Fund schemes.

Recommended Action: For information

Reason for decision to be taken: N/A

Other options considered: None

Key background documentation: None

Contact Officer Details	
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1. Programme status

1.1 West Berkshire's Better Care Fund schemes were approved subject to one condition, agreement on funding of the change in eligibility criteria. Discussions are ongoing with the DH. Project work has continued during this time but the overall programme remains at amber.

2. BCF Projects progress

(1) **Hospital At Home**
Following proof of concept, project has been re-defined with a shift in focus to early supported discharge. Business case has been developed but further work is required around finance and risk. An updated business case will be going to the three Integrated Steering Groups in February.

(2) Integrated Health and Social Care Hub
Lots of initial completed to map existing arrangements, practical requirements e.g. technology and the phasing. A new project manager has been appointed.

(3) **Enhanced Care and Nursing homes support**
Project is up and running, more detailed analysis to be completed to understand why there has been an increase in non-elective admissions.

(4) **Joint Provider Project** (incorporating 7 day working and direct commissioning by specified health staff)

PID and mapping of existing service arrangements has been completed. Focus has moved to agreeing requirements around workforce, IT and evaluation measures.

(5) **Personal Recovery Guide**
Draft PID completed, pre-tender work underway.

2.2 Appendix A has Highlight reports for both the Personal Recovery Guide and Joint Provider Project. Appendix B provides detail of the overall programme.

Appendices

Appendix A – Highlight Report
Appendix B – Programme Status Report

Consultees

Local Stakeholders: Toby Ellis/Paul Coe/Steve Duffin

Officers Consulted:

Trade Union: Not applicable

PROGRAMME	WEST BERKSHIRE BCF PROGRAMME	**PROGRAMME & PROJECT MANAGERS**	Tandra Forster & Steve Duffin Toby Ellis	**OVERALL RAG STATUS**	
REPORTING PERIOD	01 – 31 Dec 2014	**REPORT ISSUE DATE**	09.01.15	**STATUS**	Draft

JOINT CARE PROVIDER (inc 7 day services and direct commissioning)

PROJECTS/ SCHEMES STATUS		
West Berkshire Better Care Fund plan not yet approved by Department of Health. Revised submission due 9 Jan 2015 but will be missed whilst discussions continue with the Secretary of State regarding funding. There is only one condition applied to the plan (funding the costs of the change in the social care eligibility threshold) and this remains a risk to the overall BCF, reflected in the overall Amber status. Whilst the Better Care Fund schemes have yet to be approved, all planned work has continued and therefore the delivery of this project is on track. Whilst the CTA funding was significantly less than bid for every effort is being made to manage the project from the resources available. At this stage it is not possible to predict if this will be sustainable hence the Amber status.		**Project Status**
		**Finance Status**
		**Activity Status**
		**Milestone Status**

KEY ACHIEVEMENTS	
Joint Care Provider (inc 7 day services and direct commissioning)	• Detailed Process Mapping completed • Meeting with Programme Director to confirm template commonality • Full Team Meeting to review progress of 'To Be' model and receive improvements • Conversion of key documents (PID, Risk Register, Plan) to agreed BCF format (PID with PL for review prior to despatch to co-sponsors) • Initial meeting regarding likely performance measurements completed • Initial meeting regarding likely IT systems requirements completed • Initial meeting regarding Workforce Design • December Progress Report written • Expansion to 7 Work Packages: Pathway Packages: – 1 – Care Supplier (model) design, 2 – Workforce Design, 3 – 7 day Services, 4 – Transfer to Long Term Care. Enabler Packages – A – IT systems, B – Trusted Assessor, C – Performance Data/Measurement November 2014 achievements • Draft PID completed • Draft Risk Register completed • Draft Project Plan to be completed • 6 x 'To Be' Model meetings/workshops completed • November Project Progress Report written • November Project Progress Report reviewed by full Project Team • Outline Work Packages (currently 6 'activity' and 2 'enabler' – subject to change) in preparation - detailed within the November Progress Report • (from last month) Joint Provider 'To Be' Model to be agreed – not yet agreed as still in development • (from last month) Affordable 7 Day Service model to be agreed – not yet agreed as still in development • (from last month) Procedure allowing direct commissioning of social care by Community Nurses

	to be agreed and documented – not yet agreed as still in development

NEXT STEPS / PLANNED ACTIVITIES

Joint Care Provider (inc 7 day services and direct commissioning)	• Converted PID circulated to be approved • Work Package details to be drafted • Work Package meetings to be arranged • Work Package staff to be allocated • Communications plan to be created • Communications strategy to be created

NEW ISSUES RAISED THIS PERIOD

c/f from previous report - West Berkshire Better Care Fund plan not yet approved by Department of Health. There is only one condition applied to the plan (funding the costs of the change in the social care eligibility threshold) but a further 27 areas where particular actions are required. An action plan to address the 27 areas has been approved by the DH and the work has been progressed by a joint LA and CCG team. The aim is to be in a position to submit the amended plan by the final deadline of 9th January 2015, subject of course to agreement around the single condition.

NEW RISKS IDENTIFIED THIS PERIOD

BW 10 Joint Care Provider/Personal Recovery Guide Project Risks Log

Risk Ref	Category	Source & Date Raised	Risk Description	Inherent risk score			Required controls and actions to reduce/mitigate risk	Review Dates	SRO and Monitor/ Review body	Residual Risk Score and Rating		
				L	I	RR				L	I	RRR
Joint Care Provider only												
JCP 10	Performance	10/12/2014	'Small Increases of Care' - concern that new service model proposal might attract workload that would otherwise be part of BAU (business as usual) and/or used as a destination where need does not fit current BAU model. This would be outside of the new ser	3	3	9	Processes & Procedures to ensure 'To Be' service model is ring fenced and does not attract BAU workload. Clear demarcation required to distinguish between new model offer and unchanged existing services	Monthly	Integrated Steering group	2	3	6
JCP 11	Performance	20/12/2015	EDT (Emergency Duty Team) contract with Bracknell expires 31 May 2015. A continuation of emergency cover is required in order for the proposed model to effectively function	5	2	10	WBC Commissioning Team exploring options including contract extension	Monthly	Integrated Steering group	3	2	6

PROJECT MILESTONES, DELIVERABLES					
Project Milestones (Include all milestones from last month onwards)	*Task Owner*	*Original Delivery Date*	*Planned delivery Date*	*Conf H/M/L*	*Explanation for slippage, impact on workstream and actions being taken. Has any re-planning been approved by appropriate Board?*
Joint Care Provider (inc 7 day services and direct commissioning)					
PID Sign Off	TE	Nov	Dec	H	Conversion to BCF format no impact
Milestone 3: Service Redesign	TE	Jan	Jan	H	In development, on target for Jan
Milestone 4: Work Package Preparation	TE	Jan	Jan	H	In development, on target for Jan
Milestone 5: Work Package Activity	TE	Jan	Jan	H	In development, on target for Jan
Milestone 6: Service Implementation	TE	Apr	Apr	H	
Milestone 7: Service Review	TE	May	May	H	
Milestone 8: 1st Phase (Frail Elderly) Project Closure	TE	Jun	Jun	H	

Project Budget/Cost Summary (£000s) as at 31/12/2014								
Cost Type	*Funding Source*	*Original baseline (in Business Case)*	*Current baseline*	*Actual spend to date*	*Forecast to 31st March 2015*	*Forecast To Complete (inc. spend to date)*	*Forecast To Complete - date*	*Explanation for slippage, impact on workstream and actions being taken. Has any re-planning been approved by appropriate Board?*
Project Delivery Costs - Joint Care Provider Project								
Project Manager	CTA		53,200	16,077	36,058	51,800	30/06/2015	Projects go-live planned for April 15 but closure will need to allow for a period of monitoring /adjusting
Subject Matter Experts (backfill)	CTA		55,720	35,469	49,000	57,400	30/06/2015	Projects go-live planned for April 15 but closure will need to allow for a period of monitoring /adjusting
Project Office Administration Support	CTA		4,200	2,596	4,200	4,200	31/03/2015	
ICT Equipment	CTA		1,050	693	560	560	31/03/2015	
Room Hire & Catering	CTA		2,730	1,392	2,730	2,730	31/03/2015	
Specialist Support HR	CTA		3,500	0	3,500	3,500	31/03/2015	
Specialist Support Legal	CTA		3,500	0	3,500	3,500	31/03/2015	
Specialist Support Finance	CTA		7,000	0	7,000	7,000	31/03/2015	
Training	CTA		3,500	0	3,500	3,500	31/03/2015	
Contigency	CTA		9,100	0	9,100	9,100	30/06/2015	
Sub Total		**0**	**143,500**	**56,227**	**119,148**	**143,290**		
Pump Priming for Go Live								
		0	0	0	0	0		
Sub Total		**0**	**0**	**0**	**0**	**0**		
Totals		**0**	**143,500**	**56,227**	**119,148**	**143,290**		

RESOURCE SUMMARY		
Number of Main (FTE) Resources Required	*Number Now In Post*	*Explanation for variance, impact on workstream and actions being taken.*
1 x Project Manager	1	Shared across both projects
0.5 x Project Administrator	0.5	Administrator supports both projects and ISG
1.4 x Subject Matter Experts	1.4	Shared across both projects

PERSONAL RECOVERY GUIDE / KEY WORKER PROJECT

PROJECTS/ SCHEMES STATUS		
West Berkshire Better Care Fund plan not yet approved by Department of Health. Revised submission due 9 Jan 2015. There is only one condition applied to the plan (funding the costs of the change in the social care eligibility threshold) and this remains a risk to the overall BCF, reflected in the overall Amber status. Whilst the Better Care Fund schemes have yet to be approved, all planned work has continued and therefore the delivery of this project is on track. Whilst the CTA funding was significantly less than bid for every effort is being made to manage the project from the resources available. At this stage it is not possible to predict if this will be sustainable.	   	**Project Status** **Finance Status** **Activity Status** **Milestone Status**

KEY ACHIEVEMENTS	
Personal Recovery Guide	• Royal Berkshire Hospital added as key partner • Conversion of key documents (PID, Risk Register, Plan) to agreed BCF format (PID with PL for review prior to despatch to co-sponsors) • Single Work Package identified – service specification • Workshop to scope service specification completed • Meeting with Programme Director to confirm template commonality • Full Team Meeting to confirm how to deploy specification • Agreement regarding organisation to undertake tender process and award contract if that pathway is pursued – WBC • Agreement to explore possibility of undertaking pilot scheme prior to award of contract • Procurement Planning undertaken with WBC Contracts & Commissioning Team and resource identified to manage process • Early Supplier involvement with Age UK, Village Agents, Sue Ryder Home, British Red Cross • Early user involvement with patient representatives • 1st Draft of specification completed From November Report: • Second team meeting held • Key RBH contacts identified & briefed • Pre-tender planning commenced (Early Supplier Involvement, Early User Involvement) • Workshop arranged • Draft PID completed • Draft Project Plan completed • Draft Risk Register completed • November Project Progress Report written • (from last month - not yet agreed) Detailed definition of the role to be produced – still in development • (from last month - not yet agreed) Key decision around service delivery method to be taken (employed staff, commissioning, use of voluntary sector or combination) – still in development

NEXT STEPS / PLANNED ACTIVITIES	
Personal Recovery Guide	• Second Workshop to review draft specification • Peer review of similar specification at Bracknell Council • Initial discussions regarding pilot scheme • Communications plan to be created • Communications strategy to be created

NEW ISSUES RAISED THIS PERIOD

West Berkshire Better Care Fund plan not yet approved by Department of Health. There is only one condition applied to the plan (funding the costs of the change in the social care eligibility threshold)

but a further 27 areas where particularly actions are required.

NEW RISKS IDENTIFIED THIS PERIOD

BW 10 Joint Care Provider/Personal Recovery Guide Project Risks Log

Risk Ref	Category	Source & Date Raised	Risk Description	Inherent risk score			Required controls and actions to reduce/mitigate risk	Review Dates	SRO and Monitor/ Review body	Residual Risk Score and Rating		
				L	I	RR				L	I	RRR
Personal Recovery Guide only												
PRG 09	Delivery	23/12/2015	Ability to undertake pilot scheme in lieu of tender process as part of market testing exercise - legal framework to be explored	3	3	9	discussions with legal teams (principally WBC) regarding format and restrictions surrounding pilot	Monthly	Integrated Steering group	2	2	4

PROJECT MILESTONES, DELIVERABLES

Project Milestones (Include all milestones from last month onwards)	*Task Owner*	*Original Delivery Date*	*Planned delivery Date*	*Conf H/M/L*	*Explanation for slippage, impact on workstream and actions being taken. Has any re-planning been approved by appropriate Board?*
Personal Recovery Guide					
PID Sign-off	TE	Nov	Dec	H	Conversion to BCF format no impact
Milestone 2: Assessment of requirements	TE	Dec	Dec	H	Delayed until January – 2nd workshop
Milestone 3: Specification completed	TE	Jan	Jan	H	In development, on target for Jan
Milestone 4: Pilot/Tender Process	TE	Apr	Apr	H	
Milestone 5: Contract Award	TE	Apr	Apr	H	
Milestone 6: Service Commencement	TE	May	May	H	
Milestone 7: Project Closure	TE	Jun	Jun	H	

Project Budget/Cost Summary (£000s) as at 30/11/2014

Cost Type	*Funding Source*	*Original baseline (in Business Case)*	*Current baseline*	*Actual spend to date*	*Forecast to 31st March 2015*	*Forecast To Complete (inc. spend to date)*	*Forecast To Complete - date*	*Explanation for slippage, impact on workstream and actions being taken. Has any re-planning been approved by appropriate Board?*
Project Delivery Costs - Personal Recovery Guide Project								
Project Manager	CTA		22,800	5,330	15,453	22,200	30/06/2015	Projects go-live planned for April 15 but closure will need to allow for a period of monitoring /adjusting
Subject Matter Experts (backfill)	CTA		23,880	12,110	21,000	24,600	30/06/2015	Projects go-live planned for April 15 but closure will need to allow for a period of monitoring /adjusting
Project Office Administration Support	CTA		1,800	771	1,800	1,800	31/03/2015	
ICT Equipment	CTA		450	195	240	240	31/03/2015	
Room Hire & Catering	CTA		1,170	415	1,170	1,170	31/03/2015	
Specialist Support HR	CTA		1,500	0	1,500	1,500	31/03/2015	
Specialist Support Legal	CTA		1,500	0	1,500	1,500	31/03/2015	
Specialist Support Finance	CTA		3,000	0	3,000	3,000	31/03/2015	
Training	CTA		1,500	0	1,500	1,500	31/03/2015	
Contigency	CTA		3,900	0	3,900	3,900	30/06/2015	
Sub Total		**0**	**61,500**	**18,820**	**51,063**	**61,410**		
Pump Priming for Go Live								
		0	0	0	0	0		
Sub Total		**0**	**0**	**0**	**0**	**0**		
Totals		**0**	**61,500**	**18,820**	**51,063**	**61,410**		

RESOURCE SUMMARY

Number of Main (FTE) Resources Required	*Number Now In Post*	*Explanation for variance, impact on workstream and actions being taken.*

1 x Project Manager	1	Shared across both projects
0.5 Project Administrator	0.5	Administrator supports both projects and ISG
1.4 x Subject Matter Experts	1.4	Shared across both projects

Berkshire West 10 Integration Portfolio Status Report

Reporting Period: 18 December 2014 to 13 January 2015

Scheme / Programme		Description / Key Achievements	Responsible Lead	Next Steps	BRAG Rating	Issues / Actions/ Item to Note
Berkshire West Programmes	Health and Social Care Hub	Dedicated full time PM John Rouke appointed – starting 13/01/15. Task and Finish group meetings being held fortnightly to design and plan implementation of phase 1 of the H&SC Hub. Clinical lead for 111 procurement has accepted invitation to join the T&F group. Task and Finish group members visited Berks Health Hub to experience Hub working. While important to identify whether the H&SC Hub should be co-located or hosted virtually, agreed that decisions first need to be made about what to include in the Hub, with associated costs. Agreed need for stakeholder input (seek views of professionals for Phase 1 via short survey; and seek views of service users when work begins on development of Phase 2). Outcomes from survey findings will help to inform possible options for full appraisal and CBA, as well as development of metrics. Detail of processes / services to be included in Phases 1 and 2 of H&SC Hub development reviewed and updated. Intention to complete Phase 1 by March 2016; delayed from provisional target of June/July 2015.	SRO - Katie Summers / Project Manager John Rouke	The complexity of plans for developing H&SC Hub may require consideration of some external support. T&F group meeting agenda, action notes and Terms of Reference to be amended to match BW10 templates. To include reference to review of dependency register. Reference to Section 75 to be included amongst dependencies. Stakeholder survey to be developed and proposed questions to be brought to T&F group meeting on 22/1/15 for agreement. Although inclusion of Children's Services unlikely to be included in SPA development until phase 2, Children's Services to be informed about this work now. Findings from "deep dive", and from survey will contribute to development of potential models of delivery of Phase 1 for full options appraisal, including costs of proposed model(s), prior to submission for consideration at BWPB (March 2015). Then to Council members and other stakeholders before final sign off (June/July 2015). Decision required where responsibility lies for developing plans for common referral and shared assessment processes – FEP to define & identify appropriate group by 22nd Jan. Financial costs of existing single point of access service related to adult services (excluding mental health) to be identified - by 22nd Jan Work ongoing to update and refine PID/Business case – finalise once proposed design agreed by BWPB (March 2015).	Green	
	Hospital at Home	The Hospital @ Home model development process has demonstrated strong integrated working and whilst the Proof of Concept (POC) was unable to identify the predicted numbers of patients for admission avoidance, the data gathered does show that there are real opportunities for reframing the original scope of the project to include other opportunities such as early supported discharge, enhanced support for care homes and addressing frequent re-attenders. The Provider led Hospital at Home Business case went to the December QIPP and Finance Committee for approval. Approval was given pending the production of revised finance and risk schedules for the January QIPP and Finance Meeting.	SRO Katie Summers CCG Fiona Slevin-Brown SRO Providers	• An update including the revisions to the pathway model and any changes to the activity and financial assumptions will go to local Integration Steering groups in February 2015. • Wider CCG led communications to go out in February describing the changes to the reframed model and the timelines for implementation. • Reframed model will be included in the CCG planning assumptions for 2015/16 • Provider Transformation lead to be identified to lead implementation.	Amber	
	Enhanced Services for Care Homes	Obtain and analysed length of stay data by HRG code, Breakdown of A&E vs Admissions Reported on length of stay by Care homes for LTC board meeting (18/11) Liaise with Maggie Woods, Unitary Authority leads & In reach teams regarding leadership training course. – initial contact made. Date for meeting pending. Activity data is reduced by 13% against data from 13/14 and Finance Spend data is reduced by 30% against data from 13/14 Both Activity & Finance data are both at its lowest point of variance versus our target figures since the project started.	SRO Katie Summers / Project Manager Nina Vinall	• Meet with Maggie Woods & produce outline course plan. • Report on findings from analysis to UA leads. • Begin to collect data & produce a case study on 5 care homes and their admission & Length of stay data. (this will provide insight as to why there is an increase in NEL) • Care Home Steering group in January.	Green	
Frail Elderly	Pathway Activities	BW10 Integration programme members to join the Acute Frailty Network, Lead agreed as Andrew Wearing, RBH. The Frailty network is a year long programme of activities and will help communities implement known good practice and will encourage sites to innovate and develop new models of care that help to improve the acute frailty services provided in the NHS. Each system will have access to clinical and improvement experts to support them in local measurement, improvement and innovation and will be encouraged to learn from one another and share and adopt changes across the network. Delivery Group activities have included mapping the integration programmes and schemes Kings Fund	SRO's Stuart Rowbotham, Lindsey Barker and Bev Searle PM David Mphanza	A visit by NHS Elect (who are leading the Acute Frailty Network) to the RBH taking place on 1/4/15, action to arrange for partners of the work streams to be in attendance. Outputs from the Finnamore Financial modelling - Optum to undertake a high level review of the methodology, and the tool itself to validate its use for this purpose. Update expected early January and is expected to include detailed findings.	Green	Following the last FEP meeting on Thurs 8th Jan, the 3 sponsors are to give consideration to nominating a single SRO to drive forward the pathway work.
Reading	GREEN	Continued risk regarding independent provide capacity Progress to develop the operating manual for the Discharge to Assess model has slipped due to capacity issues in BHFT to participate in the development.				
	Discharge to Assess	NB Discharge to Assess covers both the Full Intake Model and the Discharge To Assess beds at The Willows. Recruitment for social care staff remains on track. Recruitment of BHFT staff is in progress. Draft Operating Manual reviewed and being updated with key outstanding issues have been allocated and points of further work have been allocated. Continue to run pilot using one of the beds at The Willows.	SRO Suzanne Westhead & Brigid Day PPM's Melanie O'Rourke	Merge and finalise Operating Manual in progress Meet with RBH staff to agree interface and role of social worker Continue to provide service in Res DE bed Finalised BHFT contract to enable recruitment finalise light touch assessment finalise social worker role with interface team	Green	
Whole System Whole week	Full Intake Model	TOR now in situ Representative from Reading North CCG now confirmed Voluntary Sector event completed and concept signed up to Proposed geographical patches confirmed. Project scope still on track to be submitted to the January Reading Integration Board. Draft operating manual developed and will feed in to the overarching document.	SRO Suzanne Westhead & Brigid Day PPM's Melanie O'Rourke / Jan Caulcutt	Develop the Reading Model further communication with voluntary sector at the Care and Support conference on 13 01 15 Complete Scoping document	Green	
	Improved Access to GP Services	Plans for Reading South and North West Reading CCG are being finalised.	SRO Eleanor Mitchell PM Melanie O'Rourke	Finalisation of process, pathway and criteria to be completed.	Green	
Wokingham	Red	Final BCF submission deadline of 9th January not met, deadline extended to 16th January. Response expected on Care Act Funding-Eligibility criteria by w/e 23rd January. James Burgess has been appointed as the Locality Integration & BCF Programme Manager. However due to backfill arrangements he will not be working on the role full time until the end of March - Mitigation James will try and undertake key BCF tasks whilst holding his current duties.				
	Step up Step Down Beds	Consultation with Alexandra Place residents completed regarding siting SUSD in their scheme. Referral pathway from HLT WISH team for Step Down element of service drafted and circulated. Landlord sending and WBC drafting lease agreement for first 2 flats, service provider is recruiting staff required.	SRO Stuart Rowbotham/Programme Manager Post Vacant	Consultation ended 27/11/14. service specification and referral pathways drafted, care provider costs for additional staff agreed agree lease agreement with housing provider for units being drafted.	Green	

Berkshire West 10 Integration Portfolio Status Report

Reporting Period: 18 December 2014 to 13 January 2015

Scheme / Programme		Description / Key Achievements	Responsible Lead	Next Steps	BRAG Rating	Issues / Actions/ Item to Note
	Integrated short term health & social care team	Short Term Integrated Team (WISH). Item in Wokingham Borough News. Project/Development Manager still required to take forward phase 2 integration.	SRO Stuart Rowbotham/Programme Manager Post Vacant	Appoint Project/Development Manager to take forward phase 2 integration	Green	
	Domiciliary Care Plus	Proposed expansion of the service expanded to include large Assistive Technology and response component agreed, project group formed, draft service specification drawn up	SRO Stuart Rowbotham/Programme Manager Post Vacant	Business case agreed, drafting AT service specification and referral, looking at procurement options, examining resources needed to progress project	Green	
	Self-Care and Primary Prevention & Neighbourhood	Self Care / Primary Prevention: - WBC has appointed F/T manager to co-ordinate action to comply with Care Act requirements regarding information to service users – will include information to facilitate self care and prevention of ill health. - v 3.0 draft prevention strategy completed by Public Health team; preliminary meeting planned to review and if necessary amend prior to wider consultation Neighbourhood Cluster teams: - Scoping workshop with GPs with contributions from WBC, BHFT and Age UK (Berks) took place in December. Consideration being given to creating 3 larger clusters rather than 5 smaller ones. Further development of options underway, in line with emerging Primary Care Strategy – to be further discussed with key stakeholders during January.	SRO Stuart Rowbotham/ Project Manager Jane Brooks	**Self Care / Primary Prevention:** - Service user involvement to be incorporated into plans for improving self care via the Co-production network, now integrated into the Place & Community Partnership - Survey for stakeholders regarding maximising independence through prevention and self care - planned to be distributed from 20/01/15 - Findings expected in Jan 15 from Wokingham Healthwatch study with service users about how people access information about health and social care, which could incorporated into planning - Meeting scheduled for 12/01/15 to review draft Prevention strategy and if necessary amend prior to wider consultation - Reference to requirements re prevention, personal health budgets outlined in "The Forward View into action: planning for 2015/16" (NHS E Dec 14) to also be incorporated into development and planning work **Neighbourhood Cluster teams:** - Further development of options to be discussed with LA, BHFT, and vol sector in order to explore feasibility of 3 clusters - Discussion with elected members to be arranged asap, to seek their views about the potential areas / clusters / preferred services to be included in the NCTs - Shinfield surgery to be involved in discussions - Possible options for next steps to be taken to next GP council meeting on 20 Jan for discussion; also to Practice Managers meeting (22 Jan), to WISP (21 Jan), to Patient Participation Group Forum (22 Jan) and to Place & Community Partnership / Co-production network (29 Jan) - Reference to requirements re the design and implementation of new models of care such as multispecialty community providers (similar to NCTs) outlined in "The Forward View into action: planning for 2015/16" (NHS E Dec 14) to also be incorporated into development and planning work Work ongoing to develop and refine PID / business case, including project plans with timescales, risk register and dependencies. Will also develop an agreed a service spec (linked to risk sharing) in line with BW 10 DG requirements.	Green	
	GP Access					
West Berkshire	Amber	West Berkshire Better Care Fund plan not yet approved by Department of Health. Revised submission due 9 Jan 2015 but will be missed whilst discussions continue with the Secretary of State regarding funding. There is only one condition applied to the plan (funding the costs of the change in the social care eligibility threshold) and this remains a risk to the overall BCF, reflected in the overall Amber status.				
	Joint Care Provider (inc 7 day services and direct commissioning)	• Detailed Process Mapping completed • Meeting with Programme Director to confirm template commonality • Full Team Meeting to review progress of 'To Be' model and receive improvements • Conversion of key documents (PID, Risk Register, Plan) to agreed BCF format (PID with PL for review prior to despatch to co-sponsors) • Initial meeting regarding likely performance measurements completed • Initial meeting regarding likely IT systems requirements completed • Initial meeting regarding Workforce Design • December Progress Report written • Expansion to 7 Work Packages: Pathway Packages: – 1 – Care Supplier (model) design, 2 – Workforce Design, 3 – 7 day Services, 4 – Transfer to Long Term Care. Enabler Packages – A – IT systems, B – Trusted Assessor, C – Performance Data/Measurement	SRO Shairoz Claridge & Tandra Forster Project Manager Toby Ellis	• Converted PID circulated to be approved • Work Package details to be drafted • Work Package meetings to be arranged • Work Package staff to be allocated • Communications plan to be created • Communications strategy to be created	Green	
	Personal Recovery Worker	• Royal Berkshire Hospital added as key partner • Conversion of key documents (PID, Risk Register, Plan) to agreed BCF format (PID with PL for review prior to despatch to co-sponsors) • Single Work Package identified – service specification • Workshop to scope service specification completed • Meeting with Programme Director to confirm template commonality • Full Team Meeting to confirm how to deploy specification • Agreement regarding organisation to undertake tender process and award contract if that pathway is pursued – WBC • Agreement to explore possibility of undertaking pilot scheme prior to award of contract • Procurement Planning undertaken with WBC Contracts & Commissioning Team and resource identified to manage process • Early Supplier involvement with Age UK, Village Agents, Sue Ryder Home, British Red Cross • Early user involvement with patient representatives • 1st Draft of specification completed	SRO Shairoz Claridge and Ian Mundy Project Manager Toby Ellis	• Second Workshop to review draft specification • Peer review of similar specification at Bracknell Council • Initial discussions regarding pilot scheme • Communications plan to be created • Communications strategy to be created	Green	

Berkshire West 10 Integration Portfolio Status Report

Reporting Period: 18 December 2014 to 13 January 2015

Scheme / Programme		Description / Key Achievements	Responsible Lead	Next Steps	BRAG Rating	Issues / Actions/ Item to Note
Enabling Programmes						
	Connecting Care - West Berkshire	• Orion SoW – Final version due from Orion today (9 Jan). CSU Sign-off/return 12 Jan. Critical Path. • Orion Kick-Off meeting – Completed 6 Jan, initiation actions defined. • Infrastructure Procurement – OCSL contract internally reviewed. Sign-off 12 Jan. Critical Path. • Infrastructure SoW – CSU awaiting OCSL final version (overdue). Sign-off required 12 Jan. Critical Path. • BHFT – Technical specs – Final data extract format supplied by Orion - to be reviewed by BHFT. • MIG - Kick-off meeting complete. Deliverables and dependencies identified/documented. • RBFT/BHFT/CSU/Orion - Technical kick-off meeting scheduled 12 Jan. Critical Path • Benefits base lining – Started to identify and request data to measure/track anticipated benefits. • Comms – Newsletter final revision complete. Sub-group approval 15 Jan. Circulation - end of Jan. • Board ToR for phase 2 reviewed. To be submitted for Project Board approval 20 Jan. • Board roles & responsibilities for phase 2 reviewed. To be submitted for Project Board approval 20 Jan. • IG – Completed 1st Drafts – Phase 2 ISA Sched D, Data Mapping, IG checklist. Critical Path. • IG – Kick-off meeting arranged 15 Jan. Output - IG compliance deliverables and outline plan	SRO Katie Summers / Programme Manager John MacDonald	• Orion SoW – CSU to sign-off/return to Orion 12 Jan. Critical Path. • Infrastructure Procurement – OCSL contract - CSU Sign-off 12 Jan. Critical Path. • Infrastructure SoW – OCSL final version – CSU Sign-Off required 12 Jan. Critical Path. • RBFT/BHFT/CSU/Orion Technical kick-off meeting via T conf call 12 Jan. critical Path. • MIG – schedule implementation meeting between MIG/Orion/CSU. Mid- Feb. Critical Path. • Orion/BHFT/RBFT/CSU/CSU IG – Schedule "Round table" meeting -Late- Jan. Critical Path • Benefits base lining - COCOC visit scheduled 12 Jan. • Benefits base lining – Schedule Cardiology and Community Hospitals x2 base lining visits. • Benefits tracking – Collate Phase 1 MIG audit results. Input to Project Board meeting 20 Jan. • IG – Kick-off meeting 15 Jan –Output - Scope, deliverables, plan, Phase 2 schedule D review. • Project Management – Finalise Project Plan, PID for Project Board review 17 Feb. • PMO – Review/ratify Project Board members. Send monthly invites for Feb/March/April/Ma	Green	
	Market Management	• PM JD approved • PID and project Plan approved • Wokingham and Reading signed up to CP feasibility study. West Berkshire declined at this stage	SRO Stuart Rowbotham / Project Manager – Lyndon Mead	Next stage priorities – • Commission Care Place feasibility study and build BC for MI system procurement • Placement cost/Market rate evaluation (L&B etc.) • Draft Joint Market Failure management document/protocol Actions – • RBC to approach RBWM regards involvement in CP feasibility study • GA to review CCG participation in study • Subject to above, commission study	Green	PM role now vacant – recruitment to post to be undertaken in January
	Integrated Carers Commissioning	Carers Needs Analysis for Berkshire commissioned from Public Health Shared Services Team and data being collated to inform this. Healthwatch Reading commissioned to undertake project trialling approaches to developing carer support from a GP practice base. 'In principle' agreement reached on continued funding to VCS providers of carers' breaks services across Berkshire West.	SRO Gabrielle Alford ? Jeanette Searle	Carer Assessment tools and processes to be updated to be Care Act compliant for April 2015. Carer and provider engagement to be undertaken to inform future re-tender of carer information and advice contract. Arrangements for oversight of the care specific element of locality Better Care Fund pooled budgets to be finalised.	Green	
		• Steering Group meeting/teleconference held on the 11th December. • The group reviewed the proposal sent from Jill Barrow of a framework for taking forward the programme in Berkshire West and which was circulated by FS-B to the group on the 10th November. • The group agreed: o Jill/Matt to contact and speak individually with the members of the Leadership Steering group, and the Chief Officers across the partnership during January o Jill/Matt to attend meetings in January and February, including the Chief Officers group, the Berkshire West Partnership Board, the Local Integration groups, and an internal meeting at both the BHFT and the RBFT. o Dates would be scheduled at this stage for two workshops one in March and one in April	SRO's Fiona Slevin Brown & Rachael Wardell	o To circulate the contact details to Jill and Matt. Feedback from these calls would be shared with the group in January at the meeting on the 15th. o Forward the dates to Matt/Jill in relation to the Chief Officers, Partnership Board and Integration meetings. Lindsey and Bev to provide the details of the BHFT and RBFT meetings by end of December. o To circulate dates, and the provision details of the workshops including the agendas to be agreed by the Leadership Steering Group at the 12th February meeting. o Matt agreed to investigate the learning network to be led by the Kings Fund which is open to participants of the programme and to feed back at the January meeting o To circulate for the January meeting the outputs from the launch event in November for further discussion and to enable the themes from this to be pulled through into the planning for the March workshops o To investigate the opportunities for pass porting any unused enabler time into the next financial year and to feedback offline to FS-B o Membership of the Kings Fund led learning Network to be agreed. o Enablers, Jill and Matt will be contacting Chief Officers, Clinical chairs and Steering group members over the coming weeks for 1-1 discussions. o Dates held for workshops to be agreed and hold the date invitations to be sent out after Steering group meeting on the 15th January 2015.	Green	Draft MOU has been circulated to steering group members for agreement. To be shared at the Partnership Board for ratification. Funding for enablers to be hosted by one of the partners yet to be agreed with a view to unspent allocation being rolled over into 2015/16.
	Integrated Workforce Development	Successful recruitment of workforce specialist due to start Jan 15 Initial scoping of Generic Care Support Worker role has been completed	SRO Bridgid Day Programme Manager - Derek Williams	Priority for PM - Analysis of Skills 4 Care and Skills 4 Health reports to develop recommendations for programme Re- establish Workforce Development Group Scope and define component work streams for development of PID and Business Case	Green	Derek Williams Programme Manager started 6th January
Integration Programme	Integration Programme delivery & Finance Sub Group updates	Finance sub group meeting held to understand S75 requirements and draft an action plan. This was reviewed at both the DG and FSG meeting FEP working group meeting to agree input into NHS Elect Frailty programme and develop action plan for pathway. Induction for new starters completed, Derek Williams Workforce Development, John Rouke Health & Social Care Hub, Adam Williams BW10 PMO Officer. Resource Schedule developed and reviewed at Finance Sub Group to help identify funding to meet Partnership wide roles: Updated finance template agreed to capture spend across Programmes and schemes, to be included in highlight report template from February.	Naseema Khan	Further work with Locality Programme Managers to develop/ review PIDS/ Milestone plans/ Dependencies, Risks etc. FEP Working group established, requirement to confirm SRO Further work to progress 7 day working group Integration Programme Managers and Finance Leads to complete Schedule 1 of Section 75, deadline 30th January Start Recruitment for Market Management PM and Comms Manager	Amber	Capacity and engagement

BCF National Conditions		Description/ Key Achievements	Responsible Lead	Next Steps	BRAG Rating	Issues / Actions/ Item to Note
7 Day Services		DG meetings have developed outline analyses tables to frame the work to be taken forward by a dedicated 7 working sub group. Meeting scheduled 15 December to set up a 7 Day working Sub Group which will utilise the toolkit developed by NHS Improving quality to develop a comprehensive picture across the system	Gerry Crawford SRO	Outstanding - to confirm scope of working group	Amber	
Data Sharing and the NHS Number		• Further clarification obtained around: o Requirements for N3 connections o information sharing and information sharing agreements o shape of possible LA involvement in the pilot o approach to ascertaining requirement for Client Portal o funding o data management within Orion • Project plan and schedule being pulled together	Mike Ibbitson on behalf of joint LA's (Project Manager – Richard Waller)	1. Define chosen NHS number option 2. Start definition of business benefits of interoperability for LA's 3. Agree project plan to cover following: 4. Start fact finding on pilot technology & understand fit for LA's 1. Obtaining an initial batch of NHS numbers to be matched and incorporated in the client/customer record on each Council's Case Management System; and 2. Enabling ongoing acquisition of NHS numbers for new clients. Additionally, ascertaining costs, timescales and complexity for each option in relation to connection to N3. It is critical to establish clarity around how PSN organisations can access N3. The rules and costs/impact are unclear and this is hindering immediate progress.	Red	Risk; NHS numbers agreed for 1.4.15 – timescales are very challenging as none of the options are straightforward and costs/complexity is either high or unknown. Will need to review the feasibility of this date. Still ascertaining costs, timescales and complexity for each option available in terms of

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Title of Report:	**Health & Social Care - Alignment of Commissioning Plans**
Report to be considered by:	The Health and Wellbeing Board
Date of Meeting:	22 January 2015

Purpose of Report: **To inform Health and Wellbeing Board about progress on alignment of commissioning plans for Health &Social Care Partners**

Recommended Action: **N/A**

When decisions of the Health and Wellbeing Board impact on the finances or general operation of the Council, recommendations of the Board must be referred up to the Executive for final determination and decision.		
Will the recommendation require the matter to be referred to the Council's Executive for final determination?	Yes: ☐	No: ☒

Is this item relevant to equality? Please tick relevant boxes	**Yes**	**No**
Does the policy affect service users, employees or the wider community and:		
• Is it likely to affect people with particular protected characteristics differently?	☐	☐
• Is it a major policy, significantly affecting how functions are delivered?	☐	☐
• Will the policy have a significant impact on how other organisations operate in terms of equality?	☐	☐
• Does the policy relate to functions that engagement has identified as being important to people with particular protected characteristics?	☐	☐
• Does the policy relate to an area with known inequalities?	☐	☐
Outcome Where one or more 'Yes' boxes are ticked, the item is relevant to equality. In this instance please give details of how the item impacts upon the equality streams under the executive report section as outlined.		

Health and Wellbeing Board Chairman details	
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Executive Report

1. Introduction

1.1 The Health and Social Care Act (2012) introduced a requirement for Health and Wellbeing Boards (HWB) to provide a forum for System Leaders to take a strategic approach to promote integration across health and social care throughout their locality.

1.2 Their primary responsibility is to produce Joint Strategic Needs Assessments (JSNAs) to identify the current and future health and social care needs of the local community, which feeds into a Health and Wellbeing Strategy (HWS) setting out priorities for local commissioning.

1.3 The intention is that the Local authority, CCG and NHS England commissioning plans should then be informed by these documents.

2. Current Progress

2.1 Initial work of the West Berkshire HWB has focused on the development of a new Health and Wellbeing Strategy; which has identified a number of key priorities. The strategy and the identified priorities are subject to consultation; once finalised this should inform future commissioning across the system.

2.2 Service commissioning has continued throughout this period on the basis of the individual requirements of each partner organisation. There has been some joint commissioning e.g. Carer Services or the Berkshire Community Equipment Service. These examples are limited, and recent work around voluntary sector commissioning has shown that there is some duplication with different partners funding organisations for broadly similar services.

2.3 This disparate approach could mean that we have not had the opportunity to consider what more could be achieved through commissioning on a partnership basis. Therefore it is now proposed that work is undertaken to map commissioning arrangements across the partners to establish a detailed understanding of what is already in place.

2.4 Some initial work has been completed. The table at Appendix A shows services under three main areas – those historically commissioned on a joint basis, those that we are planning to through the Better Care Fund and other areas where there are synergies that mean we may want to.

2.5 We need to look at this in greater detail and therefore further work has to be completed that will confirm timeframes and existing priorities across the local Health and Social Care system. It should reveal gaps, opportunities and challenges which will allow the board to make an informed decision about future commissioning arrangements.

2.6 It is proposed that the outcome of this more detail work is brought to HWB in March 2015.

3. Equalities

3.1 This item is setting out proposals for Health and Social Care partners to align commissioning plans to enable a strategic approach to commissioning. Any future commissioning plans would be subject to a full EIA.

Appendices

Appendix A – Commissioning Alignment

Consultees

Local Stakeholders:

Officers Consulted: Shairoz Claridge, Operations Director, N&DCCG

Lesley Wyman, Head of Public Health, WBC

Other:

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Existing joint Commissioning	
Activity	**Partners**
Carers joint commissioning Range of services commissioned across Berkshire West to support carers	CCGs, RBC, West Berkshire, Wokingham Borough Council
Voluntary Sector Commissioning	Initial work has been focused on West Berkshire ASC and Public Health, work is underway to extend it across Berkshire West
Berkshire Community Equipment Service	Berkshire CCGs and Local Authorities
LD Services – Transforming Care Supporting adults with learning disabilities back into the community from assessment and treatment units	CCGs and Local Authorities
Better Care Fund	
Activity	**Partners**
Connected Care Commissioning of IT solution to create a single portal to enable effective sharing of information	RBH, BHFT, SCAS, CCG, RBC, WBC and West Berkshire
7 day working Commissioning of a range of services to support delivery of 7 day services.	CCG, RBC, WBC and West Berkshire
Service Navigation Commissioning of a community led integrated discharge team based at RBH.	CCG, RBH, WBC, RBC and West Berkshire
Care Home Quality Programme	CCG, Local Authorities

Joint Provider Project – Intermediate Care. Re-design to improve capacity	CCG, West Berkshire and BHFT
Future plans/opportunities	
Activity	**Partners**
CAMHS co-commissioning T1-4	NHS England, Local Authorities and CCGs
LAC reviews	CCG and Local Authorities
Falls Service	CCG, RBH, BHFT and Local Authority
Alcohol Liaison Service – specialist nursing and MDT outreach for management and follow up of primary care	CCG, RBH, Primary Care, Public Health and BHFT

Title of Report:	**Performance Monitoring Report for Quarters 1 and 2, 2014/15**
Report to be considered by:	**The Health and Wellbeing Board**
Date of Meeting:	**January 22nd 2015**

Purpose of Report:

To give the Health And Wellbeing Board an update on progress being made toward the priorities in the current Health and Wellbeing Strategy, using the Performance Framework.

Recommended Action:

To note the performance measured against the national and local indicators. To make suggestions for action in areas that are demonstrated to be underperforming.

Reason for decision to be taken: N/A

Health and Wellbeing Board Chairman details	
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Executive Report

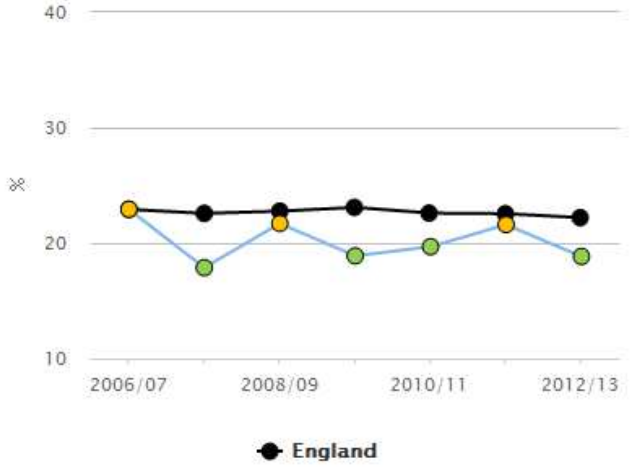
This report is to update the Health and Wellbeing Board on progress made on the priorities outlined in the original Health and Wellbeing Strategy in quarters one and two of 2014/5. Appendix 1 is the completed data set to accompany this report.

As described in the performance report for 2013/14 there are gaps in the data due to the lack of agreed local indicators. However all high level indicators have been updated using the Public Health Outcomes Framework and the Public Health indicators have also been updated. Indicators have been RAG rated where this is sensible and useful to do so. This report enables the Board to see areas where performance may need attention and there are outlines of specific actions that are being implemented to address underperformance.

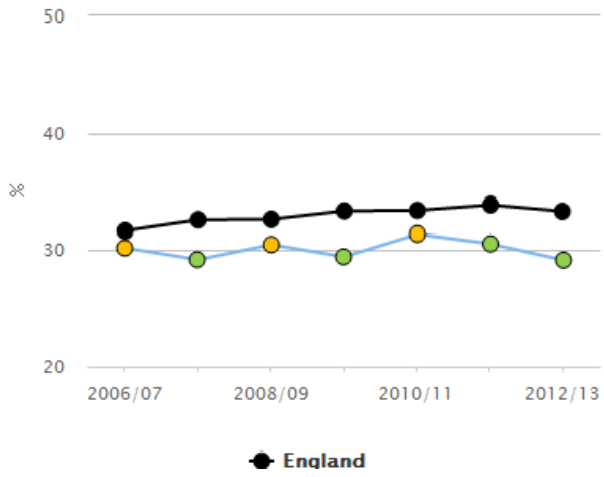
Reducing childhood obesity in primary school children

The National Childhood Measurement data for 2013/14 was published in December 2014 and it demonstrates that using a combined overweight and obesity figure for reception and year 6 there is no statistically significant change.

In reception the rate has gone up slightly from 18.9% to 19.3%



In year 6 the rate has gone down from 29.1 to 28%.



There is no overall trend up or down but yearly fluctuations.

The local indicators show that significant numbers of initiatives and projects have been implemented in the first half of the year both in schools and communities to increase healthy eating and physical activity for children and families.

Healthy eating work includes the following:

- Lets Get Going healthy lifestyle after school initiative run in 3 schools
- Phunky Foods healthy eating resources and training for schools to get healthy eating into the curriculum. Run in a further 4 schools (from a baseline of 8 in 13/14)
- Healthy eating and food safety sessions run in 12 schools for year 6 pupils
- Presentations in 3 children's Centres on healthy eating and food hygiene
- 2 cookery workshops run in secondary schools in collaboration with Food Bank

The total number of children and parents who attended these training sessions was 500.

Physical activity work includes the following:

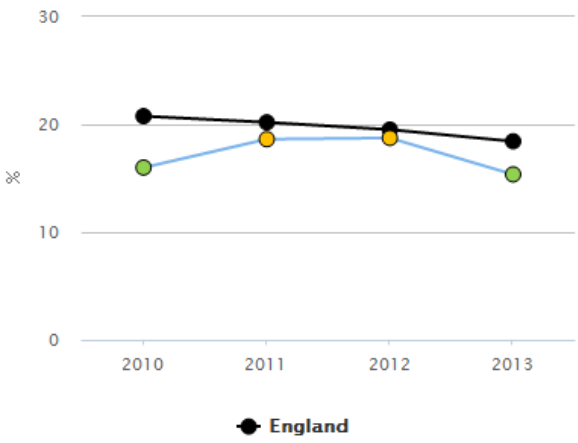
- Lets Get Going healthy lifestyle after school initiative run in 3 schools
- Free swimming lessons for a total of 24 children (out of a projected yearly total of 48)
- Free Fun Station activities run at a variety of leisure centres in half term holidays and summer holidays.

The total number of children and parents who attended these training sessions was 875.

- Mini World Cup Football Tournament run in the summer by Public Health and Get Berkshire Active also attracted 38 children
- Plus 667 pupils took part in Bikeability courses run by WBC Traffic and Road Safety team

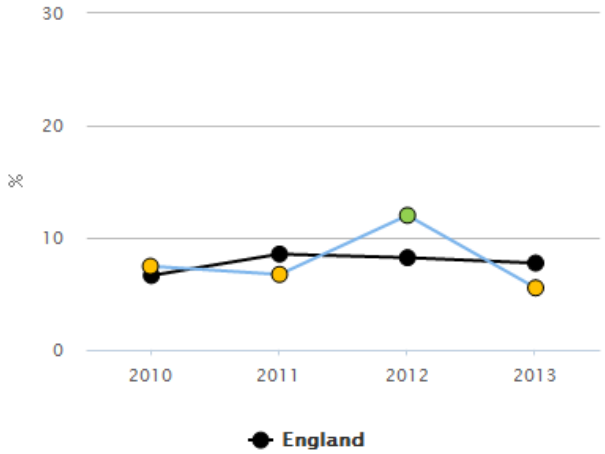
Supporting those over 40 to change lifestyle behaviours detrimental to health and wellbeing

Adult smoking prevalence has dropped from 18.76% to 15.4% which is now significantly below the national average. The overall trend over since 2010 has remained relatively unchanged



Number of 4 week smoking quitters for Q1 2014/15 has improved from Q1, 13/14 by 46% and an improvement for 12 week quitters by 85%. (Quarterly figures for smoking quitters are only available 4 months after the end of the quarter, thus 2 Q2 data for 2014/15 will be available later in January)

The successful completion of drug treatment for opiate users measures the percentage of opiate drug users that left drug treatment successfully who do not re-present to treatment within 6 months. There was a significant drop in this measure from 2012 to 2013 and the Q2 figure for 2014 has risen slightly from a low of 5% in Q1. Part of this fluctuation is due to relatively small numbers in treatment of which PHE is aware. In addition the current providers are implementing an action plan to improve the picture. The drug and alcohol service has been tendered out in the latter part of 2014 and PH and Wellbeing will work closely with the new providers to improve these figures.



The % of adults achieving 150 minutes of physical activity per week.
This figures has dropped slightly from 2012 to 2013 so that West Berkshire is now below the national average.

Physical inactivity is the fourth leading risk factor for global mortality accounting for 6% of deaths world wide. People who have a physically active lifestyle have a 20-35% lower risk of cardiovascular disease, coronary heart disease and stroke compared to those who have a sedentary lifestyle. Regular physical activity is also associated with a reduced risk of diabetes, obesity, osteoporosis and colon/breast cancer and with improved mental health. In older adults physical activity is associated with increased functional capacities. The estimated direct cost of physical inactivity to the NHS across the UK is over £1.6 billion per year.

There is considerable work going on in West Berkshire to enable residents to be more physically active. The PH and Wellbeing Team has commissioned a Physical Activity Co-ordinator who is working across the district with partners to run physical activity initiatives. In the first 2 quarters of 2014/15, 11 new health walks have been established and 89 new registrants have begun walking regularly.

Improving the self reported emotional wellbeing scores of adults
ONS currently measure individual/subjective well-being based on four questions included on the Integrated Household Survey:

1.Overall, how satisfied are you with your life nowadays?
2.Overall, how happy did you feel yesterday?
3.Overall, how anxious did you feel yesterday?
4.Overall, to what extent do you feel the things you do in your life are worthwhile?

These figures are calculated using a sample survey and are subjective however from 2012 to 2013 slightly less people had a low satisfaction score or a high anxiety score which is good but slightly more people reported a low happiness score.

The PH and Wellbeing lead for mental health and wellbeing has raised awareness of the importance of mental wellbeing through a wide variety of initiatives including publicising the importance of MIND, training front line staff in mental health first aid and running a number of mindfulness courses for staff in the council. There is a new Berkshire wide Suicide Prevention Strategy, completed in October 2014 that has been written by a multi agency Suicide Prevention Group and ratified by the Public Health Advisory Board. A countywide suicide audit is currently being carried out covering 2012-14. The strategy is available as Appendix 2.

The % of eligible population being offered and receiving and NHS Health Check.

This is the main area of underperformance within the Health and Wellbeing Strategy. Q1 figures are 30% lower for invites and Q2 26% lower for completed checks in 2014/15 compared to the previous year.

The target for West Berkshire is for 20% of the eligible population to be invited for a health check each year and for 50% of those invited to have a health check completed. The target number of invites for 2014/15 is 9720 and the target number of completed checks is 4860.

There are a variety of reasons for this underperformance but essentially the majority of the health check invitations and completion of checks has traditionally been provided by GP practices from 2009 when the NHS health check started. We built up numbers over the years and all the GP practices are currently signed up to deliver health checks. In 2013/14 the CCG chose the Health Checks programme as one of their Quality Premium targets and consequently performed well achieving 92.6% of the target for invites and 79% of the target for completions. However this has not been the case in 14/15 and consequently activity has dropped dramatically.

The PH and Wellbeing Lead has been encouraging practices, over the months, to increase their activity, making almost one visit a week to GP surgeries, plus liaising with Practice Managers frequently by phone and email. It is recognised that capacity within the surgeries is understandably tight with increasing numbers of diagnostic and treatment procedures being undertaken in Primary Care. In addition primary care staff are under pressure to deliver care in a context of constant change.

PH and wellbeing in West Berkshire continues to believe that NHS health checks should be carried out in GP practices rather than being commissioned out to private sector providers and the results being electronically relayed back to practices. A new action plan

is being developed with practices to increase both invitations and assessments in the last quarter. In addition the whole of February and March will see health checks available opportunistically at 2 rooms in West Berkshire Community Hospital and at West Berkshire Council Offices carried out by the bank Health Checks Nurses and other trained staff to boost numbers. This will be highly publicised to maximise uptake.

Decreasing excess weight in adults

Obesity is a priority area for Government. The Government's "Call to Action" on obesity (published Oct 2011) included national ambitions relating to excess weight in adults, which is recognised as a major determinant of premature mortality and avoidable ill health. https://www.gov.uk/government/publications/healthy-lives-healthy-people-a-call-to-action-on-obesity-in-england

The calculation of excess weight in adults is now done using the Active People Survey which is a national telephone survey asking respondents about the amount of physical activity they do and also asks them to give their height and weight. West Berkshire excess weight is similar to the national average at 65.5%. This figure is broken down into overweight (not obese) which is a BMI >25 and less than 30 = 47% and obese, a BMI>30 = 18.5%.

The England average is overweight = 40.8% and obese = 23% or excess weight = 63.8%

There are many different indicators that could be used to measure progress on excess weight and that includes levels of physical activity and healthy eating initiatives, both in children and adults. We have chosen just one type of indicator that is the number of weight management courses that are being run and the number of people who are completing courses.

The main weight management course commissioned in West Berkshire by Public Health and Wellbeing at tier 2 is Eat4Health (a 10 week course of 1.5 hr weekly sessions, including healthy eating and physical activity components). It is aimed at people with BMI of >25 and is largely self referral). This was commissioned out to the third sector and the new contractor Solutions 4 Health began providing courses in June 2014. This has inevitably meant a dip in number of courses being delivered and numbers of people attending, however, it is expected that this figure will grow significantly going forwards. The other course is a higher intensity course only available to Newbury and District CCG and Wokingham patients. It is aimed at patients with a BMI>30 including those with co-morbidities, and is a multidisciplinary course including input from GP, dietitian and exercise specialist. Patients are referred to the Course (Barometer) and the numbers are small. This is similar to a tier 3 course where the next tier of service would be bariatric surgery. There is also a tier 2 weight management course delivered by dietitians and commissioned by CCGs. This is GP referral only and is for patients with a BMI>30 or overweight with co-morbidities.

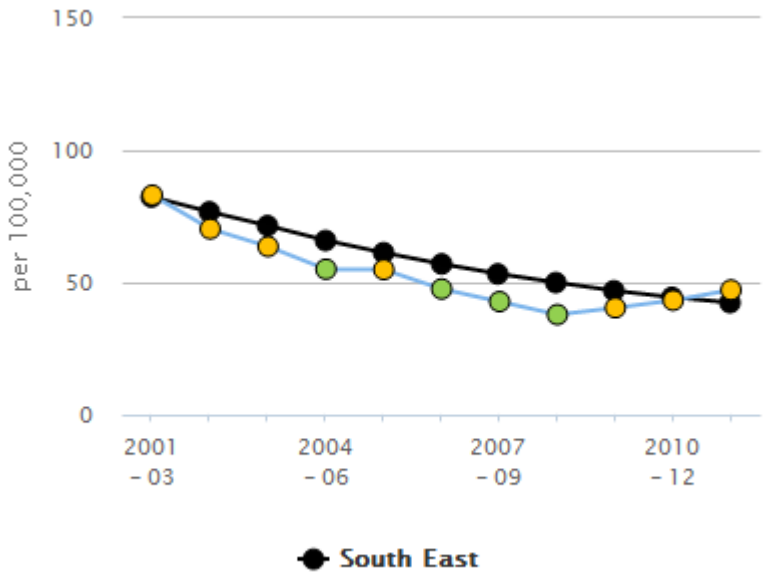
Considerable work is going on in this area including a countywide Workshop in December 2014 on the commissioning of weight management services at different levels across Berkshire attended by 60 key stakeholders. This is being followed up by the development of a Berkshire obesity care pathway plus wider, strategic work in each locality. The pathway will include all ages and all tiers of service including prevention. It has been suggested that weight management referral from GPs could be added onto a new electronic system, DSX, being piloted currently by the West CCGs.

Rate of cardiovascular disease in the under 75's considered preventable.

Cardiovascular disease (CVD) is one of the major causes of death in under 75s in England. There have been huge gains over the past decades in terms of better treatment for CVD and improvements in lifestyle, but to ensure that there continues to be a reduction in the rate of premature mortality from CVD, there needs to be concerted action in both prevention and treatment.

The basic concept of preventable mortality is that deaths are considered preventable if, in the light of the understanding of the determinants of health at the time of death, all or most deaths from the underlying cause (subject to age limits if appropriate) could potentially be avoided by public health interventions in the broadest sense.

Although the mortality rate has decreased steadily from 2001-3 to 2008-10 since this time there has been a small but continued increase. The latest reported data for West Berkshire (47.3/100,000) show an increase above the South east regional rate (42.5/100,000).



Continued focus on the major risk factors for CVD – obesity, physical inactivity, smoking and excess alcohol – is of utmost importance. In addition early identification of CVD risk through the NHS Health Check programme will help to find those who are at risk and support them with positive lifestyle change and medical treatment where needed, eg. statins, antihypertensives etc.

Breast feeding rates at 6-8 weeks.

This indicator was judged to be a valid and an important measure of public health and was therefore included in the public health outcomes framework. Inclusion of these indicators will encourage the continued prioritisation of breastfeeding support locally. Increases in breastfeeding are expected to reduce illness in young children, have health benefits for the infant and the mother and result in cost savings to the NHS through reduced hospital admission for the treatment of infection in infants (Quigley et al 2007.)

Current national and international guidance recommends exclusive breastfeeding for newborns and for the first six months of infancy.

The 6-8 week examination of babies is carried out by GPs. The data up till 2012/13 was reported by PCTs and then allocated to each LA dependent on the number of live births. Since April 2013 the data are now collected directly from providers via the data collection tool that is part of Unify2, a web based system set up to collect performance data from providers. The 13/14 data for West Berkshire was not published as the data quality was poor (ie too many babies did not have a breast feeding status recorded).

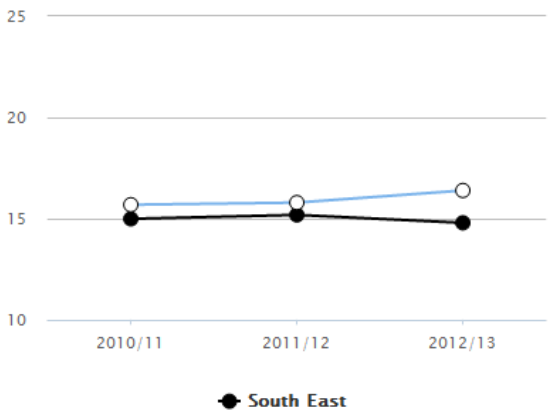
It is important that we have a full data set so that we can commission sufficient support services for mothers who need them. PH and Wellbeing currently commissions the Breast Feeding Network to provide this support through Breast Feeding Peer Support. In addition the Baby Friendly Initiative is also part funded by West Berkshire for breastfeeding support at the RBH.

Rate of domestic abuse reported to the police.

The rate of domestic abuse reported to the police has risen very slightly between 10/11 and 12/13, however this is not significant. In addition changes in the level of domestic abuse incidents reported to the police are particularly likely to be affected by changes in recording practices. These kinds of changes may in part be due to greater encouragement by the police to victims to come forward and improvements in police recording, rather than an increase in the level of victimisation.

Emotional wellbeing of looked after children

This indicator is based on the average difficulties score for all looked after children aged 5-16 who have been in care for at least 12 months on 31st March. The number of children in West Berkshire in 2013 was 55, thus the average scores have to be interpreted with care.



The score has decreased slightly from 15.7 in 2010 to 16.4 in 2013. However average scores for the South eat have improved.

It will be important going forward to ensure this upward trend does not continue or worsen. Data due for 2014 should be available imminently. The emotional health and wellbeing of Looked after children is a Hot Focus of the 2015/16 Health and Wellbeing Strategy.
The use of this type of performance monitoring spreadsheet with rag rated national and local indicators can be seen to be helpful in tracking progress and ensuring that issues are highlighted and can then be addressed through discussion and debate at the Health and

Wellbeing Board. It will be important for the new Health and Wellbeing Board that relevant organisations select the best national and local indicators that they would like to report back on to the Board.

Appendices

Appendix 1 – performance monitoring spreadsheet
Appendix 2 – Berkshire Suicide Prevention Strategy

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Appendix 1

Reducing childhood obesity in primary school children

Overarching indicator	Specific indicator		West Berkshire outturn 2012/13	2013/14	2014/15	'Good' is…		Direction of Travel on previous outturn	Benchmarks			Data caveats:	Frequency:	Lead
	Detail	Source							South East	England	Comparison with England value			
Prevent and reduce excess weight in children aged 4-5 and 10-11 years	2.06i: Excess weight in children aged 4-5 years old - % of children aged 4-5 classified as overweight or obese	PHOF	18.86%	19.30%	N/A	Low		declined		22.50%	Significantly better	each year a different cohort of children is measured.	Annual	
	2.06ii: Excess weight in children aged 10-11 years old - % of children aged 10-11 classified as overweight or obese	PHOF	29.12%	27.90%	N/A	Low		Improved		33.50%	Significantly better			LW
Local indicators	**Target**													
number of additional healthy eating intiatives commisisoned in school and community settings for children	11	PH Action plan	11 Lets Get Going, TS activity, Phunky Foods		Q1+Q2=20	high		improved					quarterly	AP
number of additional physical activity intiatives commisisoned in school and community settings for children	7	PH Action plan	7 Lets Get Going, swimming lessons, half term activities		Q1+Q2=33	high		improved					quarterly	AP
number of children and adults taking part in healthy eating projects in school and community settings		PH Action plan			Q1+Q2=500	high		improved					quarterly	AP
number of children and adults taking part in PH physical activity projects in school and community settings		PH Action plan			Q1+Q2=875	high		improved					quarterly	AP
number of additional road safety intiatives run		PH Action plan			Q1+Q2=1	high		improved					quarterly	AP

Supporting those over 40 to change lifestyle behaviours detrimental to health and wellbeing

Appendix 1

Overarching indicator	Specific indicator			West Berkshire outturn	'Good' is…	Direction of Travel on previous	Benchmarks			Data caveats:	Frequency:	Lead
	Detail	Source					South East	England	Comparison with England value			
3.1 Decrease smoking prevalence in adults aged 18 and over	2.14i: Prevalence of smoking among people aged 18+	PHOF	**2012** 18.76%	**2013** 15.4%	Low	↓	17.20%	18.40%	significantly lower		Annual (Figures will be published in Feb-15)	PH and wellbeing team
local indicators	**Target**		**2013/14**	**2014/15**								
number of 4 week quitters		local		**2014/15**	high							
			Q1 144	Q1 = 211							quarterly	FN
			Q2 149	Q2 =								FN
			Q3 157									FN
			Q4 295									FN
	Total Target for 2014/15 = 840		total 745									
number of 12 week quitters			**2013/14**	**2014/15**								
			Q1 81	Q1 = 148							quarterly	FN
			Q2 95	Q2								FN
			Q3 86									FN
			Q4 163									FN
	Total Target for 2014/15 = 70%		total 425									
3.2 Increase the successful completion of drug treatment for opiate users	2.15i: % of opiate drug users that left drug treatment successfully who do not re-present to treatment within 6 months	PHOF		**2013** 5.6%	High	↓	8.80%	7.80%	Significantly worse		This is available quarterly through NDTMS	
local indicators	**baseline**		**2013/14**	**2014/15**								
number of completers			Q1 12.2%	Q1 - 5%	high	↓						IW
									Quarter results 2013-14 fall within			
			Q2 10%	Q2 - 6.1%	high	↑			the "similar to			IW
			Q3 6.4%									IW
			Q4 6%						2014-15 Recording methods changed			IW
3.3 Increase percentage of adults achieving at least 150 minutes of physical activity per week	2.13i: Percentage of adults achieving at least 150 minutes of physical activity per week in accordance with recommended guidelines on physical activity	PHOF	2012 58.7%	2013 54.3%	High	↓	57.7%	55.6%	Similar			
local indicators	**baseline**		**2013 / 14**	**2014 / 15**								
number of new health walks started to enable people to be more physically active		local	Q4	Q1 3 Q2 8	high	↑						ZC
number of new registrations on health walks		local	Q4 12	2014/15 Q1 35 Q2 54	high	↑				Including one off seasonal walk registrations		ZC

	baseline		**2011/12**	**2012/13**								
3.4 Improve the self reported emotional wellbeing of adults	2.23i: Self-reported well-being - % of people with a low satisfaction score	PHOF	4.90%	4.4%	Low	↓	4.87%	5.77%	Similar		Annual (Figures will be published in Feb-15)	
	2.23ii: Self-reported well-being - % of people with a low worthwhile score	PHOF	NA	N/A	Low		3.64%	4.36%	-		Annual (Figures will be published in Feb-15)	
	2.23iii: Self-reported well-being - % of people with a low happiness score	PHOF	6.50%	8.5%	Low	↑	9.49%	10.36%	Similar		Annual (Figures will be published in Feb-15)	
	2.23iv: Self-reported well-being - % of people with a high anxiety score	PHOF	20.10%	18.7%	Low	↓	20.71%	20.98%	Similar		Annual (Figures will be published in Feb-15)	
local indicators	**baseline**		**2013/14**	**2014 / 15**								
number of new mental health and wellbeing intiatives started		local	Q1 - 0	Q1 - 0	high	increased				Initiatives include; Depressed cake stall, mental health first aid awareness training, world mental health day mindfullneess		RJ
			Q2 - 0	Q2 - 1								
			Q3 - 0	Q3 - 2								
			Q4 - 1	Q4								
number of people participating in mental health and wellbeing intiatives		local	Q1 - 0	Q1 - 0	high	increased						RJ
			Q2 - 0	Q2 - 30								
			Q3 - 0	Q3 - 100								
			Q4 -30	Q4								
3.6 Increase the percentage of eligible population aged 40-74 offered an NHS health check	2.22ii: % of eligible population aged 40-74 offered an NHS Health Check	PHOF/	N/A	2013/14 19.1%	High	N/A	17.10%	18.40%			Updated annually on PHOF, but we will be able to provide quarterly figures.	
3.6 Increase the percentage of eligible population aged 40-74 receiving an NHS health check	2.22ii: % of eligible population aged 40-74 who received a Health Check	PHOF/	N/A	2013/14 8.0%	High	N/A	6.60%	9.00%				
local indicators			**2013/14**	**2014/15**								
number of people offered an NHS health check			Q1 2,012	Q1 1,407 (2.9%)		↓	20% - 9,585	20% - 9,586	Similar		quarterly	EC
			Q2 2,429	Q2 1,780 (3.7%)		↓						EC
			Q3 2056									
	Total Target for 2014/15 - 9720		Q4 2079									
number of NHS health checks completed			Q1 753	Q1 585 (1.2%)		↓	10% - 4,792	10% - 4,793	Similar			EC
			Q2 916	Q2 740 (1.5%)		↓					quarterly	EC
			Q3 1057									
	Total Target for 2014/15 - 4860		Q4 1126									

3.7 decrease excess weight in adults	prevalence of overweight and obese adults	Active People Survey		2012 65.5%	low		63.10%	63.80%	similar	estimated and self reported	annual	
local indicators	**Total Target**		**2013/14**	**2014/15**								
number of Eat 4 Health (E4H) or Barometer courses run in West Berkshire	N/A		Total Barometer 3 Dietitian led course NA total E4H 8	Q1 Barometer Q2 Barometer - 1 Q1 E4H 21 Q2 E4H 5 Q1 Dietitians 2 Q2 dietitians 2 **Grand Total - 31**								LW
number of people completing a weight management course	N/A		total E4H 140 Barometer 20 Dietitian led course	Q1 Barometer Q2 Barometer - 9 Q1 E4H 88 Q2 E4H 27 Q1 dietitians 11 Q2 dietitians 11 **Grand Total - 146**								LW

Promoting independence and supporting older people to manage their long term conditions

Appendix 1

Overarching indicator	Specific indicator			West Berkshire outturn	'Good' is…	Direction of Travel on previous outturn	Benchmarks			Data caveats:	Frequency:	Lead
	Detail	Source	Baseline				South East	England	Comparison with England value			
4.1 Decrease the under 75 mortality rate from cardiovascular diseases considered preventable	4.01: rate of death per 100,000 of people under age 75 from CVD considered preventable	PHOF	**2010/12** 43.3/100,000	**2011/13** 47.3/100,000	Low	↑	42.5 per 100,000	50.9 per 100,000	Similar	three year rolling averages	Annual	CCG
local indicators												
see indicators for smoking, physical activity and weight management												
CCG indicators												
4.2 Decrease the rate of emergency admissions for fractured neck of femur in those aged 65 and over	4.14i: Rate of emergency admissions for fractured neck of femur in those aged 65+ per 100,000 population	PHOF	2011/12 577/100,000	**2012/13** 552/100,000	Low	↓	553.8/100,000	568.1/100,000	lower		Annual	CCG
CCG indicators												
4.5 Increase the proportion of people who feel supported to manage their long term condition	Directly standardised % of people who feel supported to manage their LTC	HSCIC GP Patient Survey	July 2012-March 2013 72%	July 2013 - March 2014 70.6%	high	↓		65.10%	better	sample survey	annual	CCG ASC
CCG indicators			NDCCG	NDCCG								

Giving every child and young person the best start in life

Appendix 1

Overarching indicator	Specific indicator			West Berkshire outturn		'Good' is…	Direction of Travel on previous outturn	Benchmarks			Data caveats:	Frequency:	Lead
	Detail	Source	Baseline					South East	England	Comparison with England value			
Improve the emotional wellbeing of looked after children	2.08: Emotional wellbeing of looked after children - Average difficulties score for all looked after children aged 4-16 who have been in care for at least 12 months on 31st March	PHOF	2010/11 15.8%	2012/13 16.4%		Low	↑	14.8%	14.0%	Not compared	This indicator can be affected by the relatively low cohort of looked after children in West Berkshire. For example, March-13 figures included the 'Strengths and Difficulties' scores for 55 children in West Berkshire.	Annual (Mar-14 data will be available in December 2014). Could Children's Services provide a snapshot at the end of each quarter?	C&YP
local indicators	**baseline**												
Children and yp indicators													
Improve breast feeding rates at 6 8 weeks after birth	2.02ii: Breastfeeding prevalence at 6-8 weeks after birth	PHOF	Not available	2012/13 55.6%	**2013/14** No Data	High	↓	50.06%	47.22%	Significantly better			FN

Supporting a vibrant district

Appendi

Overarching indicator	Specific indicator			West Berkshire outturn	'Good' is…	Direction of Travel on previous outturn	Benchmarks			Data caveats:	Frequency:	Lead
	Detail	Source	Baseline				South East	England	Comparison with England value			
2.5 Decrease statutory homelessness - homelessness acceptances and households in temporary accommodation	1.15i: Homelessness acceptances per 1,000 households	PHOF	2011/12 1.00/1000	2012/13 1.00/1000	Low	↓	1.53	2.31	Significantly lower		Annually updated on PHOF, although you may find that your Housing dept have monthly/quarterly stats	
	1.15ii: Households in temporary accommodation per 1,000 households	PHOF	0.8/1000	2011/12 0.77/1000	Low	↓	1.23	2.32	Significantly lower		Annually updated on PHOF, although you may find that your Housing dept have monthly/quarterly stats	
local indicators	**baseline**											
Adult services indicators												
2.4 Decrease the percentage of households that experience fuel poverty	1.17: Fuel Poverty - The percentage of households that experience fuel poverty based on the "Low income, high cost" methodology	PHOF	2011 6.8%	2012/13 6.6%	Low	↓	8.20%	10.90%			Annual (2012 figures will be published in Nov-14)	
local indicators	**baseline**											
envirnoment services indicators												
2.9 Reduce domestic abuse	1.11: Rate of domestic abuse incidents reported to the police per 1,000 population	PHOF	2011/12 18.63	2012/13 19.4	Low	↑	16.21	18.15	Not compared		Annual (Figures will be published in Feb-15)	
local indicators	**baseline**											
community safety indicators												

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Suicide and Self Harm Risk Reduction in Berkshire
Final draft Strategy

14th October 2014

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With many additions from a wide range of stakeholders in:

- **Commissioners**
- **Primary care**
- **Secondary care**
- **Local authorities**
- **Voluntary organisations**

Acknowledgement
This draft strategy drew on frameworks developed by the Bolton and SPIN (Thames Valley) suicide reduction alliances.

Executive summary

This is a draft strategic framework for reducing suicide and self-harm risk across Berkshire. It key elements are:

- Many stakeholders have contributed to this draft strategy and now recommend it to the CCGs in the east and west of Berkshire.
- Stakeholders have made recommendations for the objectives and membership of a Steering Group – comprising senior staff from the main organisations (Council, NHS, voluntary groups) to actively implement the strategy across East & West Berkshire.
- Stakeholders recommend that the CCGs and the Steering Group use the 'Whole Picture' Public Health framework (Figure 1) as the basis for their ongoing work in reducing and preventing suicide and self harm, and recommend any necessary actions to CCGs and Health & Wellbeing Board for improving preventive support to people at risk.
- Steering Group should ensure that a multi-agency confidential continuous audit of suicide and self-harm in the county informs their work.
- CCGs will wish to commission services accordingly.

Figure 1 – Comprehensive Public Health Framework for Reducing Suicide and Self Harm Risk

ECONOMIC & SOCIAL DETERMINANTS	PREVENTION	SCREENING, DETECTION, AWARENESS	PRIMARY CARE	SECONDARY CARE	SOCIAL CARE, EMERGENCY SERVICES, SERVICE USERS…
Targeted help in debt & unemployment	Improve mental health and behaviour in schools and at work	Set up active multi-agency audit and review group	Awareness training for GPs & other primary care staff	Implement Open Dialogue approach across Berkshire	Awareness training for front line staff
Target isolated, lonely, distressed groups	Use continuous audit to identify groups at risk	Identify children & adolescents at higher risk	Improve reception for people in distress	Ensure high quality self-harm service in A&E	Make bereavement support rapid and well-coordinated
Increase educational attainment for the most disadvantaged	Councils actively mitigate impact of economic & benefit changes	Train front line staff in awareness, assessment and sign posting	Map disability & chronic illness of those with mental health problems, liaise with providers, inc IAPT	Identify the barriers to vulnerable people using services	'No blame' debrief for staff affected by suicides, inc emergency services
Help mentally ill people to stay in employment and education	Initiatives for groups at higher risk: Looked After Children, Lesbian, Gay, Bisexual and Transgender	Involve agencies in touch with people at high risk	Improve referral routes for people at risk	'No blame' debriefing within secondary care	Target information to groups at risk about support in crisis
Increase access to social justice	Implement Open Dialogue approach for people with schizophrenia	Support people who know someone at risk	Reduce barriers to health-seeking behaviour among people at risk	Crisis support and Home response services	Influence bigotry, bullying, discrimination
Targeted help when at risk of losing home	Targeted support to families to prevent violence, emotional neglect	Run Berkshire conference on suicide, self harm and adolescents	'No blame' debriefing within primary care	Awareness training for front line staff including ambulance staff	Reduce access to the means of suicide
Liaison with criminal justice system, forensic team, court diversion team	Training for all staff in stakeholder organisations				
	Access to on-line and other resources				

1.0 The wider background

1.1 Suicide is a devastating event. It is an individual tragedy, a life-altering crisis for those bereaved, and a traumatic event for communities and services. The impacts are immediately and profoundly distressing. We thus need to be sure that in the Clinical Commissioning Groups (CCGs) and Local Authorities in Berkshire, an alliance of stakeholders takes preventive and ongoing action covering the main risks. The 2012 national strategy ('Preventing Suicide in England') sets us two major objectives: reducing the suicide rate in England, and giving better support to people bereaved or affected by suicide. Those objectives are thus given priority in this draft strategy. Self harm is inextricably linked with suicide and its prevention has been incorporated here.

1.3 Suicide is not inevitable. Preventing suicides is a complex and challenging issue, but there are effective solutions for many of the individual factors which contribute towards the risk of suicide. Suicide Prevention work is cost-effective when conducted in accordance with evidence of effectiveness, and by working in partnership. Local Government, statutory services, the third sector, local communities and families each have a role to play.

1.4 While self-harm and suicide have a big negative wellbeing impacts on family, friends, colleagues, they also have a huge economic impact. The average cost of a single completed suicide of a working age individual in England was estimated in 2012 to be more than £1.5 million. This includes intangible costs (loss of life to the individual and the pain and suffering of relatives), as well as waged and unwaged lost output, public service time and funeral costs. Non-fatal self harm also has major – potentially avoidable - cost implications for public services, particularly A&E and acute inpatient services and psychiatric follow-up.

2.0 Local background

2.1 In 2014, the CCGs asked Public Health to recommend a strategy for reducing suicide risk across Berkshire. This draft is the result of a study of national research and recommendations plus recommendations of many local stakeholders from a range of organisations.

2.2 This draft proposes co-ordinated prevention across all the elements influencing suicide and self harm, from the wider determinants of distress and escalating desperation, and poor mental health, through coordinated local preventive action spanning local authority and voluntary services, and primary and secondary care.

3.0 Aims and objectives of the suicide prevention strategy

3.1 The aims of this draft strategy are

- To reduce the suicide rate in local authority areas in Berkshire and give better support to people bereaved or affected by suicide.
- To reduce the local self-harm rate and ensure good support to people who have harmed themselves.

3.2 Objectives

1. Agree to take comprehensive action across social and economic determinants, prevention, risk assessment and identification of groups at higher risk, while ensuring health services, local authorities and voluntary services provide good quality support; establish a very active self-harm and suicide prevention steering group for Berkshire, to lead this work.
2. Develop continuous multi-agency audit of both self-harm and suicide (including any emerging trends or patterns) across Berkshire in order to inform and implement the aims and objectives.
3. Translate local and national intelligence and research findings into useful local action, especially commissioning, training and service quality improvement.
4. Focus on individuals and groups at high risk and continuously develop local interventions to support them in reducing their distress; ensure that barriers to support are reduced (these actions will be co-ordinated between local authorities, NHS and voluntary groups).
5. Ensure that people bereaved and affected by the suicide or self harm of others receive a rapid and automatic offer of support
6. Develop effective action, both preventive and responsive, for people who harm themselves.

4.0 Objective 1

4.1 Recommendation - Agree to take comprehensive action across each CCG on social and economic determinants, prevention, risk assessment and identification of groups at higher risk, while ensuring health services, local authorities and voluntary services provide good quality support. Establish a steering group to lead this.

4.2 Figure 1 shows the main factors influencing suicide and self harm, and key local ways to address them.

4.3 It can be seen from Figure 1 that if only part of the ‘spectrum’ is tackled, vital elements will be missed. For example, if action concentrates mostly on secondary mental health services, then people in severe distress because of issues like impending homelessness or the loss of a loved one (but who have no contact with mental health services) would not be helped. This would probably preclude them getting any preventive help to avoid getting into difficulties in the first place, and thus professionals would only be

able to intervene when the client is already in a rapidly-escalating crisis. Similarly, if our action was to concentrate just on primary care, or on A&E, major opportunities to prevent bullying in schools and at work will be missed, and the later mental health consequences on self harm and suicide will not have been prevented.

4.4 Unless action is also taken to strengthen community cohesion, a strategic opportunity would be lost to address the big risk factors of isolation, loneliness and depression (and their mental health and suicide risks) of older people, people with physical impairments, chronic disease and those isolated by discrimination.

4.5 Local Authorities have major potential to influence mental wellbeing, whether through housing, social care, employment conditions, support to children and young people at risk, support to parents or many other services. Mental health services can have major impacts on people with severe mental illness (often at higher risk) and can, by working with local authority services, have a major impact on their ability to cope with stressful factors.[1] IAPT and other primary care services help people with depression, but it can often be non-clinical 'gate-keeping' staff who can make the difference between whether patients with escalating distress feel they will get help from services or not.

4.6 While the numbers of suicides each year in Berkshire are unlikely to be especially high (because of the relative affluence of the county) every suicide is a major tragedy and missed opportunity to have helped. And each one has major impact on friends, families and colleagues. They also have major impact on people in services, such as police, social care, mental health services, Primary Care. Each time someone harms themselves and ends up in A&E, other people are similarly affected. Local Authority staff who were working with a young person who harm themselves can be profoundly distressed. And the knowledge that someone you know has been talking about suicide as a possibility is enormously worrying for friends, families and professionals. The steering group should thus use Figure 1 to address this wider impact.

4.7 All these factors may be more, or less, relevant in Berkshire. The first key actions to implement this strategy are therefore

- **to agree to establish an active steering group, with membership to include Social Care, GP, acute services, mental health services, Public Health, voluntary group, emergency services and perhaps Urgent Care Board to oversee this work on behalf of the CCGs, and,**
- **for a Steering Group to review the local situation using Figure 1 as a checklist to ensure that all the main factors are being addressed, and to recommend action where they are not**.

[1] For example, social care, housing and mental health staff already work together to support people with mental illness, but may need to work with employers and colleges to enable them to stay in work. In the UK there is high unemployment among people with psychoses, whilst in Finland, 75% of them are supported to remain in work and to live at home.

4.8 There will be many good opportunities for this group to spot opportunities and to address them, and for CCGs then to commission for better quality, more coordinated support for people at risk.

4.9 We recommend that the initial objectives of the Berkshire Steering Group should be:

1. Audit and monitor the epidemiological patterns of suicide risk in Berkshire; (this should be linked with Serious Incident Case Reviews (SIRIs) where appropriate, and avoid duplication of effort)
2. Translate local and national intelligence, research and policy into locally meaningful recommendations
3. Focus on action to reduce suicide risk across the whole spectrum (Figure 1) as the key outcome, and develop methods of measuring progress
4. Maximise opportunities to recognise and reduce risk by engaging a network of key stakeholders, statutory Safeguarding links, service leads and service user representatives in that 'whole picture' action
5. Prioritise the setting up of rapid bereavement support for those affected by others' suicide or self harm
6. Ensure that training is offered to large numbers of local authority, NHS and voluntary personnel who can influence the 'whole picture'
7. Make recommendations for action to the Safeguarding Board and the Health & Wellbeing Boards; these recommendations could include suggestions about how to drive down local numbers, and whether suicide should be regarded as a 'never event' rather than pursuing a more pragmatic 'have a go' aspiration. They should be linked to the relevant Outcomes Frameworks.

4.10 The Steering Group would also need to ensure they use the Government's national recommendations in carrying out their work. Those are:

1. Reduce the risk of suicide in key high-risk groups
2. Tailor approaches to improve mental health in specific groups
3. Reduce access to the means of suicide
4. Provide better information and support to those bereaved or affected by suicide
5. Support the media in delivering sensitive approaches to suicide and suicidal behaviour
6. Support research, data collection and monitoring
7. Develop effective action, both preventive and responsive, for people who harm themselves.

Most recent guidance issued by Public Health England (PHE gateway number 2014346, 1 Oct 2014) recommends the following actions for local areas:

- If not already in place, local areas should consider a local suicide prevention action plan that is kept up to date and fits local circumstances.
- Local Directors of public health are well placed to lead the local data monitoring/surveillance function.
- Local areas consider creating local forums to monitor suicide trends, rising threats (e.g. social media) respond to incidents, co-ordinate and deliver the suicide prevention strategy locally.
- Engage with local media regarding suicide reporting.
- Work with transport and other partners in health and wellbeing boards on mapping suicide hot spots and take appropriate actions.
- Working on local priorities to improve mental health. Both promotion of good mental health and prevention

5.0 Objective 2

5.1 Recommendation - Develop continuous *multi-agency* audit of suicide (including any emerging trends or patterns) across Berkshire in order to inform and implement our aims.

5.2 In order to have useful information about risk factors (and hence groups and individuals potentially at risk of suicide), the Steering Group would need good local intelligence.

5.3 Traditionally, mortality files (which contain very basic data extracted from death certificates) provide local information about age, gender, occupation and cause of death. This gives a useful – but rudimentary – local picture of numbers and methods of suicide. It may enable local authorities to identify, for example, 'hot spots' for suicide. But it gives no clues about motive, risk factors, life events, illness, or anything about whether the deceased got or tried to get help from services.

5.4 The suicide prevention alliance needs data that might enable preventive action to be taken, and should gain this by the Steering Group developing confidential continuous multi-agency audit of self harm and – especially – suicide data. This would involve the Steering Group setting up an audit team, led by a senior local professional or clinician (for example a GP, psychiatrist, social worker or Consultant in Public Health) and including staff members from mental health, local authority (e.g. social care, children & families, housing), to gather confidential data on each death. This would include Coroner's data, and any data about any contact the deceased had with local services. This would inform local preventive action and allow the Steering Group to determine any particular local risk factors. When conducted in a sensitive and 'no blame' way, this should enable the alliance to identify possible risk factors or even 'hot spots' so that preventive measures can be considered.

5.5 Public Health and the Coroner began the first stage of this audit in September 2014.

5.6 Identifying any particular local risk factors
(As a useful example of 'local intelligence', Bolton's suicide prevention alliance's multi-agency audit enabled them to identify a specific unusual pattern of deaths among women in a particularly age group, in contrast to the 'usual' pattern of men tending to have higher risk. The Bolton alliance were able to use multi-agency audit to identify that this particular cluster had some specific high risk factors and also history of contact with specific services. This is the kind of local data that could enable a steering group to ensure that specific help is developed.)

5.7 Drug overdoses are a fairly common means of self-harm and suicide, and stakeholders recommended examining whether pharmacists could be engaged in reviewing access to over-the-counter medicines.

5.8 The Steering Group could also recommend how the local Joint Strategic Needs Assessment should be developed so as to provide useful epidemiological data to assist all this ongoing work. While the JSNA only provides non-confidential information, nevertheless, local data relating to any of the risk factors for suicide and self harm (for example, epidemiological analyses of disadvantage and deprivation, mental health, disability, distribution of chronic illness) can assist the suicide risk reduction work in the short and medium terms.

6.0 Objective 3

6.1 Recommendation - Translate local and national intelligence and research findings into useful local action, especially commissioning, training and service quality improvement

6.2 The CCG could ensure that the Steering Group would use local and national information to recommend action. The CCG could commission accordingly. One good example of how to reduce suicide risk can be found in Bolton's strategy, and it can easily be seen how a very similar approach could be used in Berkshire:

> 'General Practices can make a big difference to suicide rates. GPs regularly encounter people with many of the known factors for higher risk of suicide, for example long-term physical health problems, self-harming, drug and alcohol misuse and mental health problems. GPs are the first point of contact for many people who are experiencing distress or suicidal thoughts and who may be vulnerable to suicide. GPs can help by providing information on sources of support and are also the key gatekeepers to specialist services. Primary Care staff may also be the first point of contact for people who are bereaved or affected by the suicide of family members, friends and colleagues.'

> Health visitors, midwives and other community staff may be in contact with children, young people and families and be the first to be aware of mental health problems or other difficulties developing. They can therefore provide direct support and also refer speedily to other services. *(Bolton Council (2013).*
> *Acting on evidence: A strategic framework of evidence based recommendations for preventing suicides in Bolton (2013-16))*

6.3 Local stakeholders have made the following recommendations for coordinated preventive awareness training to improve mental health and behaviour in schools:

6.4 Stakeholders consulted in drafting this strategy recommended using a coordinated approach for comprehensive awareness training about self-harm and support for all relevant local professionals who work with children and young people, including those working in:

- Perinatal mental health (midwives, maternity care, health visitors)
- Schools and early years settings
- Children's Centres'
- Youth workers
- Voluntary and PVI sector
- School nurses
- Community leaders/faith leaders
- Primary care staff including GPs
- Youth offending teams
- Looked After Children's teams
- Social care
- Family nurse partnership practitioners.

Note: It will be important, when approaching self harm among young people, to coordinate this work with inclusion and CAMHS initiatives. The relevant CAMHS pathway is included as Appendix 4.

7.0 Objective 4

7.1 Recommendation - Focus on individuals and groups at high risk and continuously develop local interventions to support them in reducing their distress; ensure that barriers to support are reduced (these actions will be co-ordinated between local authorities, NHS and voluntary groups)

7.2 Many people who take their own lives are believed to have found themselves facing multiple difficulties all at once in their lives. While we may cope well if we face one or two, if we then encounter more, we can quickly become very distressed. If our usual ways of coping with difficulties don't seem to work anymore, we can rapidly face severely escalating distress. If we try to get support, but services seem inflexible, it is easy to become hopeless.

People who live with disadvantage are more likely to already have to cope with more difficulties (risk factors). Disability, lack of money, constant difficulty in trying to ensure your family have decent housing, all these are stressful. Sudden changes – especially things like loss of employment and its consequences for debt – make a huge difference.

7.3 Some residents already face multiple difficulties that may not go away. Losing a partner after many years, or a series of losses, having been a Looked After Child, having a major physical or mental impairment, being old and having no social contacts any more, and especially having a severe and enduring mental illness, all weight the scales heavily against wellbeing. Stakeholders recommended that loneliness be taken very seriously as a risk factor. If someone already has more than one of these factors, encountering other severe life events can more quickly lead to escalating distress and hopelessness.

7.4 Individuals facing these difficulties may not be able to see a way out of it. But an alliance of local services actively working to ensure no-one faces too many without support could anticipate and prevent some of the likely risk and harm. Figure 1 thus gives us a potential framework for seeing how local services could act as effective buffers – and in some cases potential life-savers – for people encountering multiple risk factors for suicide. But their effective use by the Steering Group may also rely on the Steering Group having identified local 'groups' at risk. (To do this the Steering Group will need to audit suicide and self harm data from the past few years to see if any patterns appear.)

7.5 National research suggests that many of the following are risk factors for suicide:

- Socioeconomic deprivation
- Social isolation, living alone, loneliness
- Depression/stress
- Long term and/or distressing physical health conditions
- Relationship problems
- Bereavement
- Domestic violence
- Problems at work
- Recent unemployment, redundancy
- Facing discrimination or bullying
- Drug and alcohol problems[2]
- Criminal suspicion or conviction which has the potential to significantly disrupt life

[2] Stakeholders recommended that the Steering Group should actively examine the extra risk placed by increased access to alcohol (for example, 24-hour selling and home delivery of alcohol) and drugs, and propose action on local alcohol licensing, for example.

- History of suicide attempts (especially)
- Self-harm (It will be very important for the Steering Group to distinguish – where possible – between those who self harm in a very serious attempt at suicide and those whose self harm may be less driven by strong intent to die and perhaps more as a more regular means of obtaining temporary relief from unbearable feelings. Stakeholders emphasised that 'We especially need to capture repeated self harm. We may need a more effective system for recording self harm and also for ensuring effective help is given. Need to be able to differentiate between more habitual lower-level self harm and serious attempts that are potentially dangerous. Need to do a trawl of the data, especially in primary care and ambulance services, as well as A&E data. We should not neglect this group.')

7.6 It can easily be seen how mental illness, for example, may also increase the likelihood of an individual experiencing unemployment, low income, having housing problems, having relationship difficulties, and finding themselves isolated. And how much greater the risk might be if they are older and living alone, being exploited, having language barriers… Not all of these will be so relevant in Berkshire, but each of these that a person encounters increases their risk of suicide. There are many services, groups and projects locally which regularly encounter people experiencing one or more of these risk factors and hence their interactions provide opportunities to detect and reduce risk.

7.7 The actions of others can also influence vulnerability to risk, for example through bullying, harassment, stigma and prejudice. Local authority action to support communities to maintain and increase inclusivity and neighbourly support not only has the potential to reduce risk of suicides but, like so much of this work, can reduce distress and improve wellbeing for all. Initiatives that aim to decrease isolation and help people in 'higher risk groups could become important protective factors increasing resilience and reduce risk. The Steering Group could examine whether these are in place.

7.8 Alienation and the feeling of being an 'outsider' develop in adolescence or earlier, and is compounded when peers ridicule apparent differences. Anti-bullying, anti-stigmatising and mental wellbeing improvement measures in schools cannot be emphasised enough here.[3]

7.9 Similarly, when adults facing major barriers to good mental health are bullied at work, this can push them into crisis. Bullying at work is more widespread in UK public and private sectors than is often acknowledged, and has a strong negative impact on mental wellbeing. This is one of the wider determinants of stress and self harm (see Figure 1) and is an important issue for stakeholders to influence.

[3] Stakeholders suggested that the Steering Group should make recommendations based on the report: Department of Education (2014) Mental health and behaviour in schools: departmental advice. London. UK Government.

7.10 The second part of this recommendation is to ensure that support is readily available to people facing multiple risk factors. Stakeholders said: 'We need to identify the points in the 'system' where patients in crisis can get lost, fall through the net. There are missed opportunities to share information. People move around so we may need to share current info of their whereabouts'. It is not enough to say 'services are available'. There is good evidence that the more disadvantaged a person, the harder it is for them to find and make good use of health and other services. People in distress and especially those who are very disadvantaged will tend to find it much more difficult to use services. They face many barriers and will be easily discouraged. Stakeholders said: 'If only a few people with suicidal intent get as far as mental health services, then are we screening properly? People who are fine on Thursday but feel dreadful by Friday need good quick access to effective support'. We must ensure that services are sensitive to the needs of people facing escalating suicide risks and offer help quickly. This is especially true of services that are set up to offer support in times of emotional distress (mental health services, helplines, self-help groups, peer support groups, psychological support) but can be equally relevant to the places where people may present during difficult or vulnerable periods (Citizens Advice Bureau, General Practice, job centres, welfare agencies, food banks). Police, justice services and forensic services should be consulted or involved in this work. There may be a group of people with mental health difficulties in contact with court diversion services, and so on.

7.11 Commissioners of local services need thus to be responsive to needs and also pro-active towards barriers to access faced by vulnerable people. This sometimes requires research and consultation with people who access support or those who may face extra barriers, to ensure they do not quickly decide that there is nowhere to turn. This may involve commissioning active outreach services. The quality of the experience of people using support services is as important as accessibility, in terms of suicide risk reduction. Access often requires vulnerable people to overcome significant personal concerns and reservations about the quality of the service they will receive and the impact it will have. Initial contacts with a service (such as general practice) are often where vulnerable people will make instant judgements about how helpful the support is going to be, and are therefore pivotal in identifying opportunities for support and in identifying risk. (In this context we can more easily see how the attitudes and skills of non-clinical staff are vital since they are often the first point of contact with a service for someone in distress.)

7.12 The Steering Group should work with service users and voluntary organisations and make recommendations accordingly to the CCG and other commissioners about actively ensuring that good support is rapidly available to people facing multiple suicide risk factors.

7.13 Good local information may already be available about the support-seeking behaviours of very vulnerable groups. The Steering Group may wish to recommend how it can be developed more comprehensively so that it informs the suicide prevention approach shown in Figure 1.

7.14 Figure 1 can also be used as a checklist. If the Steering Group wishes to ensure that good comprehensive support is put in place, members can take many of the recommendations in the table and ask themselves: “Does this currently work for someone encountering multiple risk factors for suicide?” “Would someone with a long history of difficulty feel that these services were working and helpful to them?” If the answer is “No” then the Steering Group and the commissioners have an immediate target for improvement.

7.15 As an example of how the Steering Group should approach this, we can try to imagine the following groups who were identified in the National Strategy as high-risk groups who are priorities for prevention, and consider whether we think local services would respond effectively to them is they present with escalating distress due to multiple losses:

• Young and middle-aged men

• People in the care of mental health services, including inpatients

• People with a history of self-harm

• People in contact with the criminal justice system

Would they be likely to get help quickly and easily, particularly at a time when they might be feeling increasingly desperate, isolated and hopeless? Figure 1 might be used as the checklist for this. Similarly, while one service may be helpful, it may not always be easy to ensure smooth referral and quick access between services.

7.16 The Steering Group may want to recommend improving care pathways between key services. For example, how do we imagine those four groups (see bullet points above) might experience coordination between:

- Emergency departments
- Primary Care
- Secondary Care
- Inpatient care
- Community care
- On hospital discharge?

7.17 Bolton Suicide Prevention Strategy lists many pages of comprehensive action lists for action and for multi-agency long-term prevention. This list will be very useful to the Steering Group once their work is underway.

7.18 Stakeholders involved in drafting this strategy recommended examining whether people from any particular cultural backgroups appear at higher risk locally, and if so, whether the Steering Group should recommend action to increase awareness among local faith and/or community leaders.

7.19 Stakeholders recommended that the Steering Group could examine any harmful influences of internet websites providing information on ‘DIY means of suicide’, bullying, trolling etc. (This would be dependent on whether local audit reveals any such influences).

7.20 Stakeholders also recommended examining whether self-harm and suicide risk was elevated among armed forces veterans locally.

8.0 Objective 5

8.1 Recommendation - Ensure that people bereaved and affected by the suicide or self harm of others receive a rapid and automatic offer of support

8.2 It will be very important for the Steering Group to recommend effective action to ensure that friends, family member, colleagues and service providers likely to be affected by someone's suicide are contacted very quickly so as to offer support. It will also be vital that effective support is available. While this may sound like a daunting initiative to set up, examples are available of how this is routinely done, in a sensitive and coordinated way in some areas. For example, in one area of Northern Ireland, family members of someone suspected to have died from non-natural causes will, apparently, automatically be contacted and offered support. Bereavement support should be based on assessment of need.

8.3 Other possibilities include:

- Ensuring that GPs and Primary Care practitioners are aware of the potential vulnerability of family members when someone takes their own life, and how to respond well;
- Providing a system of emotional and practical support for families bereaved or affected by suicide;
- Providing bereaved families with explanation of policies on investigation of patient suicides, opportunity to be involved and information on any actions taken as a result.

9.0 Objective 6

9.1 Recommendation - Involve other local commissioners and stakeholders in the strategy and action, using the 'whole picture' (Figure 1) approach to ensure co-ordinated action at all levels.

9.2 The Steering Group will need to inform the work of the Health & Wellbeing Board, firstly with recommendations on reducing inequalities in mental wellbeing relating to suicide and self harm, but also with recommendations about meeting mortality targets. For example, the Public Health Outcomes Framework (January 2012) includes the suicide rate as an indicator. Further indicators with direct relevance to suicide prevention are '*self-harm and excess under 75 mortality in adults with serious mental illness'*. The indicator on excess mortality is also contained in the NHS Outcomes Framework. Within the Health and Social Care Outcomes, suicide prevention supports '*Safeguarding adults whose circumstances make them vulnerable and protecting them from avoidable harm'.*

9.3 Similarly, *No Health Without Mental Health: Delivering better mental health outcomes for people of all ages* is the latest Government mental health policy, and has an associated implementation framework. The strategy pushes for heavier focus on the mental wellbeing of the population and on early detection and prevention of mental health problems in addition to improvements in services for people with mental health problems. '*No health without mental health'* recommends that local commissioners work towards reductions in suicide rates, especially amongst vulnerable people in mental health services.

9.4 Local authorities and mental health services can between them take effective action to reduce the means of suicide. Suicide can often arise out of impulsive action in response to a sudden crisis or extremely difficult circumstances. Under these circumstances, one of the most effective ways to prevent suicide is to reduce access to high-lethality means of suicide to increase the possibility that the suicidal impulse may pass.

9.5 According to evidence, the suicide methods most amenable to intervention are:

- Hanging and strangulation in psychiatric inpatient and criminal justice settings
- Self-poisoning
- Those at high-risk locations

9.6 It is also important to be vigilant of, and respond to new or unusual suicide methods or patterns. Research and timely audit and monitoring of suicides in local areas can provide useful intelligence on emergent trends and cluster events. Just as local resilience and emergency planning groups can plan highly effective and well-coordinated prevention of disasters, so can local authorities and suicide prevention alliances can seek intelligence from police following initial investigation of the death or through the coroner's office following the police report to the coroner. The media also has an important role in preventing the circulation of detailed information concerning high-lethality suicide as detailed reports may increase the number of fatal suicide attempts. The internet is also a source of information on lethal methods.

10.0 Objective 7

10.1 Recommendation - Develop effective action, both preventive and responsive, for people who harm themselves.

10.2 It is important to ensure that in Berkshire, self-harm is taken very seriously, and that good quality support services are provided rapidly to anyone attending A&E from this cause. Many people who harm themselves are – despite some persistent negative stereotyping – experiencing very severe distress. (See Appendix 1 for examples). Anyone who harms themselves then has a much higher risk of shorter life expectancy because their risk of later suicide becomes a lot higher than the rate in the general population. Men who self-harm are more than twice as likely to die by suicide

as women and the risk increases greatly with age for both genders. It was estimated as long ago as 1994 that one-quarter of all people who died by suicide would have attended a general hospital following an act of self-harm in the previous year.

10.3 About one in six people who attend an emergency department following self-harm will self-harm again in the following year; a small minority of people will do so repeatedly. Many individual episodes of self-harm are indeed a definite attempt to end life, though some may instead be an attempt to get help or support from others. In all cases, they are a very serious attempt to obtain relief from awful and overwhelming situations or emotional states. And in fact the purpose of some acts of self-harm may be the person's attempt to preserve their life (as illustrated by vignettes 3 and 5 in Appendix 1). People who harm themselves as a way of relieving distress (through cutting, for example) may be doing this as their own coping and suicide prevention strategy (as with the person mentioned in vignette 5, Appendix 1). They are likely to continue to need to do this until they receive appropriate and sufficient psychotherapeutic interventions and support, and hence good quality effective psychological support for them is vital.

10.4 Given the big pressures on health and social care, it can be hard for a service to do more than 'patch up' someone who has sought their help. Services – such as crisis intervention – may not be able to do much preventive work. But if the Steering Group promotes a more co-ordinated network of support then Berkshire could have preventive, treatment and support services working actively to provide coordinated and comprehensive suicide risk reduction.

10.5 Self harm is not uncommon among children and young people. A survey of parents published in 2002 of 12,529 children and young people aged 5 years to 15 years reported that 1.3% had tried to harm themselves. In the same year, a survey in schools reported that 13% of young people aged 15 or 16 had self-harmed at some time in their lives and 7% had done so in the previous year. Teachers, parents and school nurses may not know how to respond to young people at risk. The Steering Group could promote a local conference to provide comprehensive information on self harm and suicide risk and prevention for a combined audience of these and other associated groups.

10.6 Self-harm is more common among people who are disadvantaged in socio-economic terms and among those who are single or divorced, live alone, are single parents or have a severe lack of social support. Poverty, childhood experiences of abuse, and experiences of domestic violence are all associated with a wide range of mental disorders, as well as self-harm.

10.7 Studies in the early 1990s showed that self-harm was also much more common among prisoners than among the general population. One-half of female remand prisoners had self-harmed at some time in their lives and more than one-quarter did so in the previous year. The corresponding figures for men were about half of those. Up to 10% of prisoners would self-harm

during their term, and risk increased with length of time in custody. The highest rates were found among sentenced female prisoners who had spent two or more years in prison, 23% of whom self-harmed during their sentence.

10.8 This high rate was largely explained by the fact that, among the prison population, there were much higher levels of the factors associated with self-harm. For example, between 12% and 21% of prisoners had at least four mental disorders simultaneously (including drug and alcohol dependence, personality disorder, neurotic disorder and psychosis); between 35% and 52% were dependent on opiates, stimulants or both; 20%–30% were severely dependent on alcohol; about one-half of female prisoners had suffered domestic violence; 10% of men and 33% of women reported previous sexual abuse.

10.9 Life events are strongly associated with self-harm in two ways. First, there is a strong relationship between the likelihood of self-harm and the number and type of adverse events that a person reports having experienced during the course of his/her life. These include having suffered victimisation and, in particular, sexual abuse. Second, life events, particularly relationship problems, can precipitate an act of self-harm. Many people who self-harm have a physical illness at the time and a substantial proportion of them report that this was the factor that precipitated the act.

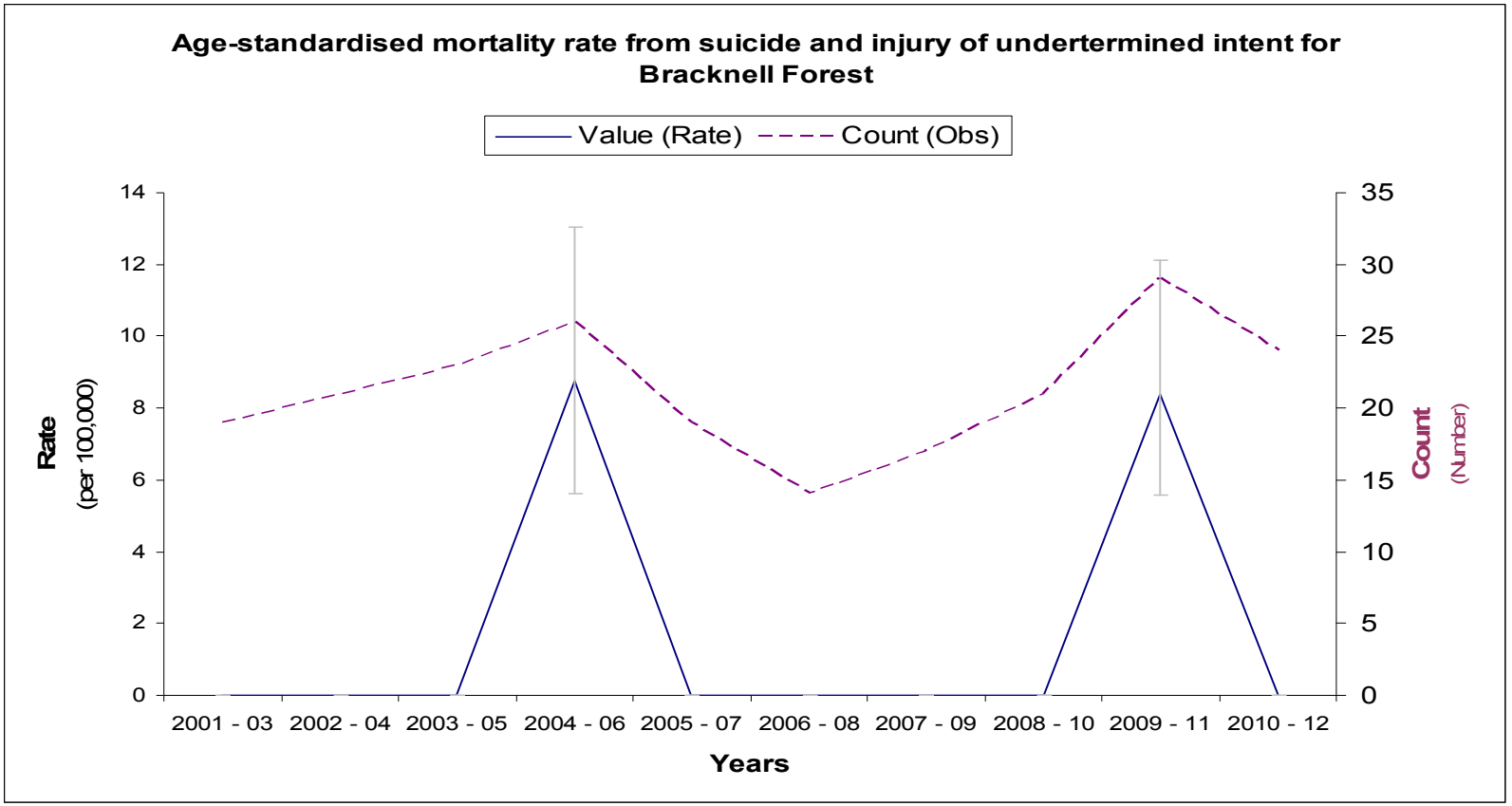
10.10 These research findings imply that local authority programmes can be planned so as to have a preventive impact on pivotal stress and life events among people at risk. For example, elected members in one London Local Authority led collaboration between their Housing, Employment, Public Health, and Children & Families Teams and the mental health services to identify residents at risk from benefit and housing changes and cuts in social care, and planned mitigating support for them. They had identified that mental health service users affected by ‘bedroom tax’ were harming themselves and attending A&E Self-harm occurs in all sections of the population but is more common among people who are disadvantaged in socio-economic terms and among those who are single or divorced, live alone, are single parents or have a severe lack of social support.

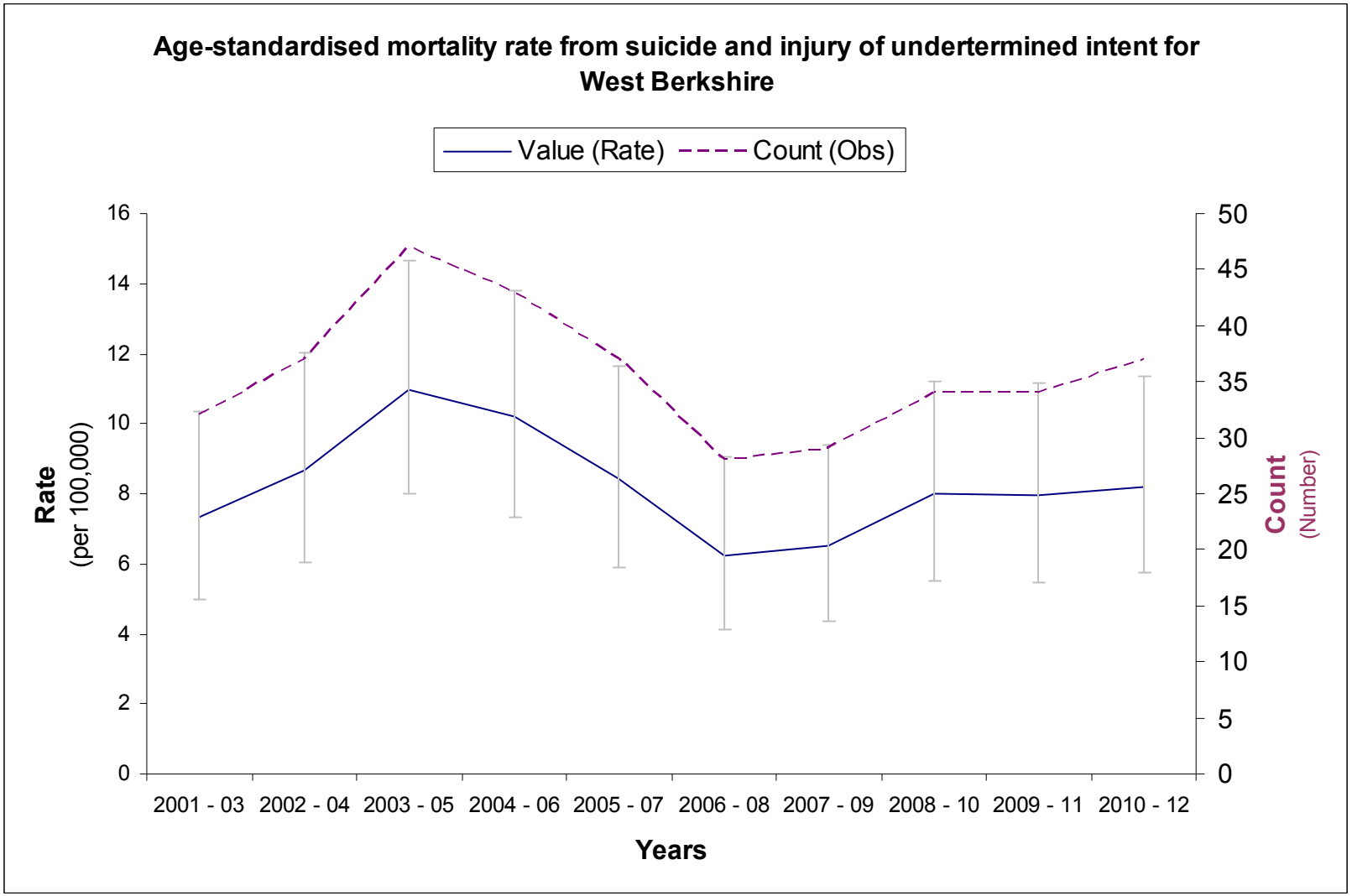
Appendix 1 - Five vignettes to illustrate the diversity of self-harm that falls within the remit of the guideline, and which highlight the seriousness of self-harm. (Source: Extracted from British Psychological Society. (2004). Self-Harm: The Short-Term Physical and Psychological Management and Secondary Prevention of Self-Harm in Primary and Secondary Care.
NICE Clinical Guidelines, No. 16. Leicester. National Collaborating Centre for Mental Health.)

1. A 55-year-old bank manager, married for 30 years and a mother of three children. She has had no recent major adverse life events. At age 30 she suffered a severe depressive illness that responded to ECT. She had been well and on no treatment for 23 years until she became depressed again 'out of the blue'. She became highly agitated and developed the depressive delusion that she was evil and would be responsible for the death of her children. To prevent this she drove to a secluded spot and took 100 tablets of her antidepressant.
2. A 19-year-old student who has no previous history of mental health problems or of self-harm. Towards the end of a party the young man, who had drunk 8 cans of lager, had an argument with his partner, went into the bathroom and swallowed a handful of aspirin tablets. He almost immediately regretted his action and told a friend who phoned for an ambulance which took him to the local emergency department.
3. A 22-year-old unemployed man who was raised in a series of children's homes. He was subjected to repeated abuse as a child and has a history of substance misuse. He has cut his arms since the age of 14 at an average frequency of about once every three weeks. This gives him relief from intense feelings of emptiness and despair. He presents to an emergency department for the third time in a month with superficial cuts to his forearm. He does not describe persisting low mood.
4. An 8-year-old boy, who was conceived when his mother was raped, was brought up by his mother and a stepfather whom the mother quickly married to avoid the shame of an illegitimate child. The boy was nevertheless called 'the bastard' by the stepfather, who also repeatedly sexually abused the boy from when he was about 4 years old. The mother was subject to frequent episodes of domestic violence at the hands of the pathologically jealous stepfather who attacked her for having a child by another man. The mother became depressed and began drinking heavily to 'escape' the beatings. When very drunk, the mother told the boy that her life was a misery and it was all because he had been born. In desperation the boy drank a bottle of bleach believing this would kill him and save his mother. He survived and was diagnosed as being depressed.
5. A woman in her thirties who was sexually abused by her father from the age of 2 until the age of 16. She has taken an overdose on two occasions with suicidal intent, and received life-saving hospital treatment. She also self-harms by cutting her arms and body as a relief from the experience of excruciating emotional pain, and as an alternative to attempted suicide. She describes herself as compelled to do this, and regards it as an act done to herself by herself which inflicts physical wounds with the intention paradoxically of helping herself rather than killing herself.

Appendix 2 - Trends in Suicide and injury of undetermined intent for Berkshire local authorities
Source: Public Health Outcomes Framework 4.10 - 2014

NOTE: Where there is no rate value it is because the Value cannot be calculated as number of cases is too small




Age-standardised mortality rate from suicide and injury of undertermined intent for West Berkshire
Value (Rate)
Count (Obs)
Rate
(per 100,000)
Count
(Number)
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2
4
6
8
10
12
14
16
0
5
10
15
20
25
30
35
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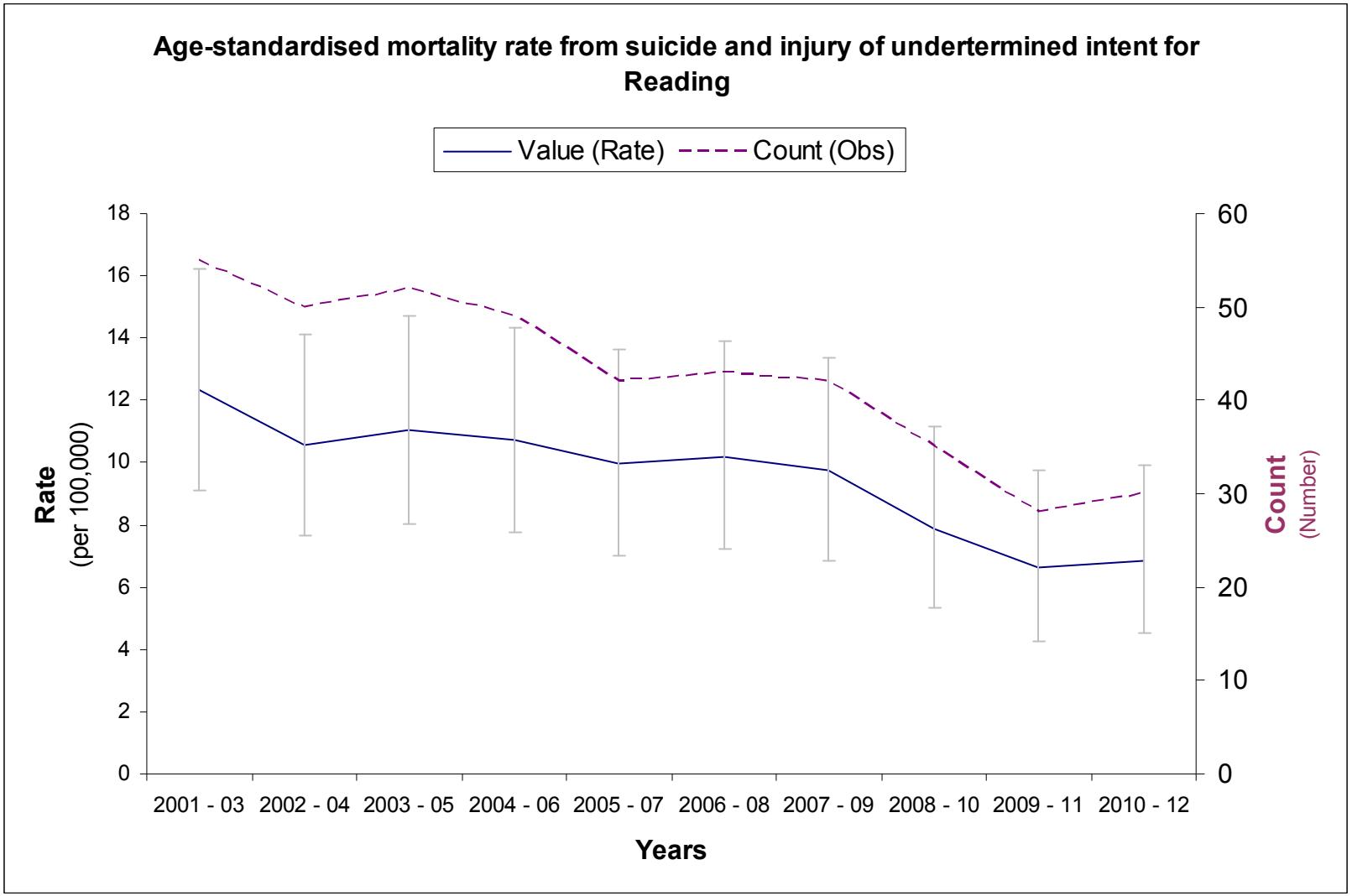
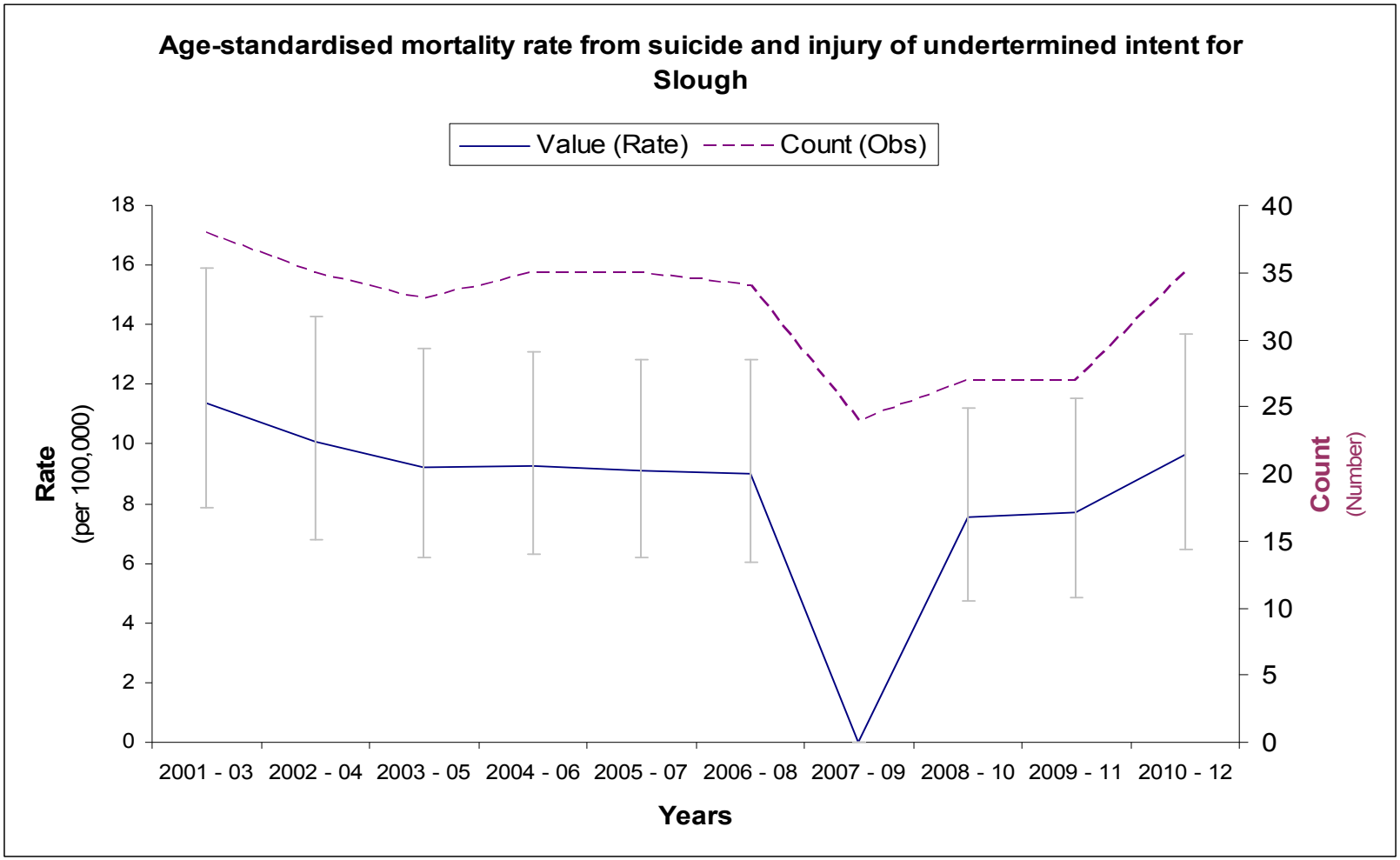
2003 - 05
2004 - 06
2005 - 07
2006 - 08
2007 - 09
2008 - 10
2009 - 11
2010 - 12
Years


Age-standardised mortality rate from suicide and injury of undertermined intent for Reading
Value (Rate)
Count (Obs)
Rate
(per 100,000)
Count
(Number)
0
2
4
6
8
10
12
14
16
18
0
10
20
30
40
50
60
2001 - 03
2002 - 04
2003 - 05
2004 - 06
2005 - 07
2006 - 08
2007 - 09
2008 - 10
2009 - 11
2010 - 12
Years

NOTE: Where there is no rate value it is because the Value cannot be calculated as number of cases is too small



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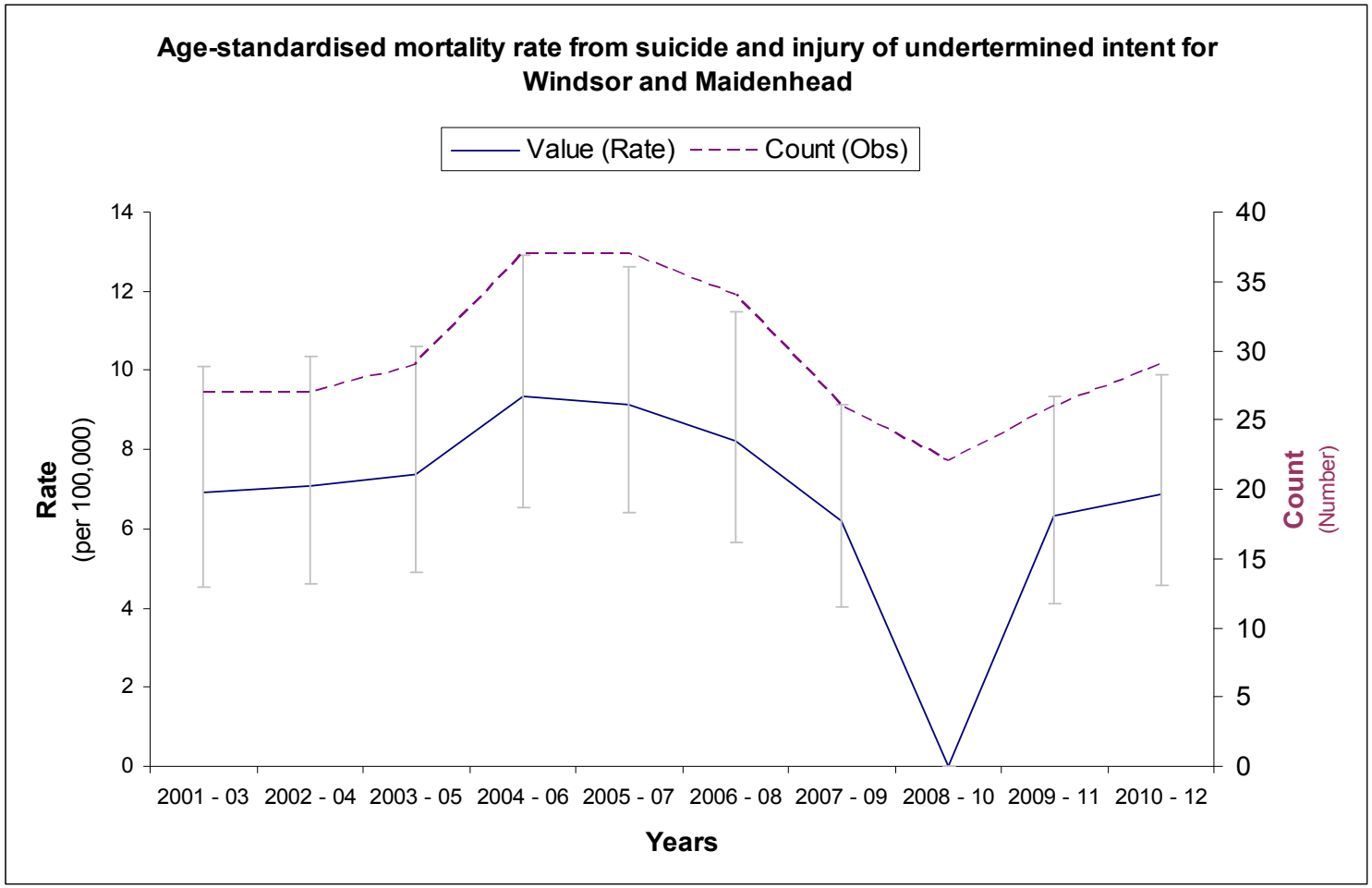

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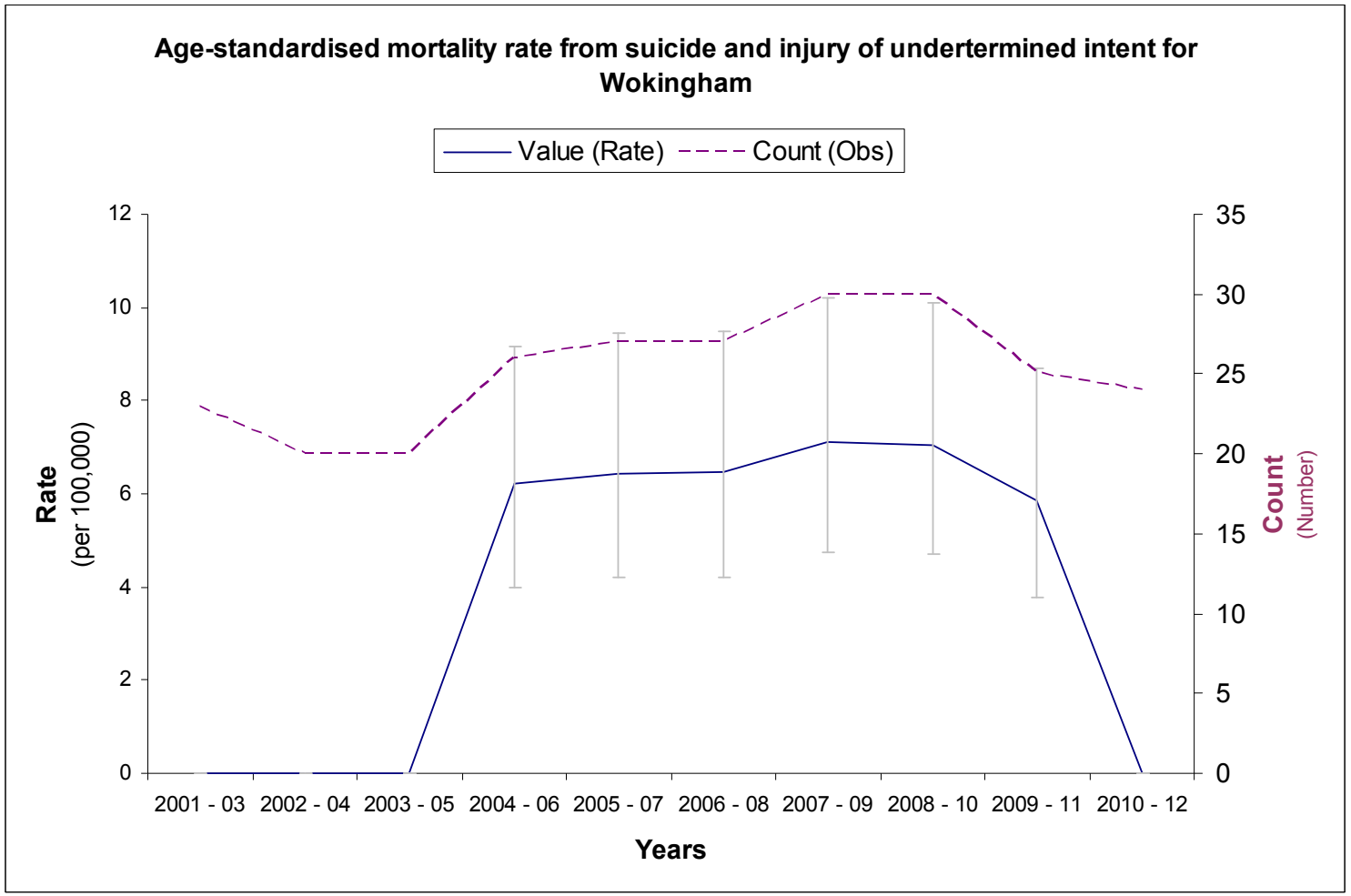
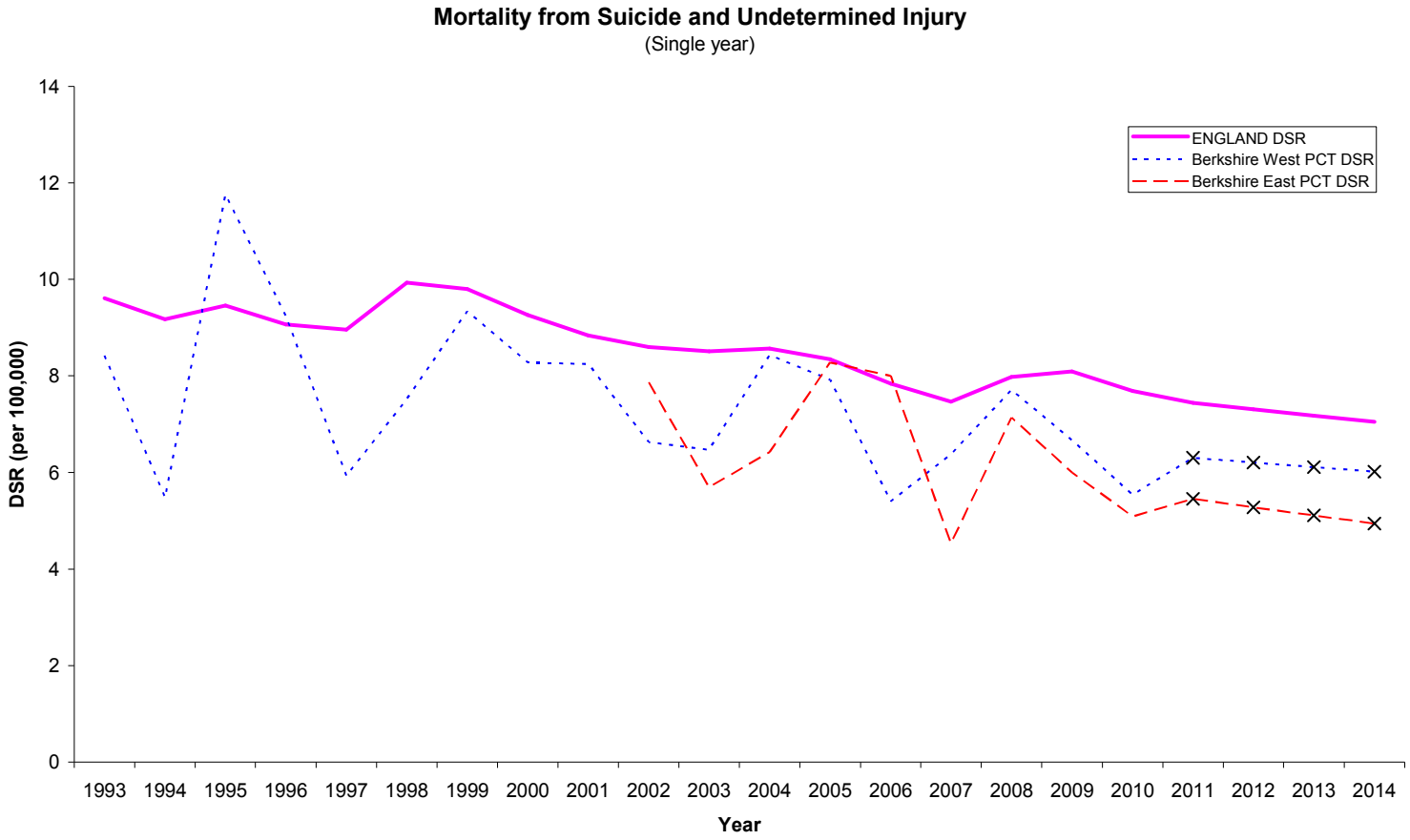


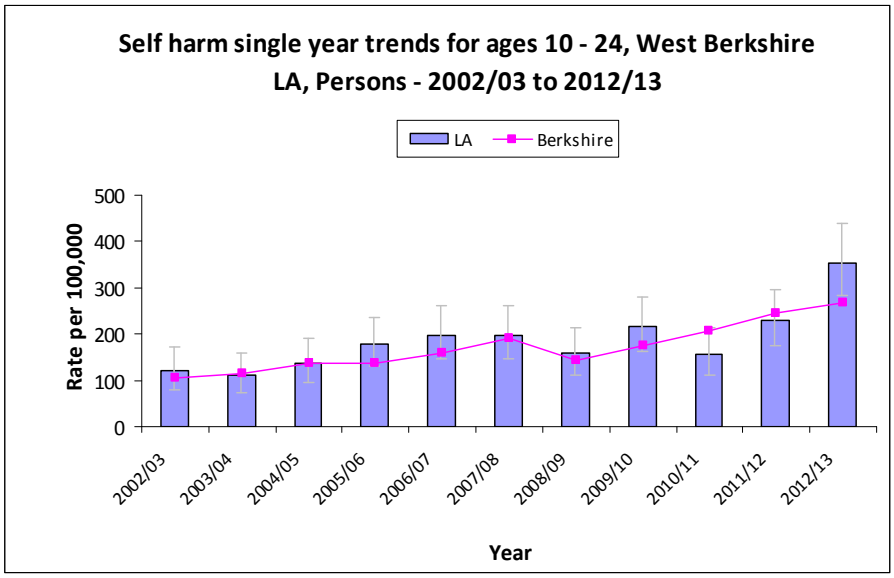
Suicide and injury of undetermined intent for Berkshire PCTs

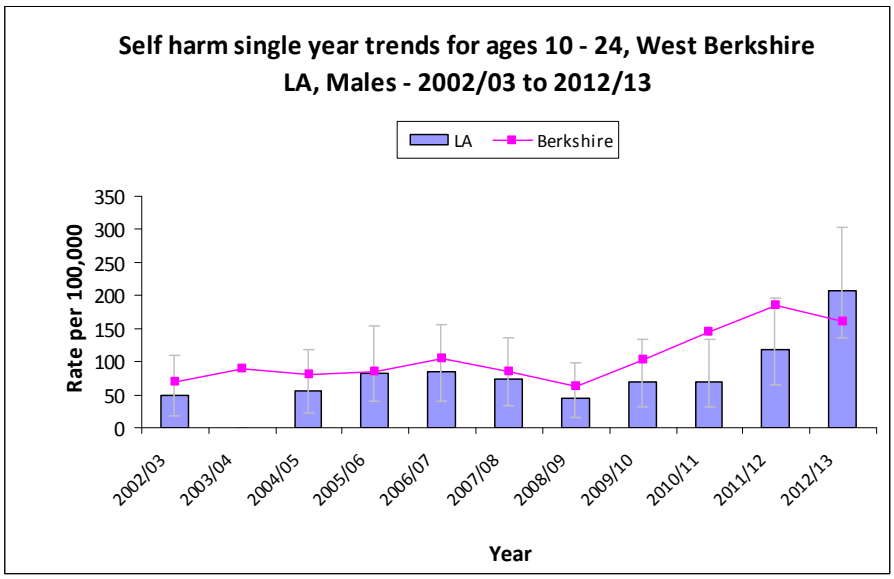
Source: Compendium of Clinical and Health Indicators / Clinical and Health Outcomes Knowledge Base - 2012

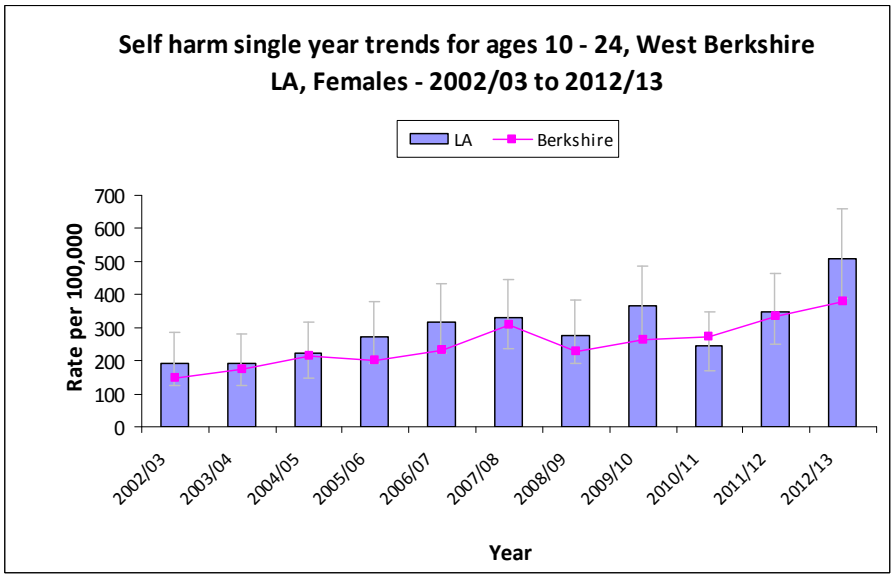


Appendix 3 – Self-Harm Charts

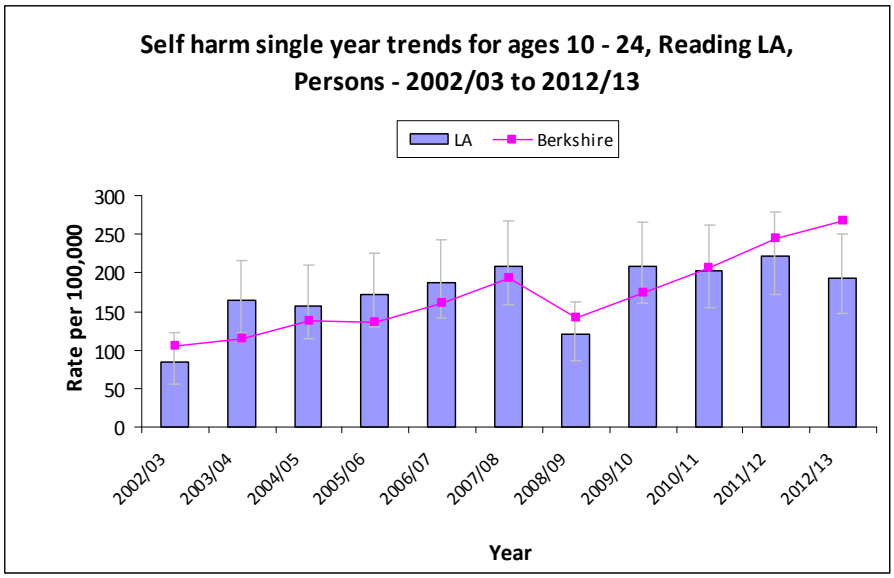
West Berkshire







Reading


Self harm single year trends for ages 10 - 24, Reading LA, Persons - 2002/03 to 2012/13
LA
Berkshire
Rate per 100,000
300
250
200
150
100
50
0
2002/03
2003/04
2004/05
2005/06
2006/07
2007/08
2008/09
2009/10
2010/11
2011/12
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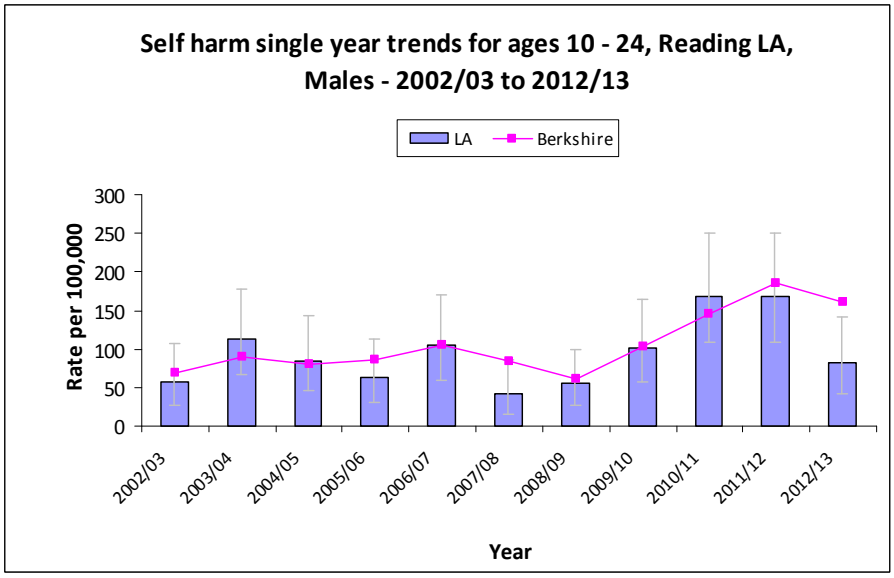
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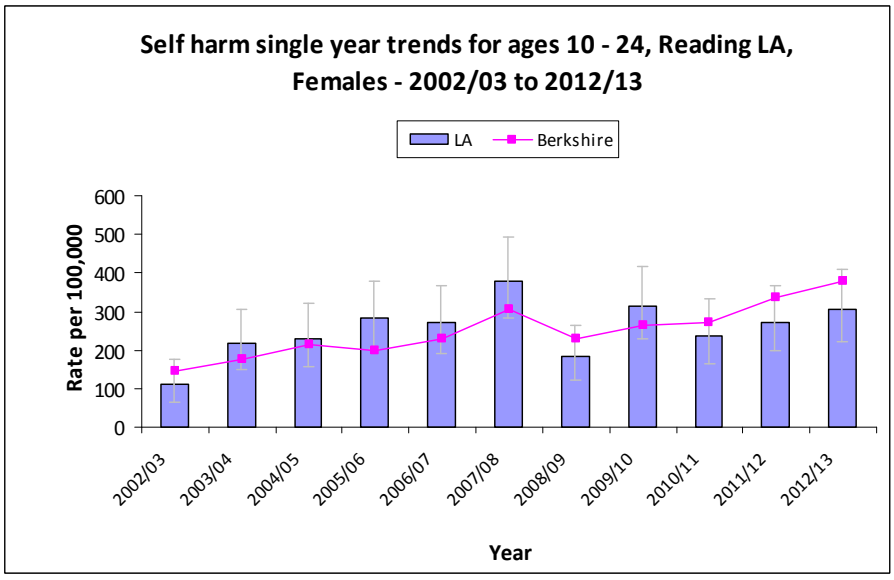
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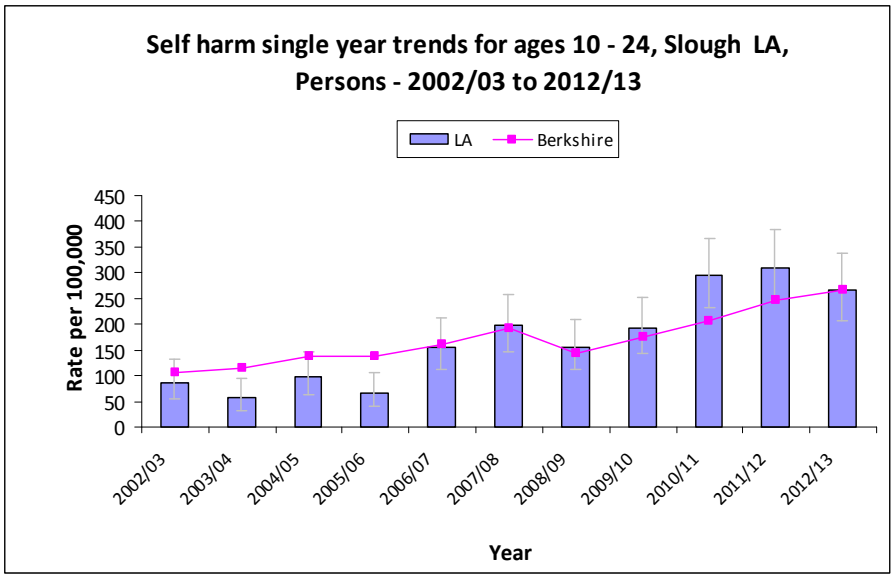
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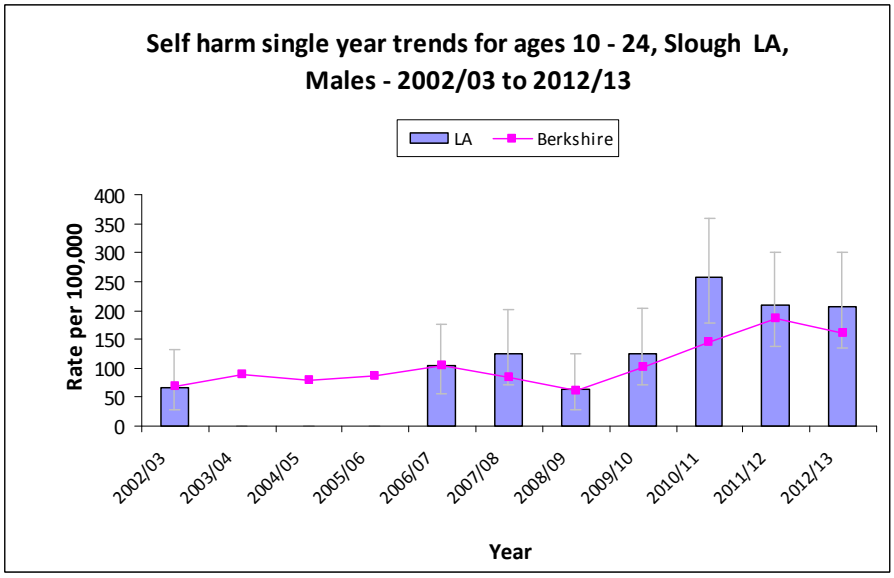
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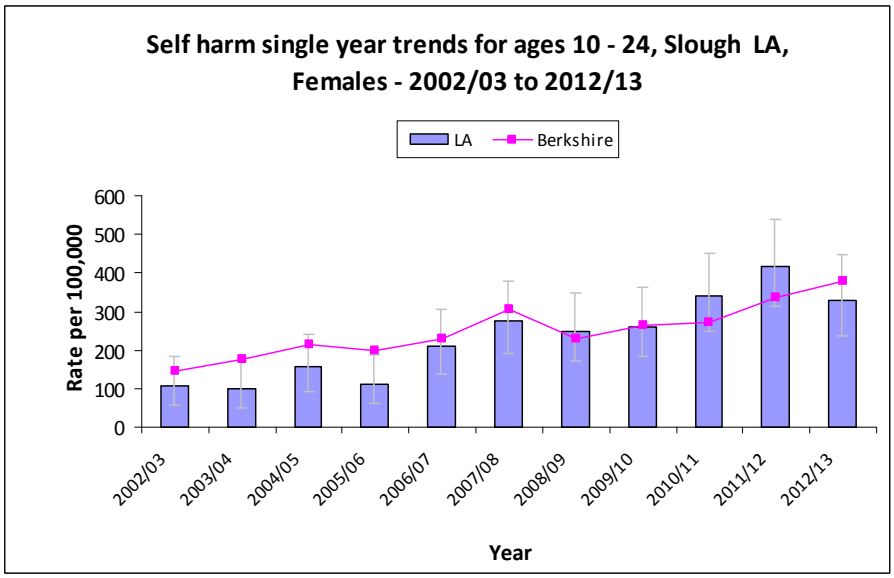
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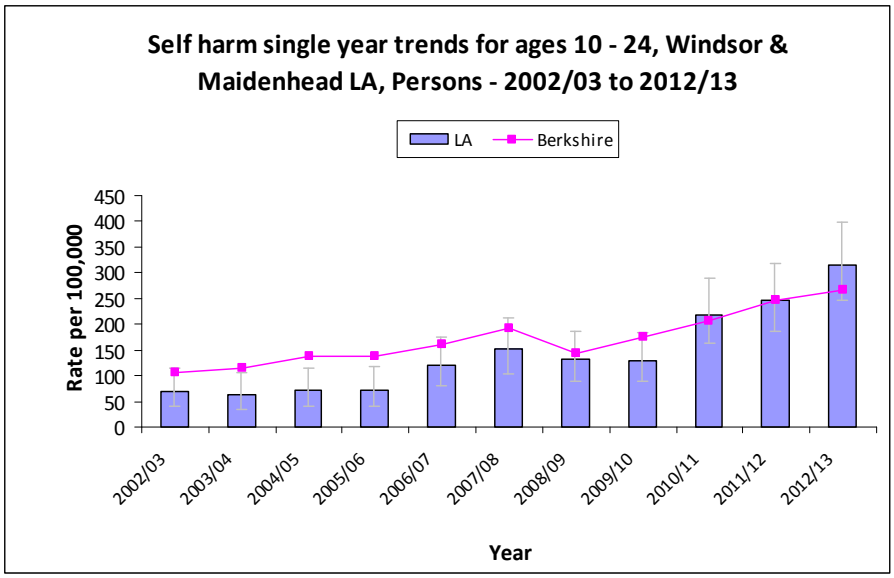

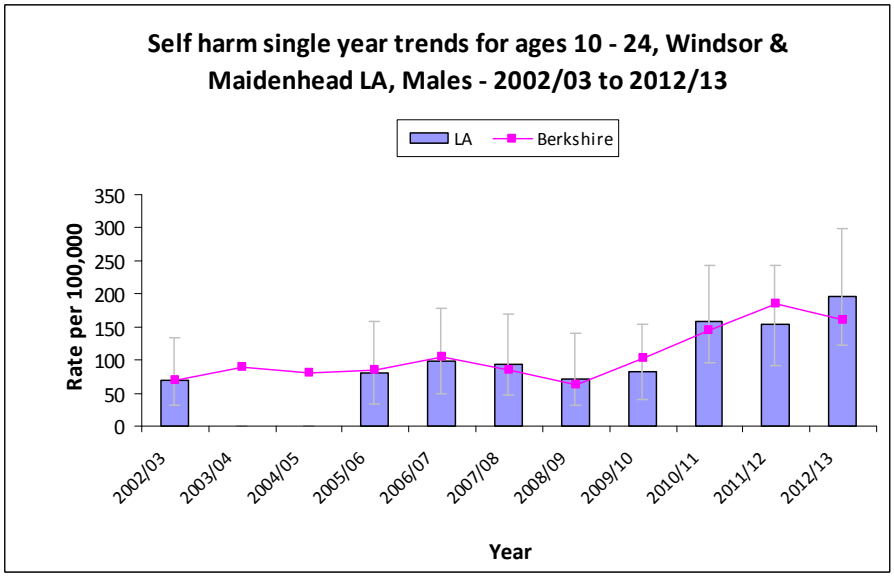

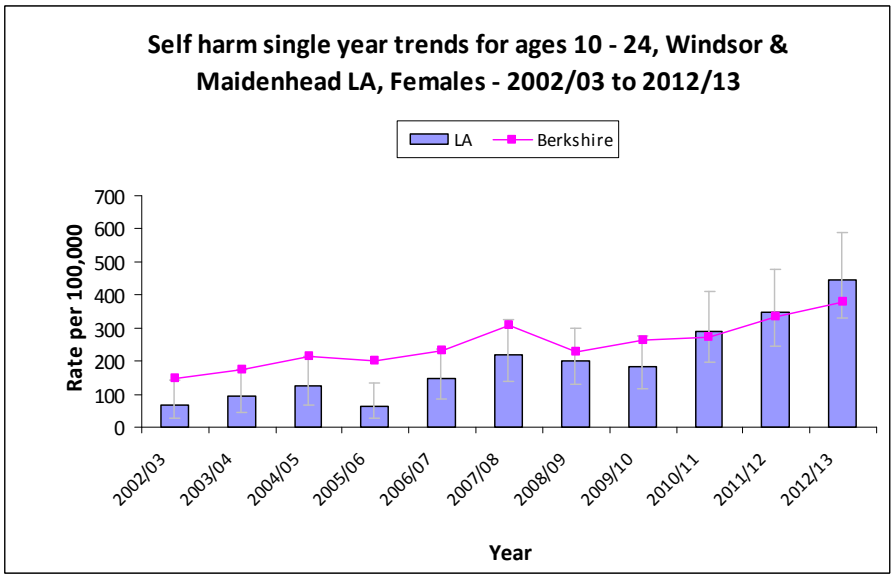

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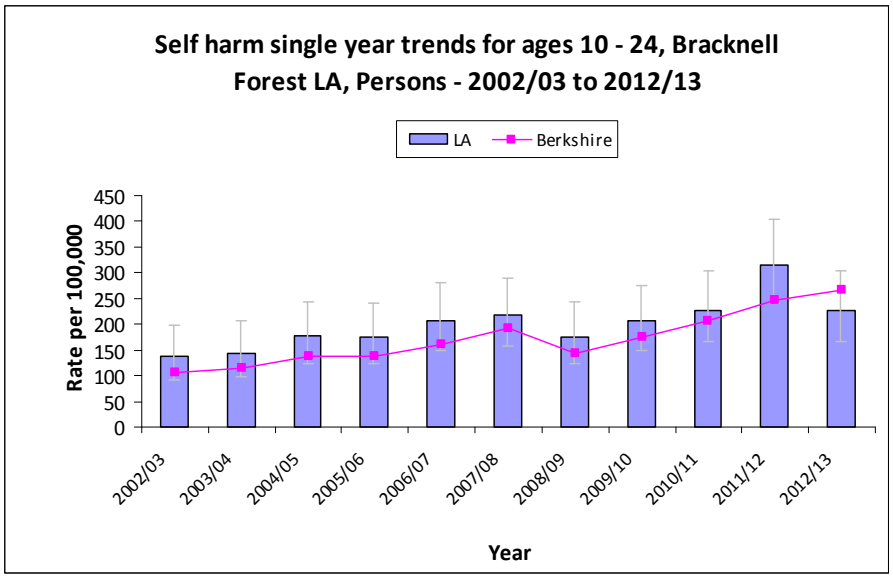
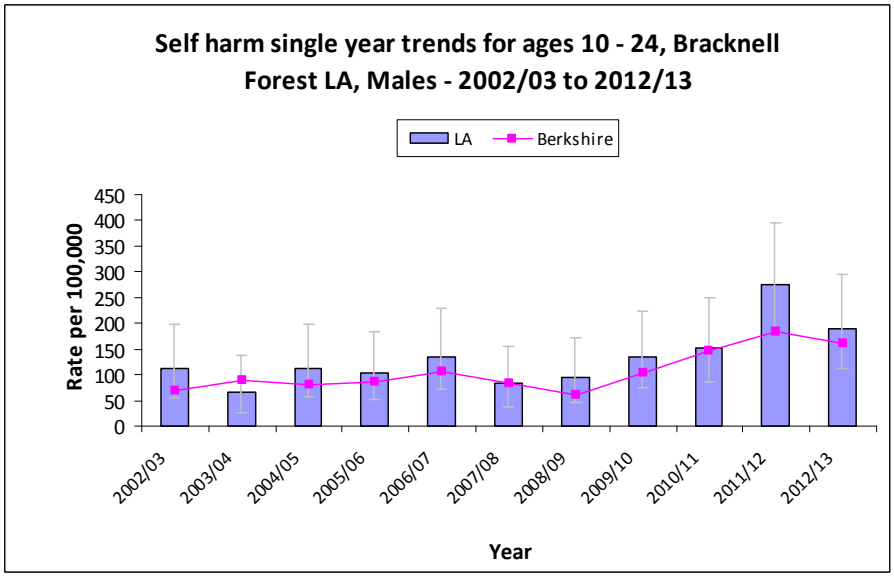
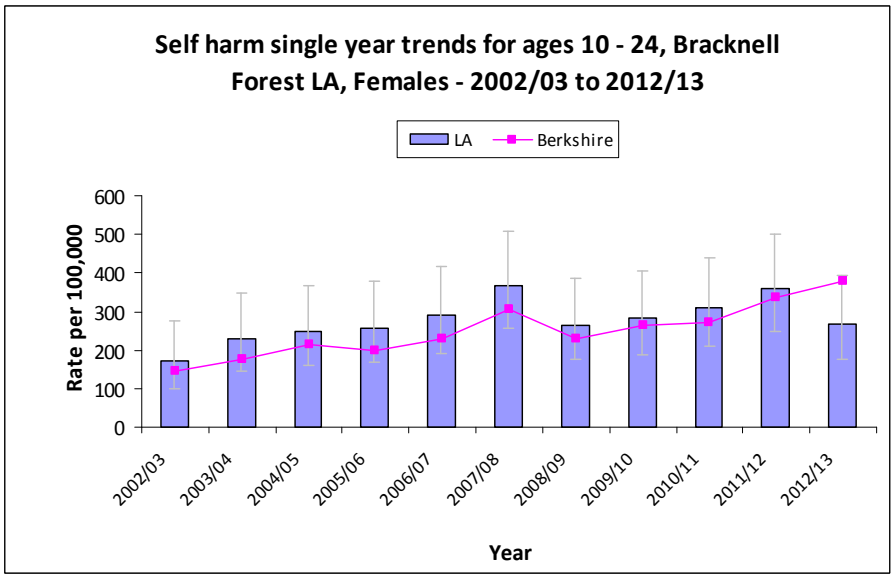
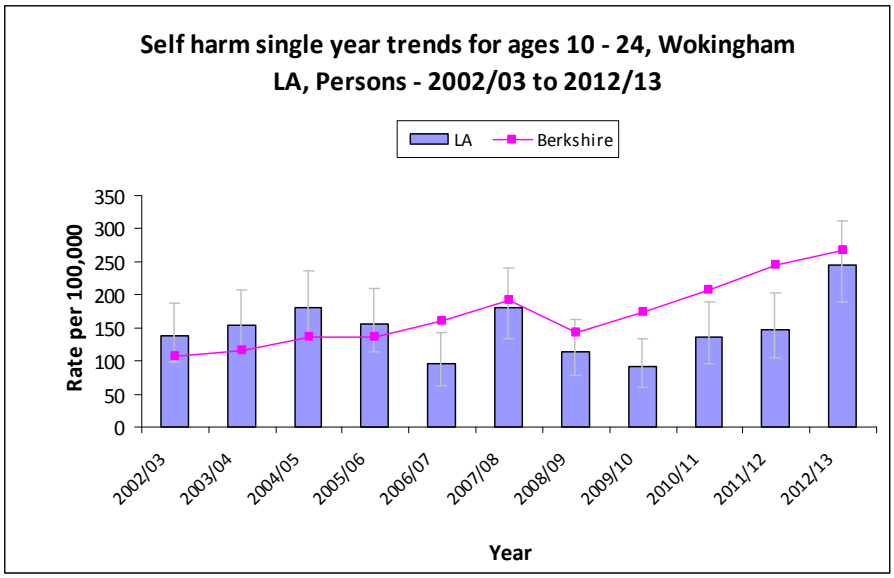






Wokingham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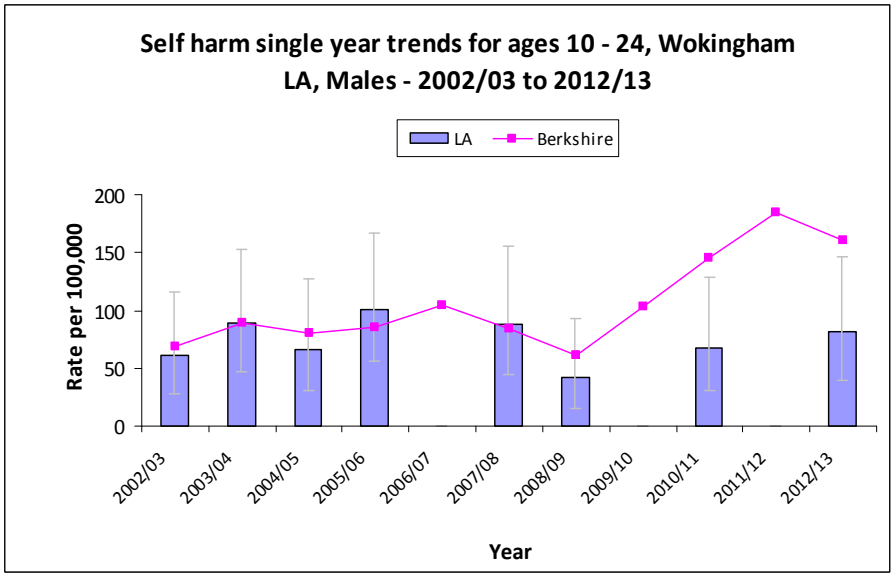
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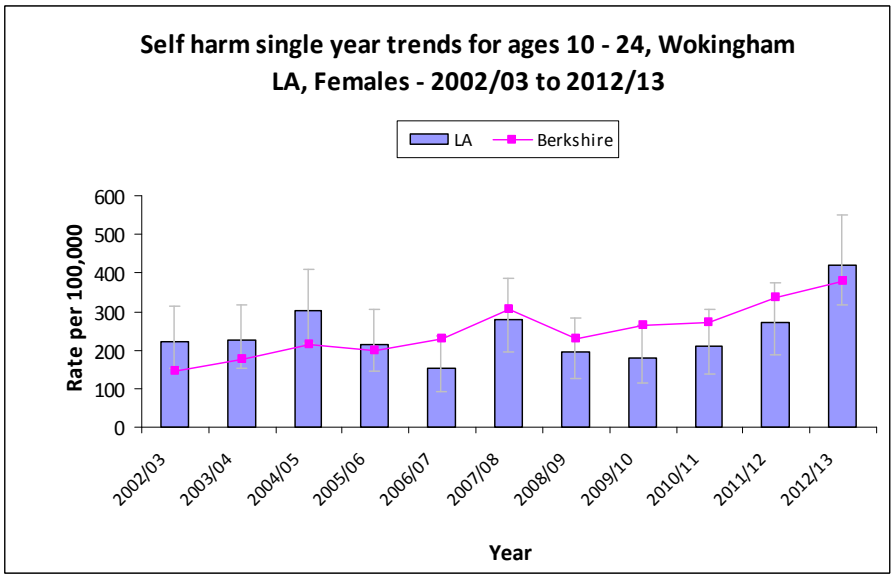
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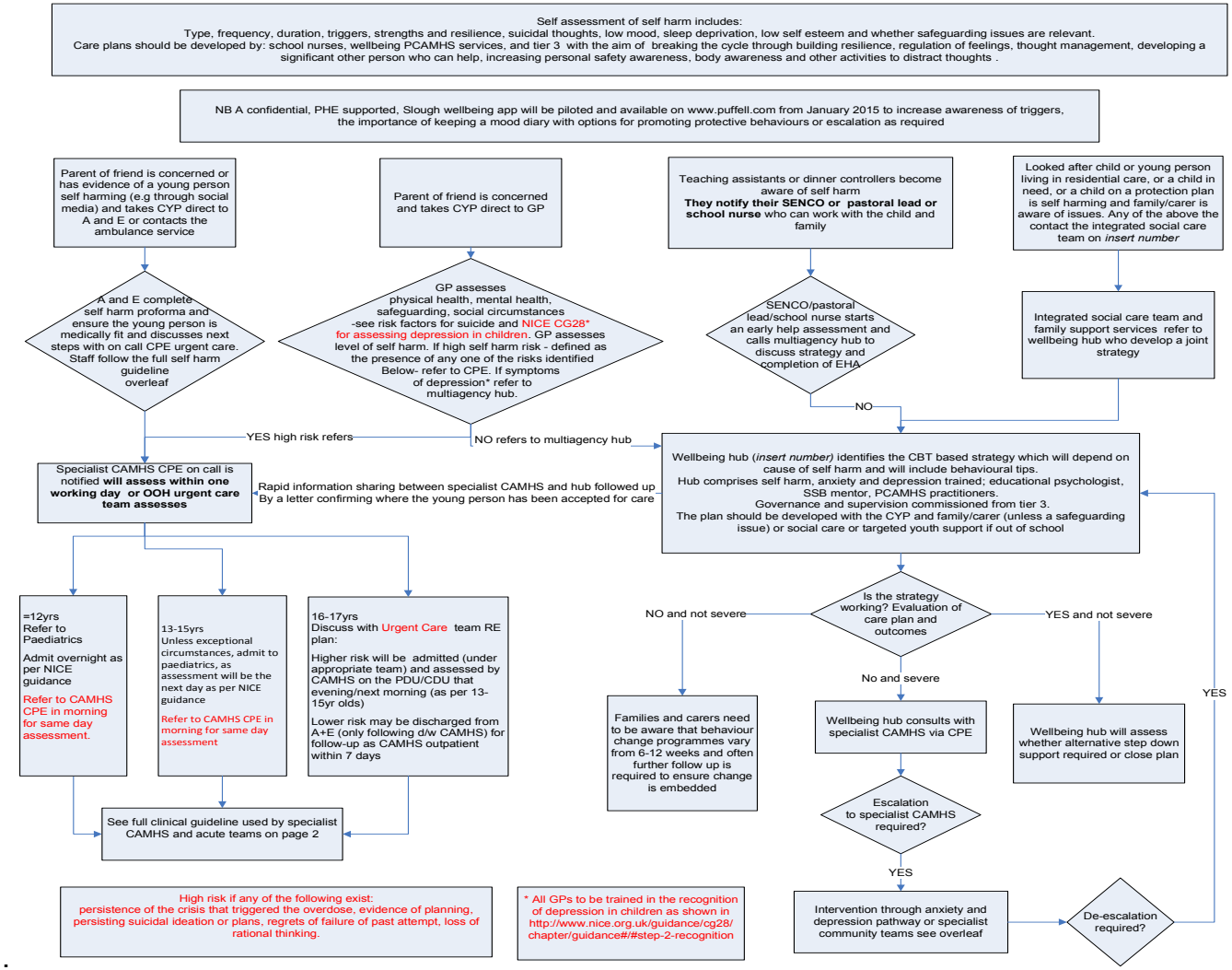
Appendix 4 – CAMHS Self-Harm Pathway to pilot with the Slough Wellbeing app 01.09.14



Self harm is a coping mechanism for underlying distress which may arise' in family disputes, from anxiety in parents/carers, from the young persons own anxiety or depression or learning difficulties, or from bullying or in relation to perceived performance at school.

Primary school children rarely present with self harm rather they may present as anxious or misbehave or say 'I don't want to be here (at school)'. Copycat self harm behaviours can occur at younger ages. Secondary school age young people are more likely to not talk to anyone and self harm in response to a range of difficulties.

Self harm is common and 12% of 14-16 year olds and 15% of 15-16 year olds will attempt this at some point,

Parents/carers and CYP older than 14 years should be offered a self help guide either app based or on line .
See the Northumberland, Tyne and Weir self help guides at http://www.ntw.nhs.uk/pic/selfhelp/
A self help guide can be found in the Slough Wellbeing app which will also link the person to the anxiety and depression pathways. The goal should be developing life skills which can include increasing assertiveness, Mindfulness, building resilience, developing positive friendships, reducing safeguarding problems, help for parents with mental health problems etc. and a series of links to wellbeing websites

NICE guidance PH012 and PH020 on social and emotional wellbeing in schools apply at http://www.nice.org.uk/GuidanceMenu/Settings-and-environment#/Guidance/Settings-and-environment/Schools-and-other-educational-settingst

Schools should review their anti bullying policies regularly and training should include how to deal with on line bullying and the Chair of Governors should champion this.
See case studies at https://www.gov.uk/government/case-studies/talking-about-and-responding-to-school-cyberbullying

Each school needs a lead person trained in the multiple causes of self harm and how to deliver effective interventions. Ideally every headteacher, school nurse, practice nurse, GP, dinner controller, teaching assistant and youth worker should be trained in emotional literacy and self harm

Teaching assistants deal with issues daily and have listening skills and nurturing skills. The training must address their own response to seeing self harm as it can be emotive when a problem solving approach is required to establish what should be done

The lead educational psychologist for the school should ensure that staff are trained and have a range of behavioural tips (provided by the behavioural, emotional and social support team) to use.

All staff require competencies in self harm appropriate to their level As an initial training resource a lesson plan might include the Bucks guidance for schools at http://www.bucks-lscb.org.uk/wp-content/uploads/BSCB-Procedures/Self_Harm_Guidance.pdf . NB the final pages are likely to be more accessible by young people

On line free learning for all for all adults working with young people is available at Minded's e-learning site at http://rcpsych.ac.uk/usefulresources/minded.aspx.

Royal College of Psychiatrists leaflets are available for many conditions in different languages at: http://rcpsych.ac.uk/expertadvice.aspx

Supervision structures in the school can be augmented by the wellbeing hub who can offer family therapy (Friends for Life) or escalate at any time to early help or Tier 3. The wellbeing hub will develop a personal care plan from mood diaries created within the app

The hub will include dedicated educational psychologists who can advise re CBT and other problem solving interventions and can train staff in emotional literacy and management techniques within PSHE or nurture groups.

CBT approaches are very effective for anxiety or depression id these are causes of self harm. Strategies to build problem solving skills that are effective are CBT or DBT based although the latter is not yet commissioned across Berkshire.
A CBT trained person within the school should support front line staff to develop their nurturing and listening skills.
Emerging evidence for more vulnerable subgroups includes the use of music therapy..
The local offer will state what additional services are on offer in each local school.

An escalation through the early help assessment process may be required if sexual abuse is suspected and post traumatic stress disorder is suspected,.

If the cause is parental separation signpost to national charities such as Relate for on line counselling or consider other local options

Appendix 5 – Risk factors in children and young people which the strategy should

Table 1: Risk factors for mental disorder in children and young people (from DH Public Mental Health review 3)

Risk factor	Impact on risk of mental disorder	Prevalence in population
Use of alcohol, tobacco or drugs during pregnancy	Increased risk of a wide range of poor outcomes including long-term neurological and cognitive-emotional development problems[10]	
Maternal stress during pregnancy	Increased risk of child behavioural problems[11] Impaired cognitive and language development [12]	
Low birth weight	Associated with increased risk of common mental disorder[13] 4-5 fold increased risk in onset of emotional/conduct disorder in childhood[14]	
Poor maternal mental health		5.7% of mothers experience depression 2 months post-natally, 6.5% at 6 months and 21.9% at 12 months[15]
Unemployed parent	2-3 fold increased risk of emotional/ conduct disorder in childhood[16] [17]	1.9 million children live in a workless household[18]
Poor parenting skills	4-5 fold increased risk of conduct disorder in childhood[19]	
Parents with no qualifications	4.25 fold increased risk of mental health problem in children[20]	
Deprivation – children in families with lower income levels	3 fold increased risk of mental health problems between highest and lowest socioeconomic groups (15% vs 5%)[21]	In 2007/8, four million (30%) children living in relative poverty (less than 60% median income)[22]
Four or more adverse childhood experiences (ACEs)[23]	12.2 fold increased rate in attempted suicide as an adult 10.3 fold increased risk of injecting drug use	15% of females and 9% of males experience four or more ACEs

Risk factor	Impact on risk of mental disorder	Prevalence in population
	7.4 fold increased risk of alcoholism 4.6 fold increased risk of depression in past year 2.2 fold increased risk of smoking	
Child abuse (physical, emotional and/or sexual abuse and/or neglect) [24]	15.5 fold increased risk of minor depression as a child 8.9 fold increased risk of suicidal ideation 8.1 fold increased risk of anxiety 7.8 fold increased risk of recurrent depression as adult 9.9 fold increased risk of adult PTSD 5.5 fold increased risk of substance misuse/ dependence	16% of children (1 in 6) experience serious maltreatment by parents[25]
Adolescent dating violence (ie. physical or sexual abuse by a dating partner)	8.6 fold increased risk of suicidality[26]	8.9% of women and 1.2% of men aged 16 to 19 sexually assaulted in previous 12 months[27]
High level use of cannabis in adolescence	6.7–6.9 fold increased risk of developing schizophrenia[28]	9% of children aged 11– 15 report cannabis use in last year, 7% of 15-year-olds report frequent drug use[29]

Source: NO HEALTH WITHOUT MENTAL HEALTH: A cross- Government mental health outcomes strategy for people of all ages Analysis of the Impact on Equality (AIE) Annex B - Evidence Base, DH Feb 2011

Suicide Risk and Self-Harm Reduction in Berkshire

Stakeholder Consultation

List of People who have commented/attended consultation meetings

Names	Job Titles
Andy Beckingham	Locum Consultant in Public Health, Public Health Services for Berkshire, (Bracknell Forest)
Belinda Dixon	Service Day, Maidenhead
Christine Price	Alzheimer's Dementia Support, UK.
Clare Stafford	Chief Executive, Charlie Waller Memorial Trust
Daren Bailey	Clinical Nurse Specialist, Prospect Park Hospital, (Reading)
Darrell Gale	Consultant in Public Health, (Wokingham Borough Council)
Dr Adrian Hayter	Chair, WAM CCG
Dr Angus Tallini	GP Partner, Falkland Surgery, Chair of Council of Member Practices, Mental Health GP Lead, Newbury & District CCG
Dr Chris Allen	Consultant Clinical Psychologist
Dr Katie Simpson	Mental Health Clinical Lead CCG Federation, (East Berkshire)
Dr Rosemary Croft	Mental Health Clinical Lead CCG Federation, (West Berkshire)
Dr Sue McLaughlin	Nurse Consultant, Prospect Park Hospital, (Reading)
Eugene Jones	Locality Manager Community Mental Health Team, (RBWM)
Jason Jongali	Interim Head of Mental Health & Learning Disabilities Commissioning, NHS Central Southern Commissioning Support Unit
Mark Evans	Head of Children's Services, (West Berkshire Council)
Nick Davies	Head of Strategic Commissioning for Adult Social Care & Housing (RBWM)
Ornella Veltri	Public Health Business Support (RBWM)
Pat Barlow	Mental Health Carer from the MH Partnership Board
Phil Dale	Information & Advice Officer, Berkshire Carers Service, Maidenhead
Adanna Nwanguma	Public Health Team, (Reading)
Rutuja Kulkarni	Head of Public Health (RBWM)
Sally Murray	Head of Children's Commissioning Support Berkshire NHS Central Southern Commissioning Support Unit, (Reading)
Shahbano Razvi	Public Health Programme Officer (RBWM)
Susanna Yeoman	Deputy Locality Director, Slough
Tandra Forster	Head of Adult Social Care, (West Berkshire Council)
Tony Dwyer	Locality Manager (Bracknell) Adult & Older Persons Mental Health Services Berkshire Healthcare NHS Foundation Trust & Bracknell Forest Council
Kate Jahangard	Education & Children's Services, Reading
Sally Grant	Team Manager, SEAP Org UK – (Support Empower Advocate Promote)

August/September 2014

References

Mental Health and Disability Division, Department of Health. Sept 2012 Preventing Suicide in England – A cross government strategy to save lives https://www.gov.uk/government/publications/suicide-prevention-strategy-launched

Mental Health and Disability Division, Department of Health. Jan 2014 Preventing Suicide in England – One year on https://www.gov.uk/government/uploads/system/uploads/attachment_data/file/278119/Annual_Report_FINAL_revised.pdf

Department of Health. Feb 2011 Preventing Suicide in England – A cross government outcomes strategy to save lives. Assessment of impact on equalities. Annex B Evidence Base. dh 125514

Acting on evidence: A strategic framework of evidence based recommendations for preventing suicides in Bolton (2013-16)) http://www.boltonshealthmatters.org/sites/default/files/BOLTON%20SUICIDE%20PREVENTION%20STRATEGIC%20FRAMEWORK%202013-16%20DRAFT%20FOR%20CONSULTATION.pdf

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Title of Report:	**West Berkshire LSCB Business Plan 2015-17**
Report to be considered by:	The Health and Wellbeing Board
Date of Meeting:	22/1/2015

Purpose of Report: **For information and support on specific actions detailed below**

Recommended Action: **The Health and Wellbeing Board to note the LSCB Business Plan and to support the items set out in section 1.**

When decisions of the Health and Wellbeing Board impact on the finances or general operation of the Council, recommendations of the Board must be referred up to the Executive for final determination and decision.		
Will the recommendation require the matter to be referred to the Council's Executive for final determination?	Yes: ☐	No: ☒

Is this item relevant to equality? Please tick relevant boxes	**Yes**	**No**
Does the policy affect service users, employees or the wider community and:		
• Is it likely to affect people with particular protected characteristics differently?	☒	☐
• Is it a major policy, significantly affecting how functions are delivered?	☐	☒
• Will the policy have a significant impact on how other organisations operate in terms of equality?	☐	☒
• Does the policy relate to functions that engagement has identified as being important to people with particular protected characteristics?	☒	☐
• Does the policy relate to an area with known inequalities?	☒	☐
Outcome Where one or more 'Yes' boxes are ticked, the item is relevant to equality. In this instance please give details of how the item impacts upon the equality streams under the executive report section as outlined.		

Health and Wellbeing Board Chairman details	
Name & Telephone No.:	Marcus Franks (01635) 841552
E-mail Address:	mfranks@westberks.gov.uk

Contact Officer Details	
Name:	Claire Fletcher
Job Title:	LSCB Clerk
Tel. No.:	01635 519982
E-mail Address:	cfletcher@westberks.gov.uk

Executive Report

1. Introduction

At a Business Planning session held October 2014, West Berkshire LSCB agreed five new top level priorities for the next two years, 2015-2017 as follows:

- Early Help
- The Child's Voice and Journey
- Child Sexual Exploitation
- Domestic Abuse and Vulnerable Groups
- Effectiveness and Impact of the LSCB

Actions are clearly focused on multi-agency working.

The LSCB is seeking support from the Health and Wellbeing Board on the following items:

Priority 1 Early Help – actions 1.2 to 1.4
Priority 2 The Child's Voice & Journey – actions 2.3, 2.4 and 2.7
Priority 3 Child Sexual Exploitation – all actions
Priority 5 Effectiveness & Impact of the LSCB Actions 5.2 and 5.6

2. Equalities

The vision of the LSCB is that every child and young person in West Berkshire grows up safe from maltreatment, neglect and crime. The LSCB agreed priorities through consultation with members and a development session held in June 2014. The Business Plan identifies children going through the child protection system, looked after children, children suffering or at risk of child sexual exploitation, missing children and children affected by domestic abuse as vulnerable groups. The Plan aims to address specific issues identified by partner agencies.

Appendices

Appendix A – LSCB Business Plan

Consultees

Local Stakeholders: LSCB members

Officers Consulted:

Other:

.

West Berkshire Local Safeguarding Children Board

BUSINESS PLAN 2015 – 2017

Version 3 – November 2014

West Berkshire Local Safeguarding Children Board

BUSINESS PLAN 2014-2017

Introduction

Version 3 of the Business Plan for 2015/17 is designed to support the West Berkshire Safeguarding Children Board in achieving its aims in the forthcoming year.

The Business Plan has four parts:

- The Vision of the West Berkshire Safeguarding Children Board
- The Statement of Intent
- Key strategic objectives
- The detailed Work Plan for the next year

The Vision

Our vision continues to be that every child and young person in West Berkshire grows up safe from maltreatment, neglect and crime. We aim to sustain a strong safeguarding culture and arrangements where the focus is firmly on the experience of the child or young person and their journey to getting effective early help and support.

Statement of Intent

The West Berkshire Safeguarding Children Board will provide strong and effective leadership in order to co-ordinate and ensure effectiveness of the work done by agencies for the purpose of safeguarding and promoting the welfare of children and young people. We aim to ensure that children and young people in West Berkshire are adequately safeguarded at all stages of their journey through universal, targeted and specialist services. The Board believes that everyone is responsible for safeguarding and promoting the welfare of children. We will achieve our vision by:

- Working with partner agencies to improve the quality and effectiveness of safeguarding practice
- Monitoring and where necessary challenging the performance of agencies in relation to safeguarding
- Developing and implementing effective policies, guidance and procedures.

- Implementing an effective Quality and Performance Framework that enables us to learn from good practice and also from when things go wrong and which enables us to influence the delivery and commissioning of services in the Area.
- Analysing, reviewing and understanding the key factors identified in cases where children have been harmed and the changes that can be made to all agencies services to address these factors.
- Providing high quality multi□agency training to the children's workforce.
- Promoting awareness of safeguarding within agencies and in the wider community.

Strategic Priorities

The LSCB held its annual development day in July 2014 to review progress on the priorities from 2013/14, consider key challenges and how to make best use of its resources and to set its future priorities. In setting the priorities for 2015/17 the Board considered a number of presentations and information sources.

The following top level strategic priorities were agreed:

1. **Early help**
2. **The child's voice and journey**
3. **Child sexual exploitation and missing children**
4. **Domestic abuse and vulnerable groups**
5. **Effectiveness of the LSCB**

Other key priorities include:

6. Further direct involvement of children and young people in the work of the Board
7. Improving support for children whose parents have mental health issues
8. Further development of the LSCB Quality and Performance Framework

These priorities reflect a number of drivers including the Ofsted Inspection held in 2013, areas for improvement arising from the LSCBs self-assessment, Learning Lessons and Serious Case Reviews as well as the LSCBs response to the revised 'Working Together' (2013) and 'Facets of an effective LSCB' published by the National Association of Independent LSCB Chairs.

Supporting information sources included:

- Achievement against the 2013/14 priorities
- LSCB multi-agency Dataset
- Quality and Performance Management Framework
- Early Help Action Plan
- National Government drivers
- Local knowledge (e.g. Serious Case Reviews, learning lessons reviews)
- Outcome of single and multi-agency audits and Section 11 audit
- Performance management reports

Theme 1 Early Help

Ref	Desired outcome	Action	Lead	Timeframe	Progress
1.1	Referrals to Children's Services meet the threshold criteria and are consistently applied by all agencies and front-line practitioners	Carry out a multi-agency audit on threshold criteria for Children's Services	M Evans	May 2015	
1.2	Health Visiting and School Nursing services are provided in line with identified need	Ensure commissioning arrangements are in place for health visiting and school nursing	I Mundy	March 2015	
1.3	An effective Tier 2 mental health service is provided by Education in order to relieve pressure on Tier 3 services	Evaluate impact of the Tier 2 mental health/anxiety project	I Pearson/ M Sancho	January 2015	
1.4	Health in Schools Co-ordinator has a positive impact on young people's wellbeing	Clarify the expectations of the Health in Schools Co-ordinator role and produce quarterly performance report	I Wootton/ I Pearson	January 2015	
1.5	All West Berkshire schools (including academies and independents) sign up to an exclusion protocol in relation to substance misuse and deliver a decrease in exclusions	Monitor sign-up to protocol in relation to substance misuse by West Berkshire schools and the number of exclusions	C Burnham/ D Oku	March 2015	

Theme 2 – The Child's Voice and Journey

Ref	Desired outcome	Action	Lead	Timeframe	Progress
2.1	Children have a positive journey through the child protection process and their voice is central to this	Carry out a multi-agency audit to measure effectiveness of child protection conferences for young people	L Campion/ Quality & Performance Group	July 2015	
2.2	Young people are directly engaged and contribute to the LSCB	Identify young people who may be interested in fulfilling this role and agree options for their engagement	C Gill	March 2015	
2.3	Looked after children's health needs are met by receiving a medical which is of a good standard and within prescribed timescales	Health and Children's Services work together to address issues around provision of medicals	I Mundy/ M Evans	January 2015	
2.4	Young people who present self harm receive appropriate assessment and support services	Benchmark and audit current provision identifying gaps/barriers	I Mundy/ S Murray	May 2015	
2.5	Children and Adult Services work effectively together where there are parents with mental health issues	Develop, implement and monitor a Protocol for these services working together	L Campion/ A Luke	January 2015	
2.6	Police attend all initial Child Protection Conferences and reviews as per invitation	Thames Valley Police provide a police officer to complete reports and attend when required	L York	March 2015	
2.7	GPs attend all initial Child Protection Conferences and reviews as per invitation		D Daly		

Theme 3 - Child Sexual Exploitation (CSE)

Ref	Desired outcome	Action	Lead	Timeframe	Progress
3.1	Information from safe and well checks and return home interviews is used to safeguard young people	Monitor implementation of safe and well checks and return home interviews and the impact on safeguarding	L Finch/ M Evans	January 2015	
3.2	Young people receive appropriate support where CSE is identified	Carry out a multi-agency audit on cases where CSE has been identified to ensure effective intervention	M Evans/ Quality & Performance Group	January 2015	Audit completed by D Pearson – presented to Quality & Performance Group 19/11/2014
3.3	Relevant staff are trained in Child Sexual Exploitation (CSE)	Monitor and promote use of the LSCB CSE e-learning package	C Gill/ CSE Sub-Group	January 2015	
3.4		Develop face to face training package on CSE for appropriate agencies	C Gill/ CSE Sub-Group	July 2015	
3.5	There is a good shared understanding of the nature and prevalence of CSE across West Berkshire	Update local analysis from front line staff and services about the prevalence and nature of Child Sexual Exploitation across West Berks	CSE Sub-group	May 2015	
3.6	Increased levels of community awareness of child sexual exploitation	Further develop prevention and awareness advice on CSE for children, parents/carers and wider community	C Gill/ CSE Sub-Group/ Public Health	October 2015	

Theme 4 – Domestic Abuse and Vulnerable Groups

Ref	Desired outcome	Action	Lead	Timeframe	Progress
4.1	Domestic abuse has a high profile in all education settings	Promote and train domestic abuse champions for each setting	I Pearson/ C Burnham/ J Boden	July 2015	
4.2	Health professionals have access to domestic abuse notifications for cases they are working with	Monitor flagging of domestic abuse cases on RIO database	I Mundy/ G Garnett	January 2015	
4.3	Schools have access to domestic abuse notifications for children on their roll	Provide domestic abuse information sharing training to all schools	J Boden/ C Burnham	May 2015	
4.4		Carry out a survey of schools to assess impact of the information sharing system	J Boden/ C Burnham	December 2015	
4.5	MAPPA effectively safeguards children and young people	Carry out a multi-agency audit of MAPPA cases	M Evans/ Quality & Performance Group	October 2015	MAPPA cases to be anonymised to avoid issues around confidentiality
4.6	MARAC effectively safeguards children and young people	Share learning from Wokingham on effectiveness of MARAC	C Gill	January 2015	

Theme 5 – Effectiveness and impact of the LSCB

Ref	Desired outcome	Action	Lead	Timeframe	Progress
5.1	LSCB operates effectively and members are fully engaged	Carry out a survey of members on LSCB effectiveness	F Gosling-Thomas	October 2015	
5.2	Partner agencies have good awareness of the work of the LSCB and the Berkshire Child Protection Procedures	Publish a LSCB newsletter three times a year and distribute weekly information updates to members with request to cascade through agencies	C Gill/ C Fletcher	On-going	
5.3		Carry out a survey of front-line staff to assess their knowledge of the LSCB	C Gill/ Quality & Performance Group	October 2015	To tie in with item 5.1
5.4	All agencies meet Section 11 requirements	Agencies complete Section 11 self audits on a three yearly basis, to be reported into the Quality & Performance Sub- Group	C Gill/ Quality & Performance Group	October 2015	
5.5	Training provided by the LSCB is effective and meets identified needs	Develop a system for on-going evaluation of LSCB training courses to measure impact for staff + services	C Gill/ M Butler	October 2015	
5.6	Partner agencies are aware of learning from case reviews and incorporate this into their practice	Case Review Group to use thematic tool to monitor implementation of learning from case reviews Multi-agency audit programme	J Selim/ Case Review Group	July 2015	

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Title of Report:	**Crisis Care Concordat**
Report to be considered by:	The Health and Wellbeing Board
Date of Meeting:	22/01/2014

Purpose of Report: **Introduce the Crisis Care Concordat**

Recommended Action: **For the Board to note and collaborate on the Concordat**

When decisions of the Health and Wellbeing Board impact on the finances or general operation of the Council, recommendations of the Board must be referred up to the Executive for final determination and decision.		
Will the recommendation require the matter to be referred to the Council's Executive for final determination?	Yes: ☐	No: ☒

Is this item relevant to equality? Please tick relevant boxes	**Yes**	**No**
Does the policy affect service users, employees or the wider community and:		
• Is it likely to affect people with particular protected characteristics differently?	☒	☐
• Is it a major policy, significantly affecting how functions are delivered?	☒	☐
• Will the policy have a significant impact on how other organisations operate in terms of equality?	☒	☐
• Does the policy relate to functions that engagement has identified as being important to people with particular protected characteristics?	☒	☐
• Does the policy relate to an area with known inequalities?	☒	☐
Outcome Where one or more 'Yes' boxes are ticked, the item is relevant to equality. In this instance please give details of how the item impacts upon the equality streams under the executive report section as outlined.		

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Executive Report

1. Introduction

1.1 1.1 The Crisis Care Concordat is a shared agreed statement, based on a national initiative, signed by senior representatives from all the organisations involved across the whole of Berkshire. It covers what needs to happen when people in mental health crisis need help – in policy making and spending decisions, in anticipating and preventing mental health crises wherever possible, and in making sure effective emergency response systems operate in localities when a crisis does occur

2. Equalities

2.1 This agreement will serve to redress inequalities of access and service for those suffering with a Mental Health crisis, ensuring that they are treated by the appropriate service in an appropriate timescale. This applies to underserved populations equally and provisions will be made in any service redesign supporting this Concordat to ensure that the needs of these populations are met.

Appendices

Appendix A – Berkshire Declaration Document December 2014
Appendix B – Briefing Document & Update December 2014

Consultees

Local Stakeholders: See Appendices A & B

Officers Consulted:

Other:

The 2014 Berkshire Declaration on improving outcomes for people experiencing mental health crisis

We, as partner organisations in **Berkshire**, will work together to put in place the principles of the national **Concordat** to improve the system of care and support so that people in crisis because of a mental health condition are kept safe. We will help them to find the help they need – whatever the circumstances – from whichever of our services they turn to first.

We will work together to prevent crises happening whenever possible, through intervening at an early stage.

We will make sure we meet the needs of vulnerable people in urgent situations, getting the right care at the right time from the right people to make sure of the best outcomes.

We will do our very best to make sure that all relevant public services, contractors and independent sector partners support people with a mental health problem to help them recover. Everybody who signs this declaration will work towards developing ways of sharing information to help front line staff provide better responses to people in crisis.

We are responsible for delivering this commitment in **Berkshire** by putting in place; reviewing and regularly updating an action plan/action plans.

This declaration supports 'parity of esteem' (see the glossary) between physical and mental health care in the following ways:

- Through everyone agreeing a shared 'care pathway' to safely support, assess and manage anyone who asks any of our services in **Berkshire** for help in a crisis. This will result in the best outcomes for people with suspected serious mental illness, provide advice and support for their carers, and make sure that services work together safely and effectively.
- Through agencies working together to improve individuals' experience (professionals, people who use crisis care services, and carers) and reduce the likelihood of harm to the health and wellbeing of patients, carers and professionals.
- By making sure there is a safe and effective service with clear and agreed policies and procedures in place for people in crisis, and that organisations can access the service and refer people to it in the same way as they would for physical health and social care services.
- By all organisations who sign this declaration working together and accepting our responsibilities to reduce the likelihood of future harm to staff, carers, patients and service users or the wider community and to support people's recovery and wellbeing.

We, the organisations listed below, support this Declaration. We are committed to working together to continue to improve crisis care for people with mental health needs in Berkshire.

Organisation	Logo	Signatory
Berkshire East Federation Clinical Commissioning Groups: Slough CCG Windsor, Ascot & Maidenhead CCG Bracknell CCG		
Berkshire West Federation Clinical Commissioning Groups: South Reading CCG North West Reading CCG Wokingham CCG Newbury District CCG	NHS South Reading Clinical Commissioning Group NHS North and West Reading Clinical Commissioning Group NHS Wokingham Clinical Commissioning Group NHS Newbury and District Clinical Commissioning Group	
Slough Borough Council		
Windsor, Ascot & Maidenhead Borough Council		
Bracknell Forest Borough Council		
Reading Borough Council		
Wokingham Borough Council		
West Berkshire Council		

Thames Valley Police		
Thames Valley Police Crime Commissioner		
Berkshire Health Care Foundation NHS Trust	Healthcare from the heart of your community Berkshire Healthcare NHS NHS Foundation Trust	
Royal Berkshire Health Care Foundation NHS Trust		
Heatherwood & Wexham Park Health Care Foundation NHS Trust		
South Central Ambulance Service		
NHS England Thames Valley Area Team		
Berkshire East DAAT		
Berkshire West DAAT Turning Point		
Berkshire West DAAT IRiS		
Berkshire West DAAT SMART		
Berkshire MIND		

Glossary of terms used in this declaration

Concordat	A document published by the Government. The Concordat is a shared, agreed statement, signed by senior representatives from all the organisations involved. It covers what needs to happen when people in mental-health crisis need help. It contains a set of agreements made between national organisations, each of which has a formal responsibility of some kind towards people who need help. It also contains an action plan agreed between the organisations who have signed the Concordat. Title: Mental Health Crisis Care Concordat – Improving outcomes for people experiencing mental health crisis Author: Department of Health and Concordat signatories Document purpose: Guidance Publication date: 18th February 2014 Link: https://www.gov.uk/government/uploads/system/uploads/attachment_data/file/281242/36353_Mental_Health_Crisis_accessible.pdf
Mental health crisis	When people – of all ages – with mental health problems urgently need help because of their suicidal behaviour, panic attacks or extreme anxiety, psychotic episodes, or behaviour that seems out of control or irrational and likely to put the person (or other people) in danger.
Parity of esteem	Parity of esteem is when mental health is valued equally with physical health. If people become mentally unwell, the services they use will assess and treat mental health disorders or conditions on a par with physical illnesses. Further information: http://www.england.nhs.uk/ourwork/qual-clin-lead/pe

Recovery	One definition of Recovery within the context of mental health is from Dr. William Anthony: "Recovery is a deeply personal, unique process changing one's attitude, values, feelings, goals, skills, and/or roles. It is a way of living a satisfying, hopeful, and contributing life. Recovery involves the development of new meaning and purpose in one's life as one grows beyond the catastrophic effects of psychiatric disability" (Anthony, 1993) Further information http://www.imroc.org/

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Briefing Paper Crisis Care Concordat

The Crisis Care Concordat is a shared agreed statement, signed by senior representatives from all the organisations involved. It covers what needs to happen when people in mental health crisis need help – in policy making and spending decisions, in anticipating and preventing mental health crises wherever possible, and in making sure effective emergency response systems operate in localities when a crisis does occur

The Crisis Care Concordat is arranged around:

- Access to support before crisis point
- Urgent and emergency access to crisis care
- The right quality of treatment and care when in crisis
- Recovery and staying well, and preventing future crises

This Concordat expects that, in every locality in England, local partnerships of health, criminal justice and local authority agencies will agree and commit to local Mental Health Crisis Declarations. These will consist of commitments and actions at a local level that will deliver services that meet the principles of the national concordat

This Concordat serves as an important joint statement of intent and common purpose, and of agreement and understanding about the roles and responsibilities of each service. This will help to make sure people who need immediate mental health support at a time of crisis get the right services when they need them, and get the help they need to move on and stay well

In Berkshire we have agreed an action plan that commits all responsible organisations involved to sign up to and take responsibility to meet the agreed plan as outlined below:

1) Provide a safe early intervention and crisis resolution service in Berkshire
2) Provide a responsive Ambulance Response Time to those requiring transfers to psychiatric hospital
3) Improve access to support in primary care for mental health service users
4) To put in a place an improved emergency duty team to provide rapid response to those in mental health crisis
5) Improve CAMHS alternatives to admission and access to tier 4 beds in Berkshire
6) Improve ambulance response time for section 135 & 136 detentions
7) Improve training and guidance for Thames Valley Police on Mental Health, Mental Health Act & Mental Capacity Act 2005
8) Improve response time from community substance misuse team (DAAT) in Berkshire
9) Review Police use of places of safety under the Mental Health Act 1983 and results of local monitoring
10) Develop further alternatives to admission for mental health patients i.e. Yew Tree Lodge in Reading
11) Use of restraints
12) Partnership working – to monitor progress and planning future system improvements

Although the Crisis Care Concordat focuses on the responses to acute mental health crises, it also includes a section on prevention and intervention. The Concordat builds on and does not replace existing guidance. Current service provision should continue while the Action Plan is being developed in Berkshire.

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Title of Report:	**SEND Reform Update**
Report to be considered by:	The Health and Wellbeing Board
Date of Meeting:	22nd January 2014

Purpose of Report:

- **To report on implementation on the SEND Reforms arising from the Children and Families Action.**
- **To highlight specific implications of the reforms for Health.**
- **To raise awareness Department of Health Guidance, "Children with special educational and complex needs: Guidance for Health and Wellbeing Boards", September 2014.**

Recommended Action:

To note progress made on implementation and to consider areas for further development including implications of Department for Health Guidance

When decisions of the Health and Wellbeing Board impact on the finances or general operation of the Council, recommendations of the Board must be referred up to the Executive for final determination and decision.

Will the recommendation require the matter to be referred to the Council's Executive for final determination?	Yes: ☐	No: ☒

Is this item relevant to equality? Please tick relevant boxes	**Yes**	**No**
Does the policy affect service users, employees or the wider community and:		
• Is it likely to affect people with particular protected characteristics differently?	☒	☐
• Is it a major policy, significantly affecting how functions are delivered?	☒	☐
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• Does the policy relate to an area with known inequalities?	☒	☐
Outcome Where one or more 'Yes' boxes are ticked, the item is relevant to equality. In this instance please give details of how the item impacts upon the equality streams under the executive report section as outlined.		

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Executive Report

1. Introduction

1.1 The Children and Families Act took effect in September 2014, and has significantly changed the way in which services are provided for children with SEN and disabilities and their families.

1.2 A multi agency SEND Reform Steering Group has been in place since September 2013 to oversee implementation of the reforms. The Steering Group continues to meet to oversee implementation.

1.3 All relevant stakeholder groups are represented on the Steering Group including parents, schools, the FE sector, relevant voluntary bodies, Health commissioners and providers and representatives of relevant Council teams including the SEN & Disabled Children's Team, Educational Psychology Service, Locality Teams, Adult Services, School Improvement, Sensory Consortium and Children's Centres.

2. Equalities

2.1 This is national legislative change which is intended to improve the way children and young people with disabilities and their families experience services and which will enable them to have more choice and control and achieve better long term life outcomes. There has been extensive consultation prior to implementation of the reforms including co production of new systems and processes with families.

3. Requirements of the Children and Families Act in respect of children with SEN and disabilities (SEND)

3.1 The existing statutory assessment and statementing process has been replaced by a much more holistic, person centred Education Health and Care (EHC) Assessment process leading to an EHC Plan setting out the child's health and care needs in addition to their special educational needs. All existing Statements will have to be converted to EHC Plans by April 2018. EHC Assessments must be completed in 20 weeks (compared to 26 weeks for a statement of special educational needs).

3.2 Every family whose child has an EHC Plan has the right to request a Personal Budget for the education, health and / or care aspects of the EHC Plan. Previously, Personal Budgets / direct payments were only allocated to meet a young person's social care needs.

3.3 Local Authorities' responsibilities now extend potentially up to the age of 25 (Statements used to lapse at age 19 years). EHC Plans can continue up to the age of 25 if a case can be made that the young person still requires an EHC Plan in order to achieve their identified outcomes.

3.4 There is a requirement to produce a comprehensive "Local Offer" setting out all services for children with SEND aged 0 to 25 and their families and how these can be accessed, including eligibility criteria. This must include services provided by education, social care, health and the private and voluntary sectors.

3.5 There are new requirements for supporting families including greater responsibility for provision of independent advice, advocacy, disagreement resolution and mediation. These services have to be provided in relation to health and social care issues as well as SEN related issues.

3.6 There are specific requirements for joint commissioning. These include the development of clear arrangements between Local Authorities and partner commissioning bodies for commissioning of services for children with SEND (at both a strategic and individual level), the integration of education, health and care provision for SEND where this would be beneficial (which may include pooling of budgets) and the agreement of shared outcomes including joint analysis of intelligence about needs of the local population. In order to meet the requirement to commission services at an individual case level, Health are required to identify a Designated Medical Officer. Arrangements must be in place within Health to agree any health provision in EHC Plans. Where there is provision which has been agreed in the health element of an EHC Plan, health commissioners must make arrangements to secure that provision.

4. Implementation of SEND Reforms in West Berkshire

4.1 A process for Education Health and Care assessments has been developed and is now in place, including a format for the EHC Plan. Three EHC Assessment Coordinators have been recruited to oversee new EHC assessments and the conversion of Statements to EHC Plans. A transition plan has been published setting out how the Council will achieve conversion of all Statements to EHC Plans by April 2018. Evaluation systems have been developed and will be implemented from January 2015. Feedback so far from families, schools and professionals has been very positive.

4.2 Personal Budgets are already in place for children and young people with disabilities through the Disabled Children's Team and through Adult Social Care. Continuing Health Care have begun to offer Health Personal Budgets, although it is understood that take up is low. There have as yet been no requests from families for direct payments for any part of the SEN component of the EHC Plan.

4.3 The SEN Assessment Team at West Berkshire Council was restructured in September 2013 to create a post of Assistant SEN Manager for Post 16 / Transition. This has enabled the team to take on management of cases up to age 25 including young people with SEND attending FE Colleges. Discussions have been held with Adult Services about the implications of young people having EHC Plans potentially up to age 25, including the requirement for care provision to be set out in these plans. The Multi Agency Transition Protocol is in the process of being redrafted to ensure that children's and adults' teams, and other agencies, work together as effectively as possible to support young people going through transition.

4.4 A Local Offer website is now in place, accessed through the Council's website, setting out education, health and care services which are available for children with SEND and their families. A "harvesting" mechanism draws in data on a regular basis from the BHFT and RBH websites. All Berkshire Local Authorities are using the same website provider, Open Objects, which means that data can readily be shared where appropriate.

4.5 The Parent Partnership Service, now known as the West Berkshire SEN & Disability Information, Advice and Support Service (SENDIASS), is developing its service so that it can offer independent advice to young people as well as parents. The service can also now offer information and advice on health and care issues in addition to educational issues. Disagreement resolution and mediation services are being commissioned from Global Mediation, which has agreed to absorb the additional requirements for these services at no extra cost until April 2015. The service is currently being retendered with a new service specification which meets all the requirements of the new legislation.

4.6 The NHS Central Southern Commissioning Support Unit, the Berkshire Healthcare Foundation Trust and the RBH Trust have been and continue to be engaged in discussions about the SEND Reforms including attendance at Steering Group and working group meetings. A pan Berkshire SEND Strategy Group has also been established, with representation from the CSU. This has enabled progress to be achieved around joint commissioning arrangements for children with SEND. Systems are in place for provision of Health advice for EHC assessments, establishing Health approval for the health content of EHC Plans, attendance at EHC Panels where necessary and for dispute resolution in the event of disagreement about funding responsibility.

5. Further SEND Reform developments in 2014-15

5.1 The Multi Agency SEND Reform Strategy Group has agreed its programme of work for the current academic year. The themes which are being focused on to embed and further develop the SEND reform agenda are as follows:

- Better engagement of young people with SEND in strategic planning
- Evaluation of EHC processes
- Joint commissioning arrangements with Health
- Clarifying the Local Authority's expectations of schools re SEND provision
- Advice for schools on their SEN Policies
- Further development of the Local Offer
- Person Centred Approaches – rolling these out in mainstream schools
- Personal Budgets Policy
- Revision of the SEN Transport Policy
- Social Care processes and how they can mesh with EHC processes
- Continued workforce development

5.2 A Task and Finish Group has been set up to work on each of these themes. All task and finish groups will include at least one parent and some will include young people.

6. Specific implications of SEND Reforms for Health commissioners and providers and progress made

6.1 A report taken to the Children's, Maternity, Mental Health and Voluntary Programme Board in early 2014 by the CSU (authored by Pranay Chakravorti) made the following recommendations:

- *That CCGs engage in the development of personal budgets for education, health and care provision.*

This is happening.

- *That joint commissioning arrangements are established at strategic and individual child level.*

These exist at the individual child level but need to be documented. Work is being done on this. Strategic joint commissioning arrangements for SEND are less explicit and require more work.

- *CCGs should ensure contracts with service providers include the expectation of participation in EHC Assessments and development of EHC Plans.*

This expectation seems to be well established but whether it is actually embedded in contracts needs to be explored further. There have been some issues around obtaining medical advice for EHC assessments for young people over 18, which need to be resolved.

- *Health and Wellbeing Boards should be used to promote the integration of services for children with SEND including joint arrangements and pooled budgets.*

This was discussed at the Health and Wellbeing Board meeting in May 2014. Opportunities for integration of services and joint arrangements are likely to be identified by the pan Berkshire SEN Strategy Group and can be brought to Health and Wellbeing Boards as and when they arise.

- *JSNA should be used to understand levels of need and to map existing services and spend.*

There is some guidance on this in "Children with special educational and complex needs: Guidance for Health and Wellbeing Boards", Department of Health Guidance September 2014.

- *Opportunities to use funding more flexibly should be explored, eg. CCG allocations to voluntary organisations could be used in a pooled arrangement with Local Authority funding.*

Not aware of any such arrangements.

- *Potential for accessing Better Care funds should be explored (there is some indication from the Department from Health that there may be a Children's Better Care Fund)*

Update to be given at the meeting.

- *CCGs should develop a process with partners for resolving disputes.*

It has been proposed that any disputes which cannot be resolved will be referred to the Designated Medical Officer in the CCG and the Director of Communities but this requires formal agreement of those parties.

- *CCGs and NHSE must agree local governance arrangements which will ensure ownership and accountability around SEND commissioning, with clear lines of responsibility for both strategic and operational commissioning.*

Update to be given at the meeting.

- *There must be clear arrangements about what is commissioned by each CCG and by NHSE.*

Update to be given at the meeting.

- *CCGs need to decide how they will approve the health content of EHC Plans, eg. by allocating a Health representative to sit on local decision making panels.*

A process for this has been agreed.

- *CCGs should identify a Designated Medical Officer with relevant clinical experience.*

A Designated Medical Officer has been identified.

- *CCGs must ensure their acute and community providers are working proactively with Local Authorities to develop, compile and publish the Local Offer.*

There has been good engagement from BHFT and the RBH Trust with the development of the Local Offer, which includes relevant health information.

6.2 In addition to the above recommendations, a report which was brought to the Health and Wellbeing Board in May 2014 suggested that the following should also be considered by CCGs:

- *All agencies and service providers will be expected to work in a person centred way and to offer services in as personalised a manner as possible.*

EHC assessment and planning processes have been designed to be person centred. Person centred planning processes are well embedded in special schools and are being rolled out to mainstream schools. Person centred approaches have been one of the themes of multi agency training prior to implementation of the reforms and will continue to be addressed in future workforce development.

- *EHC Plans must be clearly outcome focused. All reports submitted as part of EHC Assessments must therefore be drafted in such a way that they lend themselves to the development of outcome focused plans.*

There have been positive developments, particularly in relation to therapy reports.

- *The deadline for completion of EHC Assessments and publication of final EHC Plans will be 20 weeks (compared to 26 weeks for a Statement) so it will be critical that all professionals contributing to EHC Assessments, including health professionals, submit their reports within the 6 weeks allowed for submission of professional reports, in order that compliance with the 20 week timescale is not compromised.*

Health reports are generally being submitted within statutory deadlines for EHC assessments, with the exception of CAMHs reports.

- *Local Authorities will have a new duty to provide independent advice, disagreement resolution and mediation in respect of health issues as well as education and social care issues. There is therefore an argument for contribution to the cost of these services by Health commissioners.*

Discussion has taken place with the CSU about whether Health will use the Local Authorities' mediation arrangements for EHC disputes which relate to Health matters (and make an appropriate financial contribution) or whether existing arrangements for mediation within Health will be used. This is under consideration. Similarly, where mediation has a health element as well as an education and or care element, it has been proposed that Health would contribute to the cost of the mediation on a proportional basis, but this has yet to be formally agreed.

7. "Children with special educational and complex needs: Guidance for Health and Wellbeing Boards", Department of Health Guidance September 2016

7.1 This guidance is attached at Appendix One.

7.2 It reiterates some of the specific issues which Councils and CCGs need to address together in relation to services for children with SEND and complex needs, and sets out the role of Health and Wellbeing Boards in this respect.

7.3 Attention is drawn to the section of the guidance which covers CCG commissioning plans and the extent to which these address the needs of children with SEND and complex conditions. The guidance poses a number of questions which Health and Wellbeing Boards may wish to address in relation to CCG commissioning plans and SEND.

Appendices

Appendix A - "Children with special educational and complex needs: Guidance for Health and Wellbeing Boards", September 2014

Consultees

Local Stakeholders:

Officers Consulted:

Other:

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Department of Health

Children with special educational and complex needs

Guidance for Health and Wellbeing Boards

September 2014

Title: Children with special educational and complex need. Guidance for Health and Wellbeing Boards
Author: SCLGCP/CMHI/IDC/14100
Document Purpose: Guidance
Publication date: September 2014
Target audience: Health and Wellbeing boards
Contact details: Gareth James Disabled and Ill Child Services Team Children and Young People's Health & Wellbeing Social Care, Local Government and Care Partnerships Directorate 2E60, Department of Health, Quarry House, Quarry Hill, Leeds LS2 7UE gareth.james@dh.gsi.gov.uk

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Children with special educational and complex needs

Guidance for Health and Wellbeing boards

Prepared by Disabled and Ill Child Services Team, Department of Health

Contents

Introduction

The Health and Wellbeing Board (HWB) has a pivotal role to play supporting how the local NHS, social services and schools and colleges support the needs of children with complex and special educational needs including those with acute illness or injury. In particular, the HWB has responsibility for:

- overseeing the assessment of local needs in a Joint Strategic Needs Assessment (JSNA), and agreeing with its members a Joint Health and Wellbeing Strategy (JHWS); and

- giving its views on how well that strategy is supported by CCG commissioning, e.g. when consulted on draft commissioning plans or as part of the annual performance assessment of the CCG.

Each HWB will want to support the ambitions of the Pledge *Better health outcomes for children and young people*, signed by the leading bodies which support children and young people's health in England, and, guided by its principles, ensure there is appropriate consideration given to children and young people's health and wellbeing in all the Board's activities.[i] The HWB will want in particular to consider the effectiveness of support available at transition points between primary and secondary education, and between secondary and further or higher education, and the transition to adulthood and independent living.

Many HWBs are tackling this challenge. The Local Government Association has issued a useful interactive map showing the priorities which have been identified by HWBs across England, which can be found at:
www.local.gov.uk/health-and-wellbeing-boards/-/journal_content/56/10180/6111055/ARTICLE

This guidance aims to help support all HWBs in supporting the needs of children and young people with complex and special needs, by providing some hints and sources of further information which a Board can draw on with its partners. The guidance includes questions which an HWB may wish to consider in managing its organisation, building up a picture of local need and looking at local commissioning. This guidance may be read in conjunction with *Statutory Guidance on Joint Strategic Needs Assessments and Joint Health and Wellbeing Strategies* (Department of Health, 2013).[ii]

Special educational needs and disabilities (SEND)

Children and young people with complex health needs, and in particular, special educational needs, have not always been well served by the NHS and social services in the past,[iii] not least due to the complexity of a disjointed system. The new arrangements for joint commissioning for children and young people with special educational needs and disabilities (SEND) are intended to greatly improve the way in which the needs of the individual child are assessed, and a plan of services agreed. They also intend to strengthen the effectiveness of commissioning, by supporting collaborative approaches between health, education and social care.

Defining SEND

The Children and Families Act 2014 defines a child or young person as having special educational needs, if they have a learning difficulty or disability, which requires special educational provision to be made for them.

A child or young person is defined as having a learning difficulty or disability if they have a significantly greater difficulty in learning than the majority of others of the same age, or if they have a disability which prevents or hinders them from making use of facilities provided for other children of the same age in mainstream schools or post-16 institutions.

A child under compulsory school age may have learning difficulties or disability if they are likely to fall into the categories above when at compulsory school age.

From September 2014, new arrangements will come into effect for children and young people with SEND. The Children and Families Act 2014 introduces a new statutory framework for local authorities and clinical commissioning groups to work together to secure services for children and young people – up to the age of 25 – who have SEN or disability, including a new statutory code of practice which captures key actions and behaviours (*Special educational needs and disability code of practice: 0 to 25 years* https://www.gov.uk/government/publications/send-code-of-practice-0-to-25

Each CCG will have a statutory duty to co-operate with the relevant local authority, in a co-ordinated assessment of the needs of the individual child or young person assessed as having special educational needs and agree an individual, outcomes-focused Education, Health and Care (EHC) plan. This will replace the current Statutory Statement of Special Educational Needs. From September 2014, new entrants to the SEND system will receive an EHC plan, whilst children with existing statements will move to EHC plans in a managed process of transition over three years.

CCGs and local authorities must also co-operate in joint arrangements more generally to support children and young people with a disability who might not qualify for special educational needs. It is important that HWBs recognise that local services must seek to meet a wide range of disabilities and complex needs, far wider than the cohort of children who would qualify for an EHC plan.

In brief, the new approach requires CCGs and local authorities to have joint arrangements in place (either directly or via the services they commission from their provider Trusts), for considering and agreeing the following:

- the education, health and care provision reasonably required by the learning difficulties and disabilities which result in the children and young people concerned having special educational needs,
- by whom education, health and care provision is to be secured;
- what advice and information is to be provided about education, health and care provision;
- by whom, to whom and how such advice and information is to be provided;

- how complaints about education, health and care provision may be made and are to be dealt with; and
- procedures for ensuring that disputes between the parties to the joint commissioning arrangements are resolved as quickly as possible.

The arrangements must include arrangements for securing EHC needs assessments; securing the education, health and care provision specified in the EHC plan, and agreeing personal budgets for the child or young person.

Services for children with special educational needs could include a wide range of support, including speech and language therapy, assistive technology, children's mental health services, occupational therapy, habilitation training, physiotherapy, specialist equipment, wheelchairs and continence supplies.

Speech, language and communication needs

Speech, language and communication needs are particularly common amongst children and young people. Some estimates suggest as many as 10% of all children have such a need; HWBs will want to assure themselves that there is appropriate provision across education and health in their area, to meet the SLCN needs of all young people (the Child and Maternal Health Intelligence Network Knowledge Hub includes information on likely speech and language impairment for each local authority area – see p. 12 below).

The Communication Council has produced a briefing on SLCN for health audiences, which HWBs will find useful.
www.thecommunicationtrust.org.uk/sendreforms

The Royal College of Speech and Language Therapists has a range of information resources on speech and language therapy to support effective commissioning.
http://www.rcslt.org/speech_and_language_therapy/commissioning/intro

HWBs may also find useful the following *Guidance on quality standards for local authorities and schools as commissioners of speech and language therapy services in the UK*.
http://www.rcslt.org/speech_and_language_therapy/commissioning/qual_standards_schools

These new requirements for joint working give the HWB the opportunity to act as a forum for strategic discussions between local authorities and CCGs. Some areas may also have existing multi-agency groups which lead or co-ordinate on issues relating to children and young people, which the HWB can link with as appropriate. Where there are existing formal joint commissioning arrangements between a local authority and CCG or CCGs (for example, under a section 75 agreement), the HWB can again act as system driver.

SEND Pathfinders

Local authority Pathfinders have been piloting new approaches to joint commissioning for SEND for several years, generating a considerable body of learning for all local authorities on the

workforce development and the cultural and organisational change needed to implement the reforms of the Children and Families Act.

The Department for Education and Department of Health have published an implementation pack which outlines the vision for the reforms and contains useful information for strategic leaders. Further information and case studies, together with details of the pathfinder champions available in every region, can be found at www.sendpathfinder.co.uk

Children and young people with special educational needs constitute only a proportion of those with complex needs in a local authority or CCG area. In 2011, it was estimated that 14% of children aged 0-15 had a long-standing illness and 6% of children in the same age-group had a limiting long-standing illness.[iv] The HWB will want to consider also how locally health services are meeting the needs of children and young people with acute, life-limiting conditions, such as cancer and leukaemia, and long-term conditions, such as diabetes, asthma, epilepsy and cerebral palsy.

Children's charter

Every Disabled Child Matters and the Children's Trust, Tadworth have developed the Disabled Children's Charter for all Health and Wellbeing Boards, setting out 7 commitments and a vision statement for each Board. Each HWB is encouraged to sign the Charter as a sign of its commitment to meeting the needs of disabled children and young people.

The Charter can be found at:
www.edcm.org.uk/media/140960/disabled-childrens-charter-for-hwb.pdf

The accompanying guidance includes valuable links to resources on children's disability. *Why sign the Disabled Children's Charter for Health and Wellbeing Boards?*
www.edcm.org.uk/media/140961/why-sign-the-disabled-childrens-charter-for-health-and-wellbeing-boards.pdf

Health and wellbeing board strategy

The HWB – and its individual members – will want to ask themselves the following questions in considering how the work of the HWB supports children and young people with special educational needs and disabilities locally. Some of these are questions about the way the HWB organises its work, some are about its relationship-building. A number of these reflect the statutory requirements on HWBs under section 193 of the Health and Social Care Act 2012 (to involve local people in preparing joint strategic needs assessments), and together they might provide a useful framework for how the Board organises its approach.

Does the HWB have a designated children's lead, with agreed responsibilities in relation to the health and wellbeing of local children and young people?

Has the HWB considered or adopted the Pledge or the Disabled Children's Charter?

Does the HWB have a specific policy or position statement in relation to how it intends to support the needs of local children and young people (other than the JHWS), e.g. through influencing commissioning plans?

How does the HWB ensure the views of young people are considered in drawing up its JSNA, or JHWS?

How does the HWB ensure the views of children or young people are considered?

Does the HWB have an agreed process for consulting children, young people and parents and carers on its Joint Health and Wellbeing Strategy?

How does the HWB engage with local children and young people with a range of experiences and conditions, to inform its role?

Does the Joint Health and Wellbeing Strategy specifically refer to children and young people with complex health needs or special educational needs?

To what extent are the needs of CYP with complex health needs or special educational needs are already addressed in existing multiagency strategies and plans?

What existing arrangements are there locally for consulting CYP, their families and carers and what can the HWB learn from existing information?

Joint strategic needs assessments (JNSAs) and joint health and wellbeing strategies (JHWS)

HWBs will need to ensure that they are aware of the complexity of local children and young people's needs, and have a good understanding of the key implications for children and their families of complex and special educational needs. HWBs will want in particular to consider how integrated approaches to meeting local need can provide better outcomes for the child and their family, and remove avoidable use of resources.

The HWB will want to agree how detailed it makes its assessment of the needs of local children with special educational and complex needs, and how this is reflected in the local JHWS. This should be done with regard to their role in influencing CCGs in making commissioning plans, and their role in providing a benchmark against which CCG commissioning can be measured (see below).

The biggest challenge the HWB will face in building up a picture of local needs is obtaining the right information. There are several different possible sources, which can be accessed in different ways. HWBs, with limited resources to devote to fact-finding, will need to prioritise their lines of enquiry and oversee the work of the local authority Directors of Public Health and Children's Services in building up a picture of need. Speaking to those with direct experience of service delivery, either as providers or recipients, is crucial to prioritising actions to build up the JSNA – indeed, some local organisations, such as the Parent Carer Forum, may have already undertaken extensive local research and assessment of SEN and other complex needs in the local community, on which the HWB can draw (see below).

CCG members of the HWB should play a significant part in the identification of local needs, drawing on previous commissioning plans and strategies. Their commissioning support units and local providers delivering paediatric services will also be key contacts. Hospital Episode Statistics will indicate levels of paediatric admissions (outpatient data is far less useful, as the majority of outpatient attendances are coded as "Unknown and unspecified causes of morbidity"). There is however a significant absence of key data on outcomes for children with complex needs, and the HWB may wish to highlight this as a barrier to effective local commissioning, which the members of the Board can together seek to address.

How parent carer forums can help HWBs

In most local authority areas there is a parent carer forum, whose membership is made up of parents of children with a range of disabilities and conditions.

The primary aims of parent carer forums are to work in partnership with strategic leads, service providers and commissioners to improve the services across health, education and social care that their children access.

Parent carer forums can help HWB collect both quantitative and qualitative evidence to feed into the JSNA and JHWS. They can provide specialist knowledge of the wide range of services disabled children access and can provide insight into how services can be better integrated across health, education and social care.

Some of their members take on a more active role, working directly as a representative of parents in the local area on strategic decision-making boards and ensuring that parent carers are full partners in decision making at all levels.

Parent carer forums can also work with commissioners to make sure services are commissioned that meet their children's needs and help commissioners monitor how well these services are being provided.

Parent carer forums can also help HWB reach disabled children and young people to make sure their views are heard.

Parent carer forums began to develop in 2008 across England funded by the Department for Education. Involving parent carer forums in commissioning local services was shown to be key to developing services to meet the needs of families and make best use of resources. The evidence of this was so strong that in 2011 the Department for Education agreed to continue supporting and funding parent carer forums for a further four years. This included funding the National Network of Parent Carer Forums (NNPCF), which brings together information from forums across England and works closely with the Department for Education, the Department of Health, and other partner organisations to improve outcomes for children and young people with disabilities or additional needs and their families.

Further information

Contact a Family: for examples of how parent carer forums have helped improve services and resources on parent participation, see www.cafamily.org.uk/parentcarerparticipation

National Network of Parent Carer Forums: for more information about the NNPCF and useful resources see www.nnpcf.org.uk

Contact details for all local parent carer forums can be found on both websites.

Children and Young People's Health Benchmarking Tool

The Children and Young People's Health Benchmarking Tool is being developed in response to the recommendations of the Children and Young People's Health Outcomes Forum. It brings together and builds upon health outcome data from the Public Health Outcomes Framework (http://www.phoutcomes.info/) and the NHS Outcomes Framework (https://www.gov.uk/government/publications/nhs-outcomes-framework-2014-to-2015).

The tool can be found at:
http://fingertips.phe.org.uk/profile/cyphof

Child and Maternity Public Health Observatory

By far the most useful resource for HWBs is the Child and Maternal Health Intelligence Network (part of Public Health England) which provides access to a wealth of data and advice on children's health. HWBs may find of particular value:

1. **The NHS Atlas**
   http://atlas.chimat.org.uk/IAS/

The Data Atlas collates data and statistics on child and maternal health and allows interactive maps to be created to benchmark the outcomes in an area, against regional and national comparators. The data includes a wide range of health and wellbeing indicators, including data on admissions, surgery etc.

2. **The Knowledge hub – disability**
http://www.chimat.org.uk/disability

This resource comprises the following tools.

Service Snapshot - Disability provides a summary of demand, provision and outcomes for services in a particular area. It combines data from ChiMat and the Children's Services Mapping programme.

Needs Assessment Report - **Children and young people with disabilities** provides evidence-based information on prevalence, incidence and risk factors affecting children's health and the provision of healthcare services. These support HWBs in undertaking needs assessments as part of children's and young people's planning and joint strategic needs assessments.

Needs Assessment Reports can be generated for the following topics:

- Child and adolescent mental health (CAMHS) for local authorities and CCGs updated
- Children and young people with disabilities for local authorities
- Continence in children for local authorities updated
- Demographic profile for local authorities updated
- Maternity for primary care trusts
- Speech and language impairment for local authorities

Self Assessment Tool - Disability helps commissioners, clinical and managerial leads for services supporting disabled children to assess progress against standards.

The Data Atlas brings together a range of data and statistics on child and maternal health into one easily accessible hub. It has been recently redeveloped to make it easier to use and interpret and includes updated data for maternity.

Learning disabilities and CAMHS knowledge hub where HWBs can find key resources, sign up to the monthly LD CAMHS e-Bulletin and join the e-Discussion forum to exchange questions and ideas with peers.

Support and training. If HWB members need help or advice in using the tools or interpreting the information they provide, details are available of a Local Specialist working in each area.

HWBs may also wish to explore the hubs relating to the health and wellbeing of young people (http://www.chimat.org.uk/youngpeople), and mental health and psychological well-being in children and young people (http://www.chimat.org.uk/camhs).

3. **NHS Atlas of Variation in healthcare for children and young adults**

http://www.chimat.org.uk/variation

The NHS Atlas of Variation in Healthcare for Children and Young People identifies unwarranted variation in children's services, highlighting opportunities for commissioners and clinicians to improve health outcomes and minimise inequalities.

The 25 indicators mapped at primary care trust (PCT) level include:

• perinatal mortality
• early screening such as new-born hearing and retinopathy of prematurity
• immunisation
• emergency admission rates for long term conditions such as epilepsy and asthma.
Overall levels of expenditure on children's community health services are also shown.

Right Care has published the Atlas in collaboration with clinical specialists and ChiMat. For more information and access to the full data.

4. The JSNA Navigator – Children and Young People
http://www.chimat.org.uk/jsnanavigator

This tool allows HWBs to access the key data needed for conducting a Joint Strategic Needs Assessment for children and young people.

5. Child Health Profiles
http://www.chimat.org.uk/profiles

These profiles provide a snapshot of child health and wellbeing for each local authority in England, and allows comparisons locally and nationally, including a snapshot of performance against 32 selected indicators.

Information on specific conditions

Useful information on prevalence and commissioning for specific conditions can be found in the following resources, developed by the NHS, NICE and voluntary sector organisations. Some of these go into greater detail than an HWB is likely to need, but all provide a valuable insight into how providers might meet the needs of children with a range of complex conditions.

ADHD	CG 72 Attention deficit hyperactivity disorder (ADHD) (CG72) http://publications.nice.org.uk/nice-quality-standard-for-autism-ifpqs51 Antisocial behaviour and conduct disorder in children and young people http://publications.nice.org.uk/antisocial-behaviour-and-conduct-disorders-in-children-and-young-people-recognition-intervention-cg158
Asthma	Q25 Quality standard for asthma (covering 12 years+) http://publications.nice.org.uk/quality-standard-for-asthma-qs25
Autism	CG 128 Autism in children and young people. http://guidance.nice.org.uk/CG128/Guidance CG170 Autism - management of autism in children and young people: full

	guideline. http://guidance.nice.org.uk/CG170/Guidance QS51 Nice quality standard for autism http://guidance.nice.org.uk/QS51
Cerebral palsy / spasticity	CG 145 Spasticity in children and young people with non-progressive brain disorders: management of spasticity and co-existing motor disorders and their early musculoskeletal complications. www.nice.org.uk/nicemedia/live/13803/60023/60023.pdf
Mental health	Mind Ed e-Portal https://www.minded.org.uk/ This is a free, online educational and advice programme designed to support those working with young people to identify signs of mental health needs in children and young people. The Youth Well-Being Directory http://www.youthwellbeingdirectory.co.uk/find-a-service/ This directory was developed to provide clearer information about what services are available in local areas for children and young people with mental health needs, the types of services offered and referral routes. Services are also compared against ACE-V Quality Standards. The site provides: - information on standards of practice and commissioning; - networking space for providers and commissioners; - an opportunity for services to increase their recognition; - an opportunity for service providers to self-assess against standards, to increase chances of securing funding
Paediatric continence	NICE guidance on commissioning a paediatric continence service. http://www.nice.org.uk/usingguidance/commissioningguides/paediatriccontinenceservice/CommissioningPaediatricContinenceService.jsp ERIC – Education and Resources for Improving Childhood Continence http://www.eric.org.uk/ The ChiMat Needs Assessments Reports include one for continence in children for each local authority area. http://atlas.chimat.org.uk/IAS/profiles/needsassessments
Diabetes	NICE are currently developing guidance on Diabetes in children and young people. The National Paediatric Diabetes Audit (NPDA) collects data from 178 Paediatric Diabetes Units across England and Wales. In 2010-11, audit data was collected from 23,516 infants, children and young people under the age of 25 years with diabetes. www.diabetes.org.uk/Professionals/Service-improvement/National-Diabetes-Audit/ The Diabetes UK website (www.diabetes.org.uk) and the former NHS Diabetes website. (http://webarchive.nationalarchives.gov.uk/20130316063827/http://www.diabetes.nhs.uk/) have valuable information on Diabetes.

Epilepsy	CG137 The epilepsies: the diagnosis and management of the epilepsies in adults and children in primary and secondary care (NICE, 2012). http://publications.nice.org.uk/the-epilepsies-the-diagnosis-and-management-of-the-epilepsies-in-adults-and-children-in-primary-and-cg137/about-this-guideline
Palliative care	Together for Short Lives has: - an invaluable library of research abstracts http://www.togetherforshortlives.org.uk/professionals/service_planning/research_abstracts - contact details for local palliative care networks http://www.togetherforshortlives.org.uk/professionals/service_planning/networks - a commissioning guide for CCGs which will be useful for HWBs http://www.togetherforshortlives.org.uk/about/our_policy_work/186_commissioning_children_s_palliative_care_in_the_new_nhs
Sensory impairment / communication needs. Habilitation	The ChiMat Needs Assessments Reports include one developed in conjunction with the Royal College of Speech and Language Therapists for speech and language impairment needs for children in each local authority area. http://atlas.chimat.org.uk/IAS/profiles/needsassessments Information about multi-sensory impairment http://www.ncb.org.uk/media/875200/earlysupportmulti-sensoryimpairmentsfinal2.pdf Quality standards. Delivery of Habilitation Training (Mobility and Independent Living Skills)for Children and Young People with Visual Impairment http://www.ssc.education.ed.ac.uk/resources/vi&multi/habilitation.pdf
Special educational needs	The ChiMat Needs Assessments Reports include one developed for children and young people with disabilities for each local authority area. http://atlas.chimat.org.uk/IAS/profiles/needsassessments Ann Hagell, John Coleman, Fiona Brooks, *Key Data on Adolescence 2013* (Association for Young People's Health, 2013). www.ayph.org.uk/publications/480_KeyData2013_WebVersion.pdf See in particular chapter 7, Long term conditions and disability, pp. 93-102.

The local offer and commissioning plans

Each HWB has an important role in considering and commenting on the commissioning plans of the CCG as they are developed, and when published (see the box below for the statutory elements of this role). Similarly, the HWB will be consulted by the CCG, and NHS England, when undertaking their annual report, and performance assessment respectively. In each case, the HWB's role is to assess the extent to which the CCG is contributing to the delivery of the agreed health and wellbeing strategy for the local area, and by extension, meeting the needs of the local population.

The statutory role of Health and Wellbeing Boards in relation to CCGs

The CCG must involve each relevant HWB in preparing or revising its commissioning plan ('relevant Health and Wellbeing Board', in relation to a CCG means a Health and Wellbeing Board established by a local authority whose area coincides with, or includes the whole or any part of, the area of the CCG). The CCG must give each relevant HWB a draft of the plan, and consult each HWB on whether or not the draft takes proper account of each joint health and wellbeing strategy. The HWB must give the CCG its opinion on this, and may give NHS England its opinion as well (ensuring it gives the CCG copy of this). The CCG must include in its published plan, a statement of the final opinion of each relevant HWB on the plan.*

A CCG must give a copy of its final commissioning plan to its relevant HWBs.**

If the CCG revises the plan in a way it considers significant, it must give a copy of the new plan to its relevant HWBs.*** If it revises the plan in any other way, it must publish a document setting out the changes it has made to the plan, and give a copy to each relevant HWB.†

In each financial year, a CCG must prepare an annual report on how it has discharged its functions in the previous financial year. This must include a review of the extent to which the group has contributed to the delivery of any joint health and wellbeing strategy to which the CCG was required to have regard, on which the CCG must consult each relevant HWB.‡

In conducting its annual performance assessment of a CCG, NHS England must consult each relevant HWB as to its views on the CCG's contribution to the delivery of any joint health and wellbeing strategy to which the CCG was required to have regard.§

* NHS Act 2006, section 14Z13.
** NHS Act 2006, section 14Z11(6).
*** NHS Act 2006, section 14Z12 (2)(b).† NHS Act 2006, section 14Z12 (3).
‡ NHS Act 2006, section 14Z15.
§ NHS Act 2006, section 14Z16.

Although the health and wellbeing strategy will have been informed by the HWB's assessment of local children's needs, any assessment of plans or CCG contribution to strategy delivery, should be informed by the views of HWB members, and their constituents. The role of local Healthwatch, as representative of local people, and the elected representatives who sit on the

HWB, will in particular have a key role to play in ensuring the Board's scrutiny function is effective in representing the views of the local population.

The HWB will need to ensure that the CCG is participating in the development of the statutory local offer of service to meet the needs of children and young people with SEND, and that services are being commissioned to deliver this, meeting the full range of children's complex needs, which could include the following health provision:

- autism teams;
- speech and language therapy and other communication support;
- therapies;
- children's wheelchairs;
- CAMHS/ mental health services for children and young people
- orthotics and prosthetics;
- acute services for children, including for long-term conditions;
- palliative and hospice care (including hospice at home services);
- paediatric continence;
- community and specialist nurses;
- educational and clinical psychologists to support schools and parents in supporting their child's learning and behaviour.

The HWB will need to take a view on what level of detail is appropriate for commissioning plans, but will need to satisfy itself that the CCG is commissioning appropriate services:

- to satisfy its statutory duty under section 3 of the NHS Act 2006: to commission services to meet the needs of the population for which they are responsible, to a reasonable extent, and
- meeting its statutory duties under the Children and Families Act 2014 to participate in joint commissioning arrangements for children with SEND, and in particular, to ensure that the health services specified in the child or young person's Education, Health and Care plan are secured.

Scrutiny of the CCG performance will certainly require the HWB to satisfy itself that those needs they identified in their JSNA and JHWS are fully met locally.

The HWB may wish to consider not only the range of clinical and other services, but the nature of the provision: is there sufficient consideration given to the provision of flexible and community-based services? Does the commissioning plan provide evidence of integrated pathways, or effective support for transition into adulthood? The HWB may find the following suggestions useful in considering CCG commissioning plans and the CCG contribution to the JHWS.

Do plans refer to special educational needs, or learning disability?

Do plans refer to specific children's complex conditions – either in general, or specific conditions? If not, how is the CCG intending to meet the needs of children with a complex condition?

Do plans include provision for community-based services for children, or integrated pathways?

Is it clear from the plans that assessments for SEND, as well as provision of services, will be commissioned?

Is it apparent how the plans have been quality assured? Or how young people and their families have been consulted or otherwise involved in their development?

Do plans include make specific reference to the JSNA, and the priorities of the JHWS? If not, do plans attempt to quantify local demand, or the volume of services to be commissioned?

Do plans indicate the rationale for commissioning decisions? Do they indicate the outcomes to be delivered for children and young people?

How has the CCG engaged with children and young people with SEND or complex conditions?

Does the CCG measure its performance against specific outcome measures for children? Does it publish local metrics on outcomes for children?

How has the CCG planned for, and delivered, a comprehensive local offer for children with SEN?

Useful links

Children and Young People's Health Outcomes Forum Young People and Families Factsheet
https://www.gov.uk/government/uploads/system/uploads/attachment_data/file/216860/CYP-Factsheet-Health-and-Wellbeing.pdf

Children with special educational needs: an analysis – 2012 (Department for Education).
https://www.gov.uk/government/publications/children-with-special-educational-needs-an-analysis-2012

The Disabled Children's Charter for Health and Wellbeing Boards
www.edcm.org.uk/media/140960/disabled-childrens-charter-for-hwb.pdf

Growing up with Diabetes: children and young people with diabetes in England (Royal College of Paediatrics and Child Health, 2009)
http://www.diabetes.org.uk/Documents/Reports/CYP_Diabetes_Survey_Report.pdf

Not just a phase. A Guide to the Participation of Children and Young People in Health Services (Royal College of Paediatrics and Child Health, 2010)
www.rcpch.ac.uk/system/files/protected/page/RCPCH_Not_Just_a_Phase_0.pdf

Statutory Guidance on Joint Strategic Needs Assessments and Joint Health and Wellbeing Strategies (Department of Health, 2013).
www.gov.uk/government/uploads/system/uploads/attachment_data/file/223842/Statutory-Guidance-on-Joint-Strategic-Needs-Assessments-and-Joint-Health-and-Wellbeing-Strategies-March-2013.pdf

You're Welcome. Quality Criteria for Young Persons Friendly Services (Department of Health, 2011)
https://www.gov.uk/government/publications/quality-criteria-for-young-people-friendly-health-services

Why sign the Disabled Children's Charter for Health and Wellbeing Boards?
www.edcm.org.uk/media/140961/why-sign-the-disabled-childrens-charter-for-health-and-wellbeing-boards.pdf

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Endnotes

[i] *Better health outcomes for children and young people. Our pledge* (February 2013), www.gov.uk/government/publications/national-pledge-to-improve-children-s-health-and-reduce-child-deaths

[ii] www.gov.uk/government/uploads/system/uploads/attachment_data/file/223842/Statutory-Guidance-on-Joint-Strategic-Needs-Assessments-and-Joint-Health-and-Wellbeing-Strategies-March-2013.pdf

[iii] See for example the Care Quality Commission report *Healthcare for disabled children and young people* (March, 2012), which demonstrated the lack of knowledge in PCTs of children's disability locally, with five PCTs claiming that they had no disabled children resident in their area. http://www.cqc.org.uk/media/support-families-disabled-children

[iv] *Health Survey for England, 2011* – Health and Social care Information Centre. http://www.hscic.gov.uk/catalogue/PUB09300

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Title of Report:	**Newbury Dementia Action Alliance**
Report to be considered by:	The Health and Wellbeing Board
Date of Meeting:	22/01/2015

Purpose of Report: **To inform the Board of the work that has been undertaken by the Dementia Action Alliance to promote Newbury as a Dementia Friendly Community.**

Recommended Action: **To consider options for ongoing support so this work can continue.**

When decisions of the Health and Wellbeing Board impact on the finances or general operation of the Council, recommendations of the Board must be referred up to the Executive for final determination and decision.		
Will the recommendation require the matter to be referred to the Council's Executive for final determination?	Yes: ☐	No: ☒

Is this item relevant to equality? Please tick relevant boxes	**Yes**	**No**
Does the policy affect service users, employees or the wider community and:		
• Is it likely to affect people with particular protected characteristics differently?	☒	☐
• Is it a major policy, significantly affecting how functions are delivered?	☐	☒
• Will the policy have a significant impact on how other organisations operate in terms of equality?	☒	☐
• Does the policy relate to functions that engagement has identified as being important to people with particular protected characteristics?	☒	☐
• Does the policy relate to an area with known inequalities?	☒	☐
Outcome Where one or more 'Yes' boxes are ticked, the item is relevant to equality. In this instance please give details of how the item impacts upon the equality streams under the executive report section as outlined.		

Health and Wellbeing Board Chairman details	
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Executive Report

1. Introduction

1.1 In 2012 the West of Berkshire PCT as was, the NHS Trusts and the three unitary authorities in the west of Berkshire worked collaboratively to make several bids to the Prime Minister's Dementia Challenge Fund. One of the successful bids was funding which was given to each of the local authorities to set up a project to promote the area as a dementia friendly community and as part of this to set up a local Dementia Action Alliance. The funding was sufficient to employ a part time project worker for one year.

1.2 The objectives of the project were:

- to identify ways in which Newbury could become a more dementia friendly place to live and work in line with the National Dementia Declaration. (Appendix i)
- to conduct a consultation with people with dementia and their carers to establish local needs and opportunities
- to obtain 50 action plans for positive change from within the local business, service and public sector community
- to obtain working towards dementia friendly community status for 2014/2015
- to set up a local Dementia Action Alliance
- to host a public launch of the project
- to raise awareness of dementia amongst the local community
- to look at ways to sustain the project going forward

1.3 Details of the outcomes and benefits of this project are contained in the End of Project Report which is attached as an appendix. There is also more information on the Newbury DAA website newburydaa@westberks.gov.uk However in brief summary the outcomes and benefits were:-

34 local businesses and organisations signed up to the Dementia Action Alliance

All have undertaken specific actions to make their organisation more dementia friendly

Dementia Friends training was provided and continues to be provided. During the course of the project over 100 people participated on these and became dementia friends

There was a very successful launch on 6th June which was opened by Richard Benyon and a local psycho-geriatrician

There was several very positive articles in the local Press and radio.

1.4 The funding for the project worker finished in September 2014 and since then a local group of stakeholders are attempting to carry on however without dedicated co-ordination the group is struggling to maintain momentum and there is a real danger that all the good work and local participation in helping to make West Berkshire a dementia friendly place to live will be lost.

2. Equalities

2.1 The project worker undertook wide ranging consultation and below are some of the organisation and groups she consulted with.

2.2 The objective of the consultation was to ensure that the project maintained people with dementia and their carers at the heart of its work, ensuring that this was a grass roots project that made a tangible difference to the lives of people living with dementia and their carers in Newbury

2.3 A variety of methods were used to gather information from people living with dementia, their families and carers in order to establish those things that they would like to see changed within their community.

2.4 Data Collection included :

- Discussions with users at Alzheimer's Society Service Groups
- One to one informal interviews with people with dementia and their carers
- Display stand and personal interaction with over 100 members of the public on World Mental Health Day at Newbury Hospital
- Presentations and discussions at the Carers Courses run by the Memory Clinic
- Participation at Carers Rights Day at Newbury Town Hall
- Discussion with the YPWD Empowerment Group
- Walks around Newbury Town Centre, The Memory Clinic, West Berkshire Community Hospital and the Corn Exchange with a person with dementia to give feedback on accessibility, facilities and environment
- Discussions and presentations with businesses to establish how they could contribute to a dementia friendly community

2.5 The Dementia Action Alliance Co-ordinator has carried out the following presentations and meetings to ensure delivery of the consultation feedback, raise dementia awareness and encourage participation in the dementia friendly community project.

- Newbury Town Council
- Newbury & District CCG
- St Georges Church Community
- Newbury Shop Safe
- The BID Group
- Public Forum Meeting
- The Pharmacy Group
- The Safer Communities Team – Newbury Police
- Thames Valley Public Health England
- Thames Valley Health Knowledge Team
- West Berkshire Volunteer Centre
- Empowering West Berkshire
- West Berkshire Disability Alliance
- Richard Benyon MP

2.6 In addition the DAA Co-ordinator was invited to and participated in:

Trading Standards SCAM discussion forum
Social Care Public Account
Carers Rights Day
The West Berkshire Pop Up Shop
Thames Valley Health Knowledge Team – Public Forum on Dementia in West Berks

Appendices

Appendix A – End of Project Report

Consultees:

Local Stakeholders: The Newbury DAA was established in January 2014 and held its' first Steering Group Meeting on 17th January 2014. The group meets monthly and consists of the following members:
John Flynn – YPWD
Vicky Pocock – Carer for PWD and Parkinsons
Rachel Craggs – Crime Reduction Officer – Safer Communities Team
Rachel Johnson - West Berkshire Public Health and Wellbeing
Alison Love – West Berkshire Adult Social Care
Ian Taylor – RBFRS
Carol Brindley – Adult Mental Health Team WBFHT
Nettie Griffin – BID Group Street Ranger
Dominic Bartlett – BID Group Street Ranger
Mary Lesley Downey – Solicitor
Susan Gillespie – PCOS Thames Valley Police
Sue Butterworth – DAA Co ordinator

Special thanks should be extended to the following businesses and organisations who have worked to support the Newbury DAA over the past 12 months :

The Corn Exchange
Newbury Museum
Newbury Library
Newbury College
McDonalds
Starbucks
YPWD
Rainbows Arts & Crafts
The Hands on Company
Newbury Singing for the Brain group
The Berkshire Healthcare NHS Foundation Trust & Beechcroft Memory Clinic
West Berkshire Public Health & Wellbeing
West Berkshire Adult Social Care
The Alzheimer's Society
The Safer Communities Partnership
The BID Street Rangers

Officers Consulted: Tandra Forster – Head of Adult Services

Other:

NEWBURY

DEMENTIA FRIENDLY COMMUNITY

END OF PROJECT REPORT

Sue Butterworth

September 2014

CONTENTS

Introduction & Background

The Newbury Dementia Friendly Community Project was commissioned by West Berkshire Council using funding successfully secured from the Prime Ministers Challenge on Dementia Fund and was hosted by the Alzheimer's Society. This was a one year fixed term project providing one member of staff working 17.5 hours per week. Similar projects ran simultaneously in Wokingham and Reading. In Newbury the Dementia Action Alliance Co ordinator was Sue Butterworth.

The objectives of the project were :

- to identify ways in which Newbury could become a more dementia friendly place to live and work in line with the National Dementia Declaration. (Appendix i)
- to conduct a consultation with people with dementia and their carers to establish local needs and opportunities
- to obtain 50 action plans for positive change from within the local business, service and public sector community
- to obtain working towards dementia friendly community status for 2014/2015
- to set up a local Dementia Action Alliance
- to host a public launch of the project
- to raise awareness of dementia amongst the local community
- to look at ways to sustain the project going forward

What is a Dementia Friendly Community

A dementia friendly community is a city, town or village where people with dementia are understood, respected and supported and are confident they can contribute to community life

The National Dementia Declaration

I have personal choice and control or influence over decisions about me

I know that services are designed around me and my needs

I have support that helps me live my life

I have the knowledge and know-how to get what I need

I live in an enabling and supportive environment where I feel valued and understood

I have a sense of belonging and of being valued as part of a family, community and civic life

I know there is research going on which delivers a better life for me now and hope for the future

Why this project is important

800,000 people are currently living with dementia in the UK

670,000 family & friends are acting as primary carers

500,000 with dementia are living in the community

One third of people with dementia live alone

77% of people with dementia feel anxious or depressed

67% of people with dementia do not always feel part of their community

44% of people with dementia feel they lost friends after they were diagnosed

The number of people living with dementia in the UK is expected to rise to 1,000,000 by 2021

West Berkshire Statistics

Estimated number of people currently diagnosed as living with dementia : **1267**

Current diagnosis rate for dementia : **48.7%**

Number of Social Service maintained dementia beds in care homes : **134**

Estimated cost of dementia care : **£5m**

(there are new statistics being released by the Alzheimer's Society on 10/9 so we need to decide if we should wait for these as they are likely to show a significant increase in those diagnosed)

Consultation

The objective of the consultation was to ensure that the project maintained people with dementia and their carers at the heart of its work, ensuring that this was a grass roots project that made a tangible difference to the lives of people living with dementia and their carers in Newbury

A variety of methods were used to gather information from people living with dementia, their families and carers in order to establish those things that they would like to see changed within their community.

Data Collection included :

- Discussions with users at Alzheimer's Society Service Groups
- One to one informal interviews with people with dementia and their carers
- Display stand and personal interaction with over 100 members of the public on World Mental Health Day at Newbury Hospital
- Presentations and discussions at the Carers Courses run by the Memory Clinic
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- Discussions and presentations with businesses to establish how they could contribute to a dementia friendly community

Feedback

Below is a summary of the feedbacks that were received.

- Road Safety

Uneven pavements are hazardous
Hard to see the kerbs
Not enough crossings

- Public Transport

Dementia awareness training for bus drivers,
More rural bus routes & frequent
Route maps at each bus stop

- Outside Environment

Colour coded street signs
Plenty of “you are here maps”
Public Toilet signs
More seating available for rest stops or waiting for people
Parking and pedestrian only access causing a problem for those with mobility and dementia
Dementia awareness training for parking attendant staff
Free blue badge parking available when you have to park in a non disabled space with your blue badge as all others are occupied.
Eye level signage of blue badge parking spaces

- Inside Environment

Shop aisles too narrow and cluttered
Education and awareness of dementia for retail and service staff
Hard to negotiate door ways
Too noisy
Coloured toilet seats and no mirrors on the back of toilet doors
Shiny floors can look like slippery ice or water
Black door mats can look like holes
Have “personal” help especially in the larger shops – someone to help them find things
Access to ground floor disabled toilets
A “slow” lane, trained & named staff
Bigger and more frequent signage (use pictures as well as words, make signs unambiguous (eg. 2 for 1)
DFC logo above till points serviced by a Dementia Friend
Priority seating and coloured crockery in small coffee shops

- GPs

To be better trained in dementia and hospitals to have more appointments available
Continuity of care by seeing the same GP / Practice Nurse for each visit
Offer a quiet waiting space / room away from the main reception area
Not to be rushed
The offer of double appointments
Diagnosis to be explained fully, slowly and respectfully
To be called by name, in person by the practitioner for appointments (automated announcements and flashing name alerts are either missed or cause concern and anxiety about where to go next
An acknowledgement that awareness and understanding are not the same thing
An understanding that everyone is an individual and their experience of dementia will be different
Not to be spoken down to / be patronised, especially by receptionists
Clear signage to toilets
Signposting to relevant Community Services and Charities
Receiving the same colour and shape of medication from the pharmacy in repeat prescriptions

- Awareness

Volunteers in the town to help
A local number to ring if you are worried about someone
Need for understanding, tolerance, patience and respect when in the town.

- Activities

Somewhere to go, something to do – drop-in dementia café in the town centre
Somewhere to meet other carers for peer support
Apprehension around walking to local shops 'Did I come this way?'. Solution is to memorise distinctive landmarks such as shop signs, large trees etc
Bank cards with no pin numbers to remember would be welcomed
Meeting up with friends for mutual support was considered very powerful

Newbury Dementia Action Alliance

The Newbury DAA was established in January 2014 and held its' first Steering Group Meeting on 17th January 2014. The group meets monthly and consists of the following members:

John Flynn – YPWD

Vicky Pocock – Carer for PWD and Parkinsons

Rachel Craggs – Crime Reduction Officer – Safer Communities Team

Rachel Johnson - West Berkshire Public Health and Wellbeing

Alison Love – West Berkshire Adult Social Care

Ian Taylor – RBFRS

Carol Brindley – Adult Mental Health Team WBFHT

Nettie Griffin – BID Group Street Ranger

Dominic Bartlett – BID Group Street Ranger

Mary Lesley Downey – Solicitor

Susan Gillespie – PCOS Thames Valley Police

Sue Butterworth – DAA Co ordinator

Working towards being a Dementia Friendly Community status was formally received on 11th March 2014.

Activities and Opportunities

The Dementia Action Alliance Co ordinator has carried out the following presentations and meetings to ensure delivery of the consultation feedback, raise dementia awareness and encourage participation in the dementia friendly community project.

- Newbury Town Council
- Newbury & District CCG
- St Georges Church Community
- Newbury Shop Safe
- The BID Group
- Public Forum Meeting
- The Pharmacy Group
- The Safer Communities Team – Newbury Police
- Thames Valley Public Health England
- Thames Valley Health Knowledge Team
- West Berkshire Volunteer Centre
- Empowering West Berkshire
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- Richard Benyon MP

In addition the DAA Co ordinator was invited to and participated in :

Trading Standards SCAM discussion forum

Social Care Public Account

Carers Rights Day

The West Berkshire Pop Up Shop

Thames Valley Health Knowledge Team – Public Forum on Dementia in West Berks

Opportunities that arose from the project

Participation in the Libraries Post Card Project

Participation at the West Berkshire Pop Up Shop initiative

Readibus offer of transport within Newbury – now working with YPWD in Newbury

RBFRS - process for awareness raising of free fire home safety checks

Liaison with DWP visiting officer

Coin recognition chart and tips on dementia being distributed by Memory Clinic

Gardening Club invited to participate in Make a Difference Day – Holy brook

Participation in the Pensioners Fair 12/9 organised by Richard Benyon

Judge a memory box competition on National Care Home Day

Kennet Radio – half hour live interview

BBC Radio Berkshire – Drive time live interview & follow up pre recorded interview

Breeze radio – pre recorded interview

Multiple press releases in the Newbury Weekly News

Two media releases and call to action from MP Richard Benyon

Articles in the BID, Shopsafe, Disability Alliance & Street Pastors Newsletters

Dementia Presentation & Q&A session at the Thames Valley Knowledge Dementia Event

Village Agents signposting to services and updating village noticeboards with dementia information

Production of "Communications tips for dementia" card – funded by West Berks Public Health & Wellbeing

New Memory Café facility at Corn Exchange

Arts for the Elderly at the Corn Exchange

Reminiscence Group at the Newbury Museum

Possible “Men’s Group” joint initiative between YPWD/Beechcroft Memory Clinic/Alzheimer’s Society

Activities/Courses for People with Dementia during college holidays from Newbury College

4 Dementia Champions Trained – 5 more investigating dates to train

Over 100 known new dementia friends with in excess of that number again in future planned sessions excluding Veiloa who plan to make all 200 collection operatives Dementia Friends

Conclusion & Recommendations

This has been an exciting year for the project resulting in a greatly increased awareness and understanding of dementia in the local community along with lots of positive outcomes in the goal of making Newbury a more dementia friendly place to live and work. At the onset of the project it was acknowledged that the objectives were very ambitious considering that this was an entirely new initiative which was only commissioned to run for 12 months on a part time basis. This timeframe also had to include the induction and training of the Dementia Action Alliance Co ordinator

The work that has been done in West Berkshire over the past year has evolved from the initial scope of the project due to demand from the wider community and the opportunities that have subsequently arisen. There have been positive changes to the way in which individuals and organisations network together in Newbury, sharing ideas, best practice and awareness raising opportunities for the good of the larger community. As with any new initiative it takes considerable time to new build effective working relationships within a community. This is especially the case when introducing a completely new concept that had not previously been considered by many of those approached to participate. Moving forward it would seem very important that the relationships that have been established are not only maintained but enhanced.

The project has highlighted that there is a need and benefit for having a dedicated Dementia Ambassador for West Berkshire. Having someone in this role on an ongoing rather than project limited basis would allow the community to ensure the continuation of the work that has been achieved by the initial project and also take forward the ideas and opportunities that it is identifying. It has taken time to build momentum for this initiative and the Newbury DAA Co ordinator is now being approached about new ideas and offers of support for a Dementia Friendly Community.

The establishment of a memory café by the Corn Exchange and a reminiscence group by the Museum are two examples of great tangible outcomes of the project that will directly benefit those living with dementia and their carers in their community. By supporting these establishments in their dementia awareness and development of action plans, the Newbury DAA has shown that our community is willing to work to deliver support and services that are not going to have a cost to the Public or Charity sectors. There are also a number of exciting initiatives identified on signed action plans that need to be followed up and developed further. It is very important that a way is identified of capitalising on the goodwill and commitment of local businesses and services and that those who are looking to develop services and make changes to their environments are encouraged and feel supported and receive the tools that they need in terms of training and understanding of dementia.

It would be useful to consider the formation of a working forum of interested parties from organisations in Newbury that in some way support people with dementia and carers. The project has highlighted that there are a good number of organisations and individuals in the area who are working on initiatives that in a variety of ways support those living with dementia and also their carers. At present these groups do not appear to meet to exchange ideas and plans and there would seem to be areas where initiatives overlap. In these situations the sharing of ideas and resources could not only reduce costs and relieve time and manpower pressures but would also allow for growth of new ideas and projects.

The restrictive time limitations of the DAA role has meant that at the end of the project period there are still action plans in progress that will require continued input and support to ensure that they are signed and become members of the Newbury DAA. In addition, as the DAA Co ordinator leaves it is important to consider the issues of Public Liability Insurance, email address and telephone number for public access and the role of Chairperson for the Steering Group. The Steering Group is currently discussing ways in which the good work of the project could continue. In the absence of further funding for the project the Steering Group would be required to continue in an entirely voluntary capacity. Whilst the project is very important to the members and they very much want it to continue, there will undoubtedly be limits on their time and resources that will impact the momentum of the work.

The project remit was to confine the work to Newbury and for time and resource reasons it has not been possible to extend the work further afield. However there have been requests from the community and there is a considerable need to include Thatcham, Lambourn and Hungerford in the dementia friendly community work going forward. The number of people living with dementia in West Berkshire is ever increasing and the demographic of its population indicates that the support of people living with the condition in their community is going to be a growing challenge. The work of this project has been positive and effective but has really only touched the tip of the iceberg in terms of opportunities, potential and need.

It will be important for West Berkshire Council as commissioners of the project to be aware that the status of working towards being a dementia friendly community is reviewed and awarded annually. The review for Newbury will take place in March 2015 and it will need to show ongoing work and commitment to the initiative to maintain its status.

Acknowledgments

The success of this project has been made possible by the enthusiasm and commitment of the Newbury DAA team which has been generously supported by local businesses and services who support a common goal. Special thanks should be extended to the following businesses and organisations who have worked to support the Newbury DAA over the past 12 months :

The Corn Exchange
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