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Notice of Meeting

Health and Wellbeing Board

Thursday, 26th March 2015 at 9.00am

in Council Chamber Council Offices
Market Street Newbury

Date of despatch of Agenda: Wednesday, 18 March 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
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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) and Andy Day (WBC - Strategic Support)

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 and subsequent special meeting of the Board held on 22 January 2015.	7 - 20
9.05 am	3	**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.	
9.06 am	4	**Public Questions** Members of the Executive 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.)*	

a **Question Submitted by Martha Vickers to the Health and Wellbeing Board**

"At a recent meeting, West Berkshire Council endorsed the results of the consultation (facilitated by Health Watch) on the Health and Well Being Strategy. The Board will be aware of a revision to the Strategy approved at the same Council meeting. It was agreed that addressing drug abuse be included under the section on substance misuse, alongside alcohol and tobacco, thereby acknowledging that drug abuse is a health issue rather than simply a matter of criminal justice.

Could the Board therefore clarify what measures have so far been enacted or proposed to tackle the extremely disturbing health implications of this problem?"

5 **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.

9.10 am	6	**Health and Wellbeing Board Forward Plan** For information.	21 - 24
9.12 am	7	**Actions arising from previous meeting(s)** For information.	25 - 26

Items for discussion

Systems Resilience

9.15 am	8	**Health and Social Care Dashboard (Tandra Forster/Shairoz Claridge)** Purpose: To present the Dashboard and highlight any emerging issues.	27 - 30
9.25 am	9	**Winter Resilience Programme (Carolyn Lawson)** Purpose: To give feedback on the Winter Resilience Programme.	31 - 42

Integration Programme

9.40 am	10	**An update report on the Better Care Fund and wider integration programme (Tandra Forster)** Purpose: Purpose: To update the Health and Wellbeing Board of progress on the Better Care Fund plans and projects.	43 - 64

Health and Wellbeing Strategy/Joint Strategic Needs Assessment

9.50 am	11	**Delivery plan for the Health and Wellbeing Strategy (Lesley Wyman/Adrian Barker/Shairoz Claridge/Tandra Forster)** Purpose: To give an update on the arrangements being put in place to coordinate the action plan for the Health and Wellbeing Strategy.	65 - 68
10.05 am	12	**Hot Focus Session Report (Lesley Wyman)** To discuss the format for the first Hot Topic Session in April on mental health and wellbeing in adults.	69 - 74
10.15 am	13	**The Health and Wellbeing Annual Conference (Andy Day/Lesley Wyman)** Purpose: To discuss ideas for the conference, which will help shape the refresh of the Health and Wellbeing Strategy.	75 - 78

Other issues for discussion

10.20 am	14	**Joint Self Assessment for Learning Disabilities (Tandra Forster)** Purpose: To present the feedback on this piece of work to the Board.	79 - 106
10.35 am	15	**FGM Report (Rachael Wardell)** Purpose: To give the Board an overview of the FGM Task Group. The aim of the group was to scope local statutory responses to FGM and to develop recommendations for action based upon policy recommendations from the 2013 document.	107 - 120
10.45 am	16	**Pharmaceutical Needs Assessment (Lise Llewellyn)** Purpose: For the Board to approve the final document following consultation and revisions.	121 - 126
	17	**Members' Question(s)** Members of the Executive to answer questions submitted by Councillors in accordance with the Executive Procedure Rules contained in the Council's Constitution.	

18 **Future meeting dates**

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

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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, 22 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 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), Rachael Wardell (WBC - Community Services), 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), Councillor Quentin Webb, Tandra Forster (WBC - Adult Social Care), Councillor Roger Hunneman (Deputy Liberal Democrat Group Leader), Councillor Adrian Edwards, April Peberdy (Public Health and Wellbeing), Susan Powell and Jane Seymour

Apologies for inability to attend the meeting: Leila Ferguson and Cathy Winfield

PART I

76 Minutes

The Minutes of the meeting held on 27th November 2014 and 8th January 2015 were approved as a true and correct record and signed by the Chairman.

77 Health and Wellbeing Board Forward Plan

The Health and Wellbeing Board noted the Forward Plan.

78 Actions arising from previous meeting(s)

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

79 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 they were General Practitioners, but reported that, as their interest was not personal, prejudicial or a disclosable pecuniary interest, they determined to remain to take part in the debate and vote on the matters where appropriate.

Councillor Gordon Lundie declared an interest in all matters pertaining to Health and Wellbeing, by virtue of the fact that he was a director of the pharmaceutical company UCB, 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.

Councillor Lundie declared and interest in all matters pertaining to the Royal Berkshire Hospital, by virtue of the fact that he sat on its Council of Governors, 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.

80 Public Questions

There were no public questions.

81 Petitions

There were no petitions presented to the Board.

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

(Councillor Gordon Lundie declared a personal interest in Agenda item 8 by virtue of the fact that he sat on the Council of Governors for the Royal Berkshire Hospital. As his interest was personal and not prejudicial he was permitted to take part in the debate and vote on the matter).

Tandra Forster introduced the item to Members of the Health and Wellbeing Board and briefed them on the Adult Social Care section of the dashboard. She highlighted that performance had dropped slightly for ASC1. The data for this measure however, referred to a very small cohort of people and therefore it only took one person to change the percentage significantly.

Councillor Gordon Lundie reported that he was aware of new funding that was attached to Delayed Transfers of Care (DTOC) and asked for an update. Rachael Wardell explained that money had been made available by the Department of Health (DH) specifically for hospital discharges. However there were a number of obstacles in the way of improving performance in this area and adding money was not necessarily the answer. More of what was already working well needed to take place and people who might be at risk of having a delayed discharge needed to be identified on admission. Effort needed to focus on identifying blockages in the system and targeting these areas. It was for health partners to decide the best way in which the money should be used.

Councillor Lundie further questioned how well plans were aligned with the Royal Berkshire Hospital (RBH). Tandra Forster reported that they had moved towards a trust performance system. The RBH had issues regarding a number of Care Homes.

Tandra Forster further added that the performance team were working hard to get people out of hospital efficiently. Funding had to be used by the end of the year, which was going to be challenging.

Councillor Lundie queried what the DTOC data actually represented. Tandra Forster confirmed that one of the DTOC figures was a snapshot taken on the third Thursday each month. Once a person was assessed as being well enough they were released from hospital as soon as possible, however there were a number of factors that could hold this process up such as medication, or issues at home. Those in the system had to work together to support someone leaving hospital. It was acknowledged that the longer someone stayed in hospital the higher the risk that they would become dependant on services.

Rachael Wardell added that there were often a number of people on the Fit to Go list (Fit List) however, had not yet been discharged.

Shairoz Claridge added that focus was required on those medically fit to be discharged. Tandra Forster confirmed that she had the current Fit List for the RBH and positively it was at zero.

Rachael Wardell explained that one of the DTOC measures (AS2) showed all delays and the other (AS3) showed only those attributable to Social Care. These measures were helpfully broken down by individual hospital trusts.

Adrian Barker referred to the two DTOC indicators AS2 (all delays) and AS3 (delays attributable to Social Care) and queried why the figures attributable to Social Care were higher than those for all delays regarding both Berkshire Healthcare Foundation Trust and Hampshire Hospitals Foundation Trust.

RESOLVED that Tandra Forster confirmed that she would check DTOC figures with the relevant colleagues and feedback the answer to Adrian Barker's question to the Board.

Councillor Lundie queried if the issues discussed on the dashboard were also on the relevant forward work plans. Shairoz Claridge confirmed that the acute section was discussed at the Urgent Care Board. She added that a report on winter resilience was currently under construction and a report would be brought back to the Board meeting in March.

Councillor Lundie queried how pressures faced by the RBH were being taken into account. Shairoz Claridge reported that the Urgent Care Board had actions in place to help address these pressures. Daily updates on figures were also provided and helped RBH deal with the pressures.

Shairoz Claridge referred to the pressures faced across the county by Accident and Emergency departments. She reported that anecdotal information she had received indicated that cases being presented at Accident and Emergency departments were appropriate.

Shairoz Claridge reported that Accident and Emergency figures had peaked over the Christmas period however, this had now levelled off and it was a national issue. Shairoz Claridge stated that she would ask the Urgent Care lead to present the winter resilience information to the next Board meeting in March.

Dr Barbara Barrie felt that Primary Care's efforts to mitigate the winter pressures was often excluded, and therefore many surgeries had carried out an audit of appointments dealt with over the Christmas period. This gave a snapshot of each practice. Dr Bal Bahia reported that results for his surgery showed that there had been a 14% increase in consultations and 18% increase in phone calls over the Christmas period.

Nikki Luffington felt that the data contained on the dashboard was out of date as quarter three information was available. She reported that DTOC was on the national agenda and quarter three data for West Berkshire showed that it was underperforming.

Councillor Marcus Franks responded to Nikki Luffington's point about the data being out date. In this instance this was largely due to different reporting timescales because of the Christmas period. However, this would be raised at the Management Group.

RESOLVED that the reporting timescales for the dashboard to be discussed at the next meeting of the Health and Wellbeing Management Group.

Shairoz Claridge reported that they were working with NHS England to make the Dashboard as live as possible.

Adrian Barker suggested that an indicator be included on the Dashboard, which showed the number of people seeing General Practitioners.

RESOLVED that Nikki Luffington would look into this.

(Councillor Gordon Lundie left the meeting at 9.30am)

83 Update report on the Better Care Fund (Tandra Forster)

Tandra Forster introduced the item, which aimed to inform Members of the Health and Wellbeing Board on the current position regarding the Better Care Fund schemes. Included within the appendices were highlight reports for the two West Berkshire projects and a Programme Status Report for all five projects.

Tandra Forster went on to add that the Hospital at Home project had been reframed. A number of required changes had been identified and the business case had been revised. This was due to go to the three Integrated Steering Groups in February 2015.

A number of the projects had new project managers including the Integrated Health and Social Care Hub and Enhanced Care and Nursing Home Support project.

The highlight report for the Personal Recovery Guide Project showed that positive progress was being made. A pilot was currently being carried out for this project.

Councillor Franks noted that on page 32 of the agenda under the Joint Care Provider/Personal Recovery Guide Project Risk Log, that the Emergency Duty Team contract was at high risk. Tandra Forster explained that a contract was required across the whole of Berkshire. A large part of this project was seven day working and out of hours services. The question being asked was to what extent the Emergency Duty Team helped the delivery of these areas.

84 Alignment of Commissioning Plans (Tandra Forster/Shairoz Claridge)

Tandra Forster presented the report to the Board which aimed to inform Members about the progress on the alignment of commissioning plans for health and social care partners.

The alignment of commissioning was a priority for the Health and Wellbeing Board and the purpose was to avoid duplication across the system.

A small group had come together including Tandra Forster, Lesley Wyman and Shairoz Claridge to begin listing what commissioning activity was already taking place. Tandra Forster reported that the next step was to broaden this group out. In the future it was hoped that consultation would take place on all decisions concerning commissioning.

Shairoz Claridge reported that the Clinical Commissioning Group (CCG) had looked at its commissioning intentions to see where they aligned to the Health and Wellbeing Strategy.

Rachael Wardell drew attention to the fact that there was now a Children's Commissioning Group in place. There was also a piece of work taking place between the leads for Adult Social Care across Reading, West Berkshire and Wokingham, looking specifically at joint commissioning. Councillor Marcus Franks highlighted the importance of involving the voluntary and community sector in commissioning alignment.

Tandra Forster reported that there had been a shift towards outcome focused commissioning. Shairoz Claridge added that there was currently a lot of overlap in the areas of mental health and children's, both of which fell under the Better Care Fund Plans. Information Technology was acknowledged as a key enabler.

Adrian Barker felt that it was important that there was focus on the alignment of plans as well as the alignment of commissioning. A discussion was required between the relevant people to look at how individual commissioning decisions affected one another.

Tandra highlighted that Adult Social Care used an independent market whereas the Health sector used an internal market.

Dr Bal Bahia stressed the need for an overarching vision to bring the work together. Tandra Forster felt that mapping was the key to aligning commissioning successfully. Councillor Marcus Franks agreed with Dr Bahia and highlighted the importance of other groups being aware of the Board's ambitions around commissioning. Tandra Forster confirmed that she sat on the Berkshire West Partnership and therefore would act as a link between the two Boards.

85 Finalisation and Agreement of the Health and Wellbeing Strategy (Lesley Wyman)

Lesley Wyman introduced the item to the Board which sought finalisation and agreement of the Health and Wellbeing Strategy post the consultation period.

The consultation on the Strategy had been carried out by Healthwatch and positively there had been a large number of comments received from people across a wide age range.

Although a high number of comments had been received, there had been minimal issues raised about the priorities and most had agreed that the priorities were the right ones to be focusing on. Most comments related to how the Strategy would be delivered and therefore the next step was to coordinate a delivery plan for the Strategy. Lesley Wyman suggested that task and finish groups could be set up to help pull this together. A list of stakeholders who could be involved was listed under paragraph 1.1 of Lesley Wyman's report.

Adrian Barker referred to page five of the Strategy and queried if the overarching aims could be revised. Lesley Wyman reported that these had been taken from the Public Health Outcomes Framework and could be revised. Adrian Barker felt that the first overarching aim should be amended to 'whilst maintaining a high quality of life throughout life'. Adrian Barker also felt that the third bullet under the overarching aim should be amended so that read 'and healthy life expectancy'.

Adrian Barker acknowledged that the next step was to pull the task and finish groups together and the report suggested a group could be formed to focus on each priority. He felt that the multi-agency working group should be formed to develop a strategic action plan for the strategy as a whole, as well as for each individual priority. Councillor Franks suggested that this role could be taken on by the Health and Wellbeing Management Group. Adrian Barker was concerned this group would not have time. Councillor Franks felt that this was something the Management Group needed to explore.

Adrian Barker stressed that engagement needed to be ongoing throughout the process. This could be fed into the event planned for the Board in September, where stakeholder input could be sought. Adrian Barker stated that he was happy to volunteer to sit on any of the groups.

Dr Barbara Barrie expressed her disappointment that End of Life Care was still not featured as a stand alone priority within the Strategy. Dr Lise Llewellyn confirmed that priorities had been chosen using information from the Joint Strategic Needs Assessment (JSNA).

Dr Llewellyn had noted from the consultation responses that the two priorities that were less acceptable were drinking alcohol and being overweight, which fundamentally could show social acceptance of these two issues.

Dr Barrie referred to the outcome of a Local Pathway Outcome Review, which proposed 34 recommendations around the care of those at the end of their lives. She was concerned that if end of life services were not a priority then this area would be neglected by the Board.

Councillor Franks was not in agreement that end of life care should be a stand alone priority however, felt that it should be picked up through the delivery plan for the Strategy.

RESOLVED that end of life care to be included within the delivery plan for the Health and Wellbeing Strategy.

RESOLVED that Task and Finish Groups involving the relevant people would be set up to coordinate actions plans, which would underpin each of the priorities within the Health and Wellbeing Strategy. A progress report would be given at the next Board meeting in March.

RESOLVED that the Health and Wellbeing Board agreed the Health and Wellbeing Strategy, which would be formally ratified at the Council meeting on 3 March 2015.

86 Health and Wellbeing Performance Report (Lesley Wyman)

Lesley Wyman introduced the item which updated the Board on the progress being made towards priorities within the current Health and Wellbeing Strategy.

The report focused on quarters one and two of 2014/15. Appendix one contained the completed data set to accompany the report. The report considered what was being done locally to meet national indicators. Lesley Wyman continued by giving a summary of the main issues.

Reducing Childhood Obesity

- The National Childhood Measurement data for 2013/14 was published in December 2014.
- 2013/14 data coupled overweight and obesity figures together.
- In reception the rate had gone up slightly from 18.9 to 19.3%.
- Trend data within the report showed that West Berkshire was below the national rate regarding obesity.
- For year six the rate had decreased slightly which was very encouraging.
- It was important to note that a different cohort of children were being measured each year and therefore variations were expected year on year.

Rachael Wardell queried if it was possible to compare the reception rate for the current year six children to see any changes overtime. For example, this would show if those at reception were still overweight or obese when they reached year six. It was confirmed that it would be possible to provide this data, once it was available nationally.

Councillor Keith Chopping was concerned that just under 30 percent of children in year six were overweight or obese. Lesley Wyman reported that there were numerous programs of work taking place to try and bring this figure down. Dr Lise Llewellyn stated that generally parents did not take their children to the doctors for being overweight. Weight was measured by Body Mass Index (BMI). There were different graduations including overweight, obese and morbidly obese and for children these were measured using national growth charts.

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

- Adult smoking prevalence had dropped in West Berkshire from 18.76 percent to 15.4 percent, which was significantly below the national average.
- The number of those quitting smoking at four and 12 weeks had improved compared to 2013/14.

The successful completion of drug treatment for opiate users

- This was a measure of the percentage of opiate drug users who left drug treatment successfully and did not represent to treatment within six months.
- There was a significant drop in this measure from 2012 to 2013 and the quarter two figure for 2014 had risen slightly from a low of five percent in quarter one.
- Part of the reason for the fluctuation was due to small numbers in West Berkshire. Therefore only a small number was required to change the figures significantly.
- The drug and alcohol service had been tendered out in the latter part of 2014 and Public Health and Wellbeing would work closely with the new providers once in place.

Councillor Marcus Franks queried Primary Care's involvement in this area. Lesley Wyman reported that Primary Care were involved through the Shared Care Contract. Dr Bal Bahia stated that Primary Care also played a key role in signposting to services.

The percentage of adults achieving 150 minutes of physical activity per week

- This figure had dropped slightly from 2012 to 2013 and West Berkshire was now below the national average.
- Lots of work was taking place locally within the Public Health and Wellbeing Team.
- A Physical Activity Co-ordinator had been appointed, who was working across the district with partners to run physical activity initiatives
- Stronger links needed to be made to Leisure Centres where there was often significantly less to do for the over 50's.

Councillor Franks queried if exercise was still prescribed by GPs. Lesley Wyman confirmed that exercise on prescription was still available.

Councillor Gwen Mason stressed that the cost of gym membership needed to be looked at as this was often very expensive.

Dr Barbara Barrie reported that a 'Beat the Street' campaign had been implemented in Reading. Dr Lise Llewellyn reported that this was quite an urban campaign and would need to be adapted to suit more rural areas. Lesley Wyman reported that the campaign was currently being evaluated and therefore they were awaiting the outcomes of the project.

Improving the self reported emotional wellbeing scores of adults

Lesley Wyman reported that this measured individual/subjective wellbeing based on a number of questions regarding how happy or less happy they were with their lives.

The percentage of eligibly population being offered and receiving the NHS Healthcheck

- This was the main area of underperformance within the Health and Wellbeing Strategy.

- Quarter one figures were 30% lower for invites and quarter two, 26% lower for completed checks in 2014/15 compared to the previous year.
- The target for West Berkshire was 20% of the eligible population to be invited for a health check each year and for 50% of those invited to have a Healthcheck completed.
- There were a number of reasons responsible for the underperformance.
- GPs were the main providers of Healthchecks. The Public Health and Wellbeing Team attended meetings with practices to try and address the issue, however were aware of the capacity issues faced.
- It was possible that in the future, third sector providers would be sought to carry out the health checks.

Councillor Franks noted that all those invited for a Healthcheck in 2009 could now be re-invited.

Councillor Mason felt that Healthchecks were an important preventative measure and queried if enough was being done to educate the public of the benefits of having one of these checks.

Lesley Wyman reported that publicity and promotion of Healthchecks was a difficult area. If there was suddenly an influx of people wanting Healtchecks, the GP practises would struggle to balance the demand.

Dr Llewellyn reported that Public Health would most likely look to community pharmacies and supermarkets for delivering Healthchecks in the future. The rate of cardiovascular disease in West Berkshire was rising and Healthchecks played a key part in early diagnosis. Many health issues were identified though Healthchecks including the early onset of dementia.

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

- The rate of this had decreased steadily up until 2008-10 however, from this point over the last 2 years the rate had begun to increase.
- It was vital that everything possible was done to bring this rate down.

Breastfeeding rates

- This indicator was considered a valid and important measure for public health and was therefore included in the Public Health Outcomes Framework.

Lesley Wyman reported that no data had been received for this measure, which was something she needed to look into. Dr Barrie confirmed that the data for this measure had been collected in the past and therefore was unsure why it was not available. The data was collected as part of the six week check system.

Rate of domestic abuse reported to the Police.

- The rate of this had risen very slightly.

Councillor Franks reported that the Safer Communities Partnership had a target to increase reporting.

Rachael Wardell reported that there had been a homicide in West Berkshire relating to domestic violence.

Domestic violence was a significant factor across many areas including Looked After Children, attendance behaviour and performance at school. If increased reporting was

viewed as positive then Racheal Wardell stressed that this needed to be matched by how these cases were dealt with.

Councillor Franks, welcomed comments from Susan Powell (Safer Communities Team Manager) who stated that this was one measure for a very broad area of work. Domestic violence was also included within the Local Children Safeguarding Board's Business Plan which would be reported to the Board later on the agenda.

Lesley Wyman agreed that they needed the local indicators that sat beneath the measure.

Emotional wellbeing of looked after children

- This indicator was based on the average difficulties score for all looked after children aged five – 16 who had been in care for at least 12 months as of 31 March.
- The score for West Berkshire had decreased from 2010 to 2013 however, average scores for the south east had improved.

Lesley Wyman stated that more local indicators were required from Children's Services to underpin the indicator.

Lesley Wyman continued by drawing the Board's attention to the Suicide Prevention Strategy under Appendix two. The Government had announced recently for the attention of the NHS, that suicide was preventable. A pilot of work was taking place in Liverpool around this and a dramatic decrease had been seen.

RESOLVED that The Suicide Prevention Strategy and Audit to be placed on the HWBB Forward Plan for June 2015.

Adrian Barker stated that he found the data very useful however, found it difficult to identify how the Health and Wellbeing Board had made a difference. Lesley Wyman explained that it was hard to know if an area of work being carried out at present was working. An up to date list of indicator, including local ones from the relevant areas would make a difference.

87 Draft Business Plan for the Local Safeguarding Children's Board (Fran Gosling-Thomas)

Fran-Gosling-Thomas introduced herself to the Board as the new independent Chairman of the Local Safeguard Children's Board (LSCB) and thanked them for inviting her to present. At the time of the previous LSCB Business Plan it was felt that a lot of activity was taking place however, this was largely within silos of individual organisations.

At a business planning session held in October 2014, West Berkshire LSCB had agreed five new top priorities for the next two years 2015-17 as follows:

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

The number of priorities within the new LSCB Business Plan had been reduced from the former plan to help maximise impact. Each priority was owned and shared by the LSCB however, each also had its own designated sponsor.

The LSCB was seeking support from the Health and Wellbeing Board around four particular areas:

Early Help: Fran Gosling-Thomas explained that if they got this right it would affect many other areas. Further work was required across communities and within schools. Early Help had strong links to health visiting and school nursing. There was also a link between Early Help and self harm and suicide.

Childs Voice: It was acknowledged that there was already a lot of activity taking place with regards to consulting young people. It was important that this work was not duplicated. Consultation needed to be strengthened and not be tokenistic.

Regarding health checks for Looked After children (LAC), this was an area where West Berkshire had performed poorly in the past however more recently had seen a slight improvement.

Fran Gosling-Thomas stressed that focus was required to increase Practitioner (GP) attendance at Child Protection Conferences. The huge pressures GP's were under was acknowledged however, information exchange was crucial.

Child Sexual Exploitation: It was reported that a Serious Case Review was about to be published involving a young woman who had been sexually exploited at 14 years old. There was a huge amount of learning to be taken from this case as the victim had reported the issue on numerous occasions however, nothing had been done.

Domestic Abuse and Vulnerable groups: Domestic violence had huge impact across many other areas. It was important that areas of work were not duplicated.

Effectiveness and Impact of the LSCB: Fran Gosling-Thomas explained that the aim within the new LSCB Business Plan was to have less bureaucracy.

Dr Bal Bahia referred to Fran Gosling-Thomas' comment regarding GP attendance at Child Protection Conferences. He reported that the duty to provide information had been discussed with Mark Evans (Head of Children's Services) along with the timeframes Social Services had to work to. GPs were happy to provide reports in a timely fashion. Dr Lise Llewellyn asked if a conference call system was a possibility for GPs. Rachael Wardell stated that although information sharing was required, there was also a need for conversation.

Dr Barbara Barrie reported that Social Services often did not feedback to GPs and therefore there was a disengagement issue that needed addressing. Fran Gosling-Thomas acknowledged this as a very valid point.

88 Mental Health Crisis Concordat (Angus Tallini)

Dr Angus Tallini introduced the item to Members of the Board. The Crisis Care Concordat was a shared agreed statement, based on a national initiative and was signed by senior representatives from all organisations involved across the whole of Berkshire. It was a good example of agencies working together in a coordinated way to reach an agreement.

It covered what needed to happen when a person in a mental health crisis needed help. This included across policy making, spending decisions, anticipating and preventing a mental health crisis where possible and making sure effective emergency response systems operated in localities when a crisis occurred.

If a mental health crisis was not planned for, there was risk that it could become a public disorder or a public welfare concern.

Dr Tallini reported that the Crisis Care Concordat was at the stage where agreement was being sought from all stakeholders. He was unsure if the Health and Wellbeing Board should be a signatory and asked for clarification from the Chairman.

Dr Tallini referred to the list of stakeholders included under Appendix A of the report. He highlighted that there was an error within the list and confirmed that Berkshire West and East Drug and Alcohol Action Teams no longer existed. In place of these there was Berkshire West Partnership, which consisted of: Wokingham DAAT, Reading DAAT and West Berkshire Public Health and Wellbeing. The Berkshire East Partnership consisted of: Slough DAAT, Windsor and Maidenhead DAAT and Bracknell DAAT.

Councillor Keith Chopping asked how a mental health crisis was confirmed. Dr Tallini confirmed that it was when the distress caused by ones illness reached a level which caused risk to themselves and others. These cases were normally flagged by the Police, neighbours or members of the public.

Councillor Marcus Franks confirmed that mental health and wellbeing of adults was one of the Health and Wellbeing Board's Hot Focus themes and therefore he was happy for the Board to sign up to the Crisis Care Concordat. It was requested that the action plan be shared with the Board once ready.

RESOLVED that the Health and Wellbeing Board signed up to the Crisis Care Concordat.

89 Post Implementation Reflection - Special Educational Needs Reform (Jane Seymour)

Jane Seymour drew attention to her report which updated the Board on the implementation of the Special Educational Needs and Disabilities (SEND) Reform. The Children and Families Act had taken effect in September 2014, and had significantly changed the way in which services were provided for children with SEN and disabilities and their families.

Section three of the report detailed requirements of the Children and Families Act in respect of children with SEND and section four gave an overview of the implementation of the SEND Reforms in West Berkshire. The team were now able to take on the management of cases for young people up to the age of 25.

Work taking place with partners was detailed with section six of the report. Positive progress had been made around the joint operation process. Further work was taking place around joint arrangements including joint commissioning.

Appendix A of the report included guidance for Health and Wellbeing Board's on Children with Special Educational and Complex Needs. It focused in particular on how Board's should support children with learning disabilities.

Rachael Wardell confirmed that the Board had agreed a process on the management of Charters. The aim of agreeing this process was to ensure that the Board remained focused on the priorities within the Health and Wellbeing Strategy, which were shaped by the Joint Strategic Needs Assessment.

Councillor Marcus Franks reported that Children with SEND was picked up under priority nine of the Health and Wellbeing Strategy and would be included within the proposed delivery plan.

Rachael Wardell suggested that Board review the guidance for Health and Wellbeing Boards on Children with Special Educational and Complex Needs.

RESOLVED that the Management Group would a review of the guidance as outlined above on the Forward Plan for the Board.

90 Dementia Alliance (Alison Love)

Tandra Forster introduced the item in Alison Love's absence. In 2012 the West of Berkshire PCT (now 4 West of Berkshire CCGs) and the three unitary authorities in the west of Berkshire worked collaboratively to make several bids to the Prime Minsters Dementia Challenge Fund. One of the successful bids included 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 to set up a Dementia Action Alliance.

Tandra Forster reported that this piece of work was now due to come to an end. It was stressed that dementia was a growing issue both nationally and locally and the Dementia Action Alliance had been a really effective piece of work within communities. The aim of the project had been to change the environment so that people with dementia could live within the community for longer.

The loss of funding related to the work, would result in the loss of the Dementia Action Alliance Coordinator. It was acknowledged by the Board that the project would not be sustainable without the Coordinator post.

Rachael Wardell explained that has the Board held no budget and therefore there was a question about what the Board could do apart from give the work its blessing. Alternatively it could try and suggest a funding source that could be applied to.

Tandra Forster reported that the aim of bringing the work to the attention of the Board was to gain its endorsement. Councillor Keith Chopping asked how far the work of the Dementia Alliance Coordinator extended. Tandra Forster confirmed that there had no been enough funding to roll the project out West Berkshire wide however, it had linked to the Village Agent Project. There was the potential for it to be extended further.

Lesley Wyman reported that Public Health had funded some Dementia work in 2014.

RESOLVED that Board Members would be contacted after the meeting in attempt to seek funding for sustaining the Dementia Alliance Coordinator role for 2015/16.

91 Member's Questions

There were no questions from Members.

92 Future meeting dates

It was confirmed that the next Health and Wellbeing Board meeting would take place on 26th March 2015.

(The meeting commenced at 9.00 am and closed at 11.15 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, 22 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) and Councillor Keith Chopping (Portfolio Holder for Community Care)

Also Present: Jessica Bailiss (WBC - Executive Support), Lesley Wyman (WBC - Public Health & Wellbeing), Councillor Quentin Webb, Tandra Forster (WBC - Adult Social Care) and Councillor Roger Hunneman (Deputy Liberal Democrat Group Leader)

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

Councillor(s) Absent:

PART I

74 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 they were General Practitioners, but reported that, as their interest was not personal, prejudicial or a disclosable pecuniary interest, they determined to remain to take part in the debate and vote on the matters where appropriate.

75 The Better Care Fund Plans

Councillor Marcus Franks reported that at the last Special Meeting of the Health and Wellbeing Board the sign off of the Better Care Fund (BCF) Plans had been deferred until the subsequent meeting of the Board.

The Department of Health (DH) had confirmed that funding for the Care Act would not be forthcoming and therefore there would be a funding gap that would need addressing. This would be the responsibility of the whole of the health and social care economy.

Rachael Wardell reported that the Board needed to ratify the submission of the BCF Plans. Nothing had fundamentally changed since the Board last saw the plans. Information received by the DH left the Council exploring other avenues for funding.

Councillor Gwen Mason referred to the £1.5 million that the Clinical Commissioning Group was due to contribute towards the funding gap and queried if this was still at risk, as this had been stated as a possibility at the previous Special Meeting of the Board. Councillor Franks confirmed that if the Board signed and submitted the plans this money would not be at risk.

Councillor Irene Neill advocated signing off the BCF Plans however expressed her dissatisfaction with how the DH had handled the situation. Councillor Keith Chopping

concurred with Councillor Neill and suggested that the Council should send a letter to the DH accompanying the BCF Plans stating how dissatisfied it was with the process.

Councillor Franks proposed that the Health and Wellbeing Board sign off the BCF Plans. This was seconded by Councillor Neill.

RESOLVED that the BCF plans were signed off by the Health and Wellbeing Board and submitted to the DH.

RESOLVED that a letter to be sent from the Council to the DH accompanying the BCF Plans, expressing the Council's disappointment with the way the situation regarding the Care Act had been handled.

(The meeting commenced at 11.15 am and closed at 11.45 am)

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
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	Carolyn Lawson	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	26th February	Tandra Forster	Health and Wellbeing Management Group	Part I	
	Health and Wellbeing Strategy / Joint Strategic Needs Assessment							
	Delivery plan for the Health and Wellbeing Strategy	To give an update on the arrangements being put in place to coordinate the action plan for the Health and Wellbeing Strategy.	For information and discussion	26th February	Lesley Wyman/Adrian Barker/Shairoz Claridge/Tandra Forster	Health and Wellbeing Management Group	Part I	
	Hot Focus Session Report	To discuss the format for the first Hot Topic Session in April.	For information and discussion	26th February	Lesley Wyman	Health and Wellbeing Management Group	Part I	
	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/Andy Day	Health and Wellbeing Board, key stakeholders and the public	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	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.
	FGM Report	To give the Board an overview of the FGM Task Group. The aim of the group was to scope local statutory responses to FGM and to develop recommendations for action based upon policy recommendations from the 2013 document .	For Information, discussion and decision	26th February	Rachael Wardell/Claire Fletcher	LSCB/Health and Wellbeing Management Group	Part I	
	Pharmaceutical Needs Assessment final sign off	The Board to finalise and agree the PNA.	For Agreement	26th February	Lise Llewellyn	Health and Wellbeing Management Group and Health and Wellbeing Board	Part I	
23rd April 2015 - half day Hot Focus 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**			
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	
	Commissioning Plans							
	Alignment of Commissioning Plans	To timetable/forward plan the alignment of commissioning plans	For Information and discussion	7th May	Tandra Forster/Shairoz Claridge/Lesley Wyman	Health and Wellbeing Management Group		
	Public Engagement							
	Draft Strategy for community engagement	To present the draft strategy to the Board for comment.	For discussion	7th May	Adrian Barker	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	
	Development Plan							
	Development Plan for the Health and Wellbeing Board	To keep an overview of the Boards progression	For Information and discussion	7th May	Nick Carter/Marcus Franks	Health and Wellbeing Management Group	Part I	
	Other Issues for discussion							
	Improving the Frail Elderly Pathway	To inform the Board on progress with this peice of work.	For Information and discussion	7th May	Stuart Rowbotham		Part I	

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
	Reducing the risk and impact of domestic abuse	To provide the Board with an overview of all the elements of the multi agency work currently being undertaken to reduce the risk and impact of domestic abuse (including specific pieces of work such as the MARAC Review and IRIS Project) .	For Information and discussion	7th May	Susan Powell	Health and Wellbeing Management Group /Safer Communities Partnership	Part I	
	Suicide Prevention Strategy and Audit	To present the Strategy and result of the Audit to the Health and Wellbeing Board.	For information	7th May	Lise Llewellyn/Lesley Wyman	Health and Wellbeing Management Group	Part I	
11th June 2015 - half day Hot Focus 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/Head of Children's Services**			
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	
	Other Issues for discussion							
	Children and Young People Wellbeing Survey	To give an overview of the Survey result for West Berkshire to the Board.	For information and discussion	2nd July	Ali Roe/The Children's Society	2000 children and young people in West Berkshire	Part I	
	Other information not for discussion							
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: Mental Health and Wellbeing in Adults.	To feedback on activity that has taken place over the last three months.	For information and discussion	27th August	Lesley Wyman/Rachel Johnson	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	
22nd October 2015 - half day Hot Focus 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							
	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: Looked After Children	To feedback on activity that has taken place over the last three months.	For information and discussion	29th October	Lesley Wyman/Head of Children's Services	Health and Wellbeing Management Group	Part I	

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
28th January 2016								
	Items for Discussion							
	System Resilience							
	Health and Social Care Dashboard	To present the Dashboard and highlight any emerging issues	For information and discussion	17th December	Tandra Forster/Shairoz Claridge/Jes	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	17th December	Tandra Forster/Shairoz Claridge	Health and Wellbeing Management Group	Part I	

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RefNo	Meeting	Action	Action Lead	Agency	Agenda item	Comment
42	22-Jan-15	Adrian Barker referred to the two DTOC indicators AS2 (all delays) and AS3 (delays attributable to Social Care) and queried why the figures attributable to Social Care were higher than those for all delays regarding both BHFT and HHFT.	Tandra Forster/Jessica Bailiss	WBC/CCG	Health and Social Care Dashboard	Both DTOC measues AS2 and AS3 have now been provided using a combined average.
43		It was felt that the information contained within the Dashboard was out of date. In this instance this was largely due to different reporting timescales because of the Christmas period. This would be raised at the Management Group.	Management Group	CCG/WBC/Healthwatch	Health and Social Care Dashboard	The Management Group decided that the reporting timescales should remain as they are.
44		Adrian Barker suggested that an indicator be included on the Dashboard, which showed the number of people seeing General Practitioners. Nikki Luffington would look into this.	Nikki Luffington	NHS England	Health and Social Care Dashboard	Awaiting confirmation regarding whether the data is collected.
45		The Suicide Prevention Strategy and Audit to be placed on the HWBB Forward Plan for June 2015.	Jess Bailiss	WBC	Health and Wellbeing Performance Report	Placed on Forward Plan for June.
46		End of Life Care to be included within the delivery plan for the Health and Wellbeing Strategy.	Lesley Wyman	WBC	Health and Wellbeing Strategy	This will be picked up by the delivery groups being formed to develop the implementation plan for the Strategy.
47		Task and Finish Groups (delivery groups) involving the relevant people to be set up to coordinate actions plans, which will underpin each of the priorities within the HWBS. To be reported on to the next HWBB meeting in March.	Lesley Wyman/Adrian Barker/Shairoz Claridge/Tandra Forster	WBC	Health and Wellbeing Strategy	Report coming to the Board in March.
48		Rachael Wardell suggested that the HWBB review the guidance for HWBBs on Children with Special Educational and Complex Needs.	Management Group	CCG/WBC/Healthwatch	Post Implementation Reflection - SEN Reforms	This will be picked up by the delivery groups being formed to develop the implementation plan for the Strategy.
49		Board Members would be contacted after the meeting in attempt to seek funding for sustaining the Dementia Alliance Coordinator role for 2015/16.	Cllr Marcus Franks/Jess Bailiss	WBC	Dementia Alliance	Complete
50	22-Jan-15 (Special Meeting)	A letter to be sent to the DH accompanying the BCF Plans, expressing the Council's disappointment with the way the situation regarding the Care Act has been handled.	Nick Carter/Gordon Lundie/Jess Bailiss	WBC	The Better Care Fund Plans	On the basis that there were ministerial conversations taking place with the district's MP, it was not felt that it was appropriate at this stage to send a letter to the DH.

Actions carried over from previous meeting

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	Complete
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	An update will be provided on this under the H&SC Dashboard item at the Board meeting in March.
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 information is not suitable for the Dashboard. If further information is required then the RBH will need to be invited to a future Board meeting.
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

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System Resilience
Health and Social Care Dashboard

	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

Ref.	Indicator	Basis	Frequency	2014/15 Benchmark	2014/15 Target	Positive or negative trend (see key)	Latest data	Remedial Action
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%	↑	**91.1% (Q3)**	
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	↓	**268 (Q3)**	
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	↑	**62.0% (Q3)**	

Children's Social Care

Ref.	Indicator	Basis	Frequency	Normal Range	2014/15 Target	Positive or negative trend (see key)	Latest data	Remedial Action
CSC1	The number of looked after children per 10,000 population	West Berkshire Children's Services	Quarterly	Between 38 and 46 per 10,000		↓	**50 (Q3)**	Extensive work is taking place to try to safely manage and reduce our numbers of looked after children. This includes a weekly panel chaired by the head of service scrutinising all decisions for children becoming looked after. The panel is designed to ensure threshold is met and to explore creative ways of avoiding children becoming looked after. The new head of service has committed to reviewing this work to ensure it is as effective as possible. Work is also underway to ensure that children move to permanency as quickly as possible to avoid them remaining looked after. The new head of service has also identified work in relation to potential ways to reduce the number of young people accommodated through the Southwark judgement. There is also a significant risk that as the council and partner agencies disinvest from preventative service the number of children may continue to rise.
CSC2	The number of child protection plans per 10,000 population	West Berkshire Children's Services	Quarterly	Between 28 and 34 per 10,000		↓	**39 (Q3)**	Over the last year we have recognised significant problems with our referral and assessment team that have contributed to this rise. In response to this we have redesigned the team, dealt with complex performance issues . We have now established our Contact and Assessment Service and they are working with our partners to safely reduce the number of children subject to Section 47 enquires and CP plans . There is similar risk in relation to the disinvestment in preventative services to that explained above for this area of work.
CSC3	The number of Section 47 enquiries per 10,000 population	West Berkshire Children's Services	Quarterly	Between 20 and 25 per 10,000.		↓	**34 (Q3)**	See Above - same issues
CSC4	To maintain a high percentage of (single) assessments being completed within 45 working days	West Berkshire Children's Services	Quarterly		70%	↓	**72.% (Q3)**	
CSC5	Looked after children cases which were reviewed within required timescales	West Berkshire Children's Services	Quarterly		99%	↔	**99.% (Q3)**	
CSC6	Child Protection cases which were reviewed within required timescales	West Berkshire Children's Services	Quarterly		99%	↓	**93.% (Q3)**	This is the result of recording issue, social workers are required to complete some complex operations in our social care data base to ensure all siblings are captured when CP conferences have taken place, data cleansing and training are taking place to address this issue.

Acute Sector

Ref.	Indicator	Basis	Frequency	Baseline data	2014/15 Target	Positive or negative trend (see key)	Latest data	Remedial Action
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%	↓	**94.% (Q3)**	During January, 94% of patients spent 4 hours or less in Accident and Emergency at RBFT and the target for this indicator is 95%. This was an improvement on December when performance was at 89.5%. The YTD position is at 94.8%. The Urgent Care Programme Board are working with RBFT to improve this position.
		Hampshire Hospitals NHS Foundation Trust				↓	**93.% (Q3)**	The lead commissioners for these contracts are working with providers to improve the position through their system resilience programmes.
		Great Western Hospitals NHS Foundation Trust				↓	**90.% (Q3)**	The lead commissioners for these contracts are working with providers to improve the position through their system resilience programmes.
AS2	Average number of Delayed Transfers of Care (all delays) per 100,000 population (18+)	Berkshire Healthcare NHS Foundation Trust	Monthly			↑	**1.3 (Q3)**	
		Great Western Hospitals NHS Foundation Trust				↓	**0.7 (Q3)**	
		Hampshire Hospitals NHS Foundation Trust				↑	**2 (Q3)**	
		Oxford University Hospitals NHS Trust				↔	**1.1 (Q3)**	
		Royal Berks NHS Foundation Trust				↔	**4 (Q3)**	
		Total West Berkshire		14.7 (2012/2013 data)		↑	**9.2 (Q3)**	

Acute Sector (continued)								
Ref.	**Indicator**	**Basis**	**Frequency**	**Baseline data**	**2014/15 Target**	**Positive or negative trend (see key)**	**Latest data**	**Remedial Action**
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			↑	**1.1 (Q3)**	
		Great Western Hospitals NHS Foundation Trust				↓	**0.1 (Q3)**	
		Hampshire Hospitals NHS Foundation Trust				↑	**1.9 (Q3)**	
		Oxford University Hospitals NHS Trust				↑	**0.2 (Q3)**	
		Royal Berks NHS Foundation Trust				↑	**0.8 (Q3)**	
		Total West Berkshire			4	↑	**4.1 (Q3)**	
AS4	**Community Services** Average number of Delayed Transfers of Care (all delays by patients delayed)	Berkshire Healthcare Trust as a provider	Monthly		No Target	↓	**11.6 (Q3)**	
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%	↓	**70.9% (Q3)**	Across Berkshire West, all 3 of the ambulance response time targets were not achieved in December. This was due to the significant pressures widely reported during December and over the Christmas period in particular which was experienced nationally. The CCG are working with the Ambulance Trust through contract levers to improve this position.
AS6	A&E Attendances	Royal Berkshire Foundation Trust for Berkshire West	Monthly	1256 average monthly figure from 13/14		↓	**1,371 (Dec)**	
		Hampshire Hospital Foundation Trust for Berkshire West	Monthly	300 average monthly figure from 13/14		↓	**405 (Dec)**	
		Great Western Hospital for Berkshire West	Monthly	168 average monthly figure from 13/14		↓	**207 (Dec)**	
AS7	Number of non elective admissions	Royal Berkshire Foundation Trust for West Berkshire	Monthly	547 average monthly figure from 13/14		↓	**642 (Dec)**	
		Hampshire Hospital Foundation Trust for West Berkshire		157 average monthly figure from 13/14		↓	**169 (Dec)**	
		Great Western Hospital for West Berkshire		84 average monthly figure from 13/14		↓	**96 (Dec)**	
AS8	Total number of 111 calls (Answered in 60 seconds)	Berkshire wide	Monthly			↑	**52,553 (Q3)**	

Primary Care								
Ref.	**Indicator**	**Basis**	**Frequency**	**2014/15 Benchmark**	**2014/15 Target**	**Positive or negative trend (see key)**	**Latest data**	**Remedial Action**
PC1(a)	GP referrals to secondary Care	Newbury & District CCG	Quarterly		N/A		**3,262 (Q3)**	
PC1(b)	GP referrals to secondary Care	North & West Reading CCG	Quarterly		N/A		**3,427 (Q3)**	
PC2	Friends and Family Test	TBC	TBC		TBC			
PC3	Access metric to be defined	TBC	TBC		TBC			

Community Services								
Ref.	**Indicator**	**Basis**	**Frequency**	**2014/15 Benchmark**	**2014/15 Target**	**Positive or negative trend (see key)**	**Latest data**	**Remedial Action**
CS1	Mental Health - Crisis response % of responses witih 4 hours	Berkshire West	quarterly from Q2		85% Q2, 90% Q3 and 95% Q4		**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%	↑	**92.2% (Q2)**	

Appendices

Appendix 1 - Indicator/Target Narrative

Appendix 1

Adult Social Care		
Ref.	**Target/Data Narrative**	**Further explanation on indicator**
ASC1	Figures represent a 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. Data is based on 3 monthly reporting of hospital discharges to rehabilitation/enablement and outcome at 91 days after discharge.	Adult Social Care Framework 2B Part 1 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	An increase in the figue indicates increased demand on services. 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.	Service Plan Performance Indicator This measure provides an overview of activity in Adult Social Care for the provision of long term services
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.	Service Plan Performance Indicator

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.* There has been a small increase in the number of LAC for Quarter 3 - which will place additional pressure on the service.	Looked after child: These are children who are looked after by the authority
CSC2	This is a significant increase in the number of CP Plans for Quarter 3, which will place additional pressure on the service.	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	This is a significant increase in the number of CP investigations - and has placed additional pressure on the service during the quarter.	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 for CSC 4, 5 and 6 come from those set in Children's Services' Service Plan. Trend data is based on the last quarter.* There is very little change from last quarter - performance remains above target regarding assessments being completed.	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	Looked after children cases which were reviewed within required timescales in Quarter 3.	
CSC6	There are ongoing recording issues in relation to Child Protection Reviews. This has been flagged up at management meetings	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	Data is based on Provider figures for West Berkshire residents only.	(Adult Social Care Framework 2C Part 1)
AS3	Data is based on Provider figures for West Berkshire residents only. Data for AS2 and 3 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 nationally.	(Adult Social Care Framework 2C Part 2) 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 measure of the effectiveness of the interface between health and social care services. Minimising delayed transfers of care and enabling people to live independently at home is one of the desired outcomes of social care. This is a two-part measure that reflects both the overall number of delayed transfers of care per 100,000 population aged 18 and over (part 1 - AS2) and, as a subset, the number of these delays which are attributable to social care services and to both (health and social services) (part 2 - AS3).
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 West Berkshire.	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:	**Update on Winter Resilience Investments and Impact**
Report to be considered by:	The Health and Wellbeing Board
Date of Meeting:	26th March 2015

Purpose of Report: **To update the Health and Wellbeing Board on Winter Resilience Investments and Impacts.**

Recommended Action: **To note**

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
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Executive Report

1. Introduction

1.1 This report describes the investment of national resilience monies in the Berkshire West health and social care economy during 2014-15 and a review of impact to date. The report particularly focuses on investments in the West Berkshire locality.

2. Equalities

2.1 This item is not relevant to equality.

Appendices

Appendix A – Full report on Winter Resilience Investments and Impact.

Report for the West Berkshire Health & Wellbeing Board

Update on Winter Resilience Investments and Impact

D R A F T

1. Background

On 13 June 2014 NHS England published a framework to support planning for operational resilience during 2014/15. On the same day a letter was sent to all Accountable Officers across the NHS and Local Authority Chief Executives setting out the expectations of how the system would work together to develop robust plans for managing operational resilience through 2014/15.

The planning guidance encouraged systems to move beyond traditional winter planning for urgent care and consider year round resilience across both urgent and planned care. This was partly driven by pressures in delivery of the referral to treatment (RTT) standard, but primarily driven by the principles of good local healthcare planning being equally focussed and resilient across planned and urgent care.

CCGs were required to submit an Operational Resilience and Capacity Plan on behalf of their local health and social care economy addressing the requirements outlined within the planning guidance. The Berkshire West CCGs worked with the system to produce a plan which was submitted to NHS England in line with national timelines in August 2014. The plan was then subject to an assurance process and was approved in October 2014.

£ 2.6m national resilience funding was allocated to the CCGs upon successful assurance of plans as below.

Table 1: Central Resilience Funding Allocations

CCG	Allocation
Newbury & District CCG	£609,696
North & West Reading CCG	£600,822
South Reading CCG	£648,500
Wokingham CCG	£813,536
Total	£2,672,554

2. Allocation of Non –Recurrent Funding and Bidding Process

The CCGs allocated an indicative proportion of the funds to Providers as per the table below.

Table 2: Allocations to Providers

Provider	Allocation
Primary Care	£500K
RBFT	£500K
BHFT	£500K
SCAS	£200K

Local Authorities	£200K each
Alamac costs	£100K
Contingency	£200K

The rationale for the allocations was as follows;

1. Historically Primary Care has not been allocated resilience funding but this year the guidance specifically referred to the need for plans to include the use of primary care to support patients with urgent care needs
2. The sum allocated to RBFT reflected the fact that the Monies Retained from the Emergency Tariff (MRET) had already been allocated to the Trust
3. BHFT and Local Authorities - the guidance specifically referred to the need for plans to include the use of community, mental health and social services.

Organisations were then invited to submit bids against their indicative allocation. Bids had to be linked to the principles of good practice in the planning guidance and be related to initiatives or services which had demonstrated success in supporting non elective care pathways.

3. Investments from ORCP monies

3.1 Tranche One

Due to a failure to consistently meet the A&E 4 hour standard during 2013-14, the system was required to produce an Urgent and Emergency Recovery Plan in January 2014. The diagnostic exercise undertaken as part of developing that plan, helped the system to understand where improvements were needed to improve patient flow. The decisions on which schemes to fund from the resilience monies for 2014-15 were linked to this diagnostic to ensure that investment was being targeted in the right areas. Commissioners also needed to be assured that robust metrics were in place so that the impact of schemes could be tracked.

After the evaluation and prioritisation exercise the Urgent Care Programme Board approved the following schemes to be funded from the resilience monies.

Table 3: Bids funded from Tranche One monies

What the diagnostic work told us	What we measure in Alamac to track progress	What initiatives are we investing in for winter 14-15
Need to 'know our numbers' and understand and react to the impact of changes and investments across the system	Review and add measures to Alamac as necessary to track impact of investments and developments on both health and social care	1. Alamac dashboard 2. ORCP Co-ordinator
Need to maintain flow through the ED and have rapid access to senior triage	ED 4 hour performance Daily ED attendances	3. ANPs to support STATing 4. Additional ambulatory care capacity 5. Privacy and Dignity nurses in ED at peak times
Need to maintain flow 7 days per week	Daily discharge numbers from ECU and AMU Daily numbers through the Discharge Lounge	6. Additional medical staff to discharge 7 days 7. Week-end opening of Discharge Lounge

		8. RBC 7 day capacity 9. WBC SW and OP capacity 10. Pharmacy opening evenings and week-ends
Need to have timely effective discharge from acute and community beds	Average LOS on Ready to Go list	11. Discharge and Placement Leads in the Community 12. Integrated Discharge Team at the RBH 13. Additional Reablement capacity (Reading) 14. Supported Discharge (RBC) 15. Willows supported discharge expansion (RBC) 16. Trusted Assessor training (WBC) 17. Extra Care housing (RBC) 18. Scheme to support reduction in DToCs (WBBC)
Predict and manage surges	Triggers and alerts defined	19. Additional doctors to manage surges in demand 20. Additional surge capacity in OOH Primary Care 21. Early Bird GP with SCAS (to smooth flow)
Ensure good quality access arrangements in Primary Care		22. Additional capacity across all CCGs
Find alternative pathways for mental health patients		23. Mental Health street triage (BHFT/SCAS)

3.2 Other National Monies

In addition to the Tranche One allocations Berkshire West CCG also received additional national resilience monies as follows;

- £213k for NHS 111 resilience schemes across the Thames Valley
- £406k for SCAS resilience across the Thames Valley
- £351,260 for mental health resilience schemes.

A further allocation of £1.09m was also received in November 2014.

4. Schemes specific to West Berkshire

4.1 West Berkshire Borough Council

West Berkshire Council was allocated £200,000 based on a successful bid for £100k to support 'Urgent In Hospital Assessment' and a further £100k to support 'Urgent Care Delivery'.

The Initiative was designed to improve Delayed Transfers of Care performance by West Berkshire Council which is an Authority that has been subject to scrutiny by the Secretary of State in light of the national DToC performance data.

Description of the Schemes

'Urgent In Hospital Assessment': Local Authority staff will expand the service which engages with patients at point of admission to commence formulation of their discharge arrangements. This service will provide 2 Social Workers to engage with patients in the Royal Berkshire Hospital, and 2 Social Workers to accelerate discharges of patients in the West Berkshire Community Hospital. The service in the RBH is only funded to August 31st; it is proving successful and this funding will allow the early assessment process to be extended over the winter period. Using the same approach the new initiative in the WBCH will support the system pressures by facilitating an increased flow of patients from the Acute to Community hospital. The project is based on the assumption that a significant impact on DTOC performance cannot be affected by reacting to requests for care when patients are declared fit, but rather the work needs to start at the earliest point to be opening up discharge routes and encouraging the health services to engage with accelerated safe discharges. This is of particular importance in the West Berkshire area which is experiencing major difficulty in arranging for care packages in a large rural area in which scarce care providers need longer notice periods to arrange care. It will also improve the timely availability of care home placements in an area which has limited local availability by providing a longer time frame for making the necessary negotiations with providers.

'Urgent Care Delivery': Enhanced care service providing fast response to care for patients living in rural areas where there is a lack of care availability. For the winter period the Council will build up a flexible carer team of 8.5 carers who will respond to requests for care in the most difficult rural areas providing bridging care whilst longer term care is being commissioned with the scarce supply of care in these difficult areas.

Anticipated Outcomes

The following were the anticipated outcomes of the schemes;

1. To reduce the numbers of patients appearing as delays on the 'Fit to Go List'. This will also reduce the 'decompensatory' effect of stays in hospital reducing the incidence of admissions direct to care homes, it will also maximise patient potential for independence and improve the success rate of reablement.
2. Reduction in number of delayed discharge days.
3. Patients requiring complex care packages in rural areas will no longer experience delays in provision of care due to their rural location. It will also reduce the 'decompensatory' effect of stays in hospital reducing the incidence of admissions direct to care homes, it will also maximise patient potential for independence and improve the success rate of reablement.
4. Improve the availability of beds in West Berkshire Community Hospital for patients transferring from RBFT.

Staffing for the Schemes

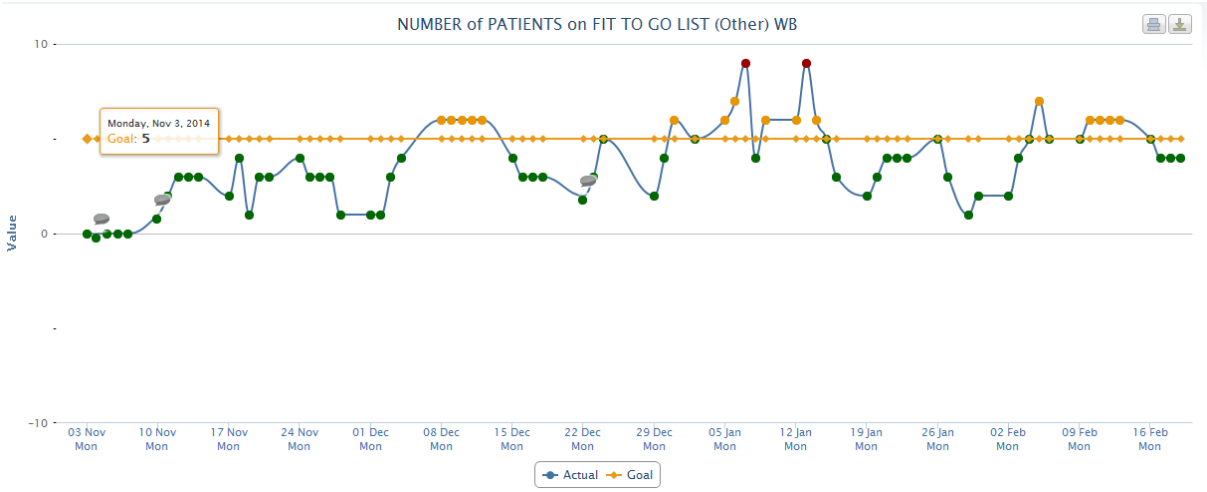
The funding was for the following staff;

2 Social Workers based at RBH for urgent assessments.
2 Social Workers based at WBCH for assessments from point of admission.

8.5 Care Workers to respond urgently to care needs of patients ready for discharge living in rural areas.

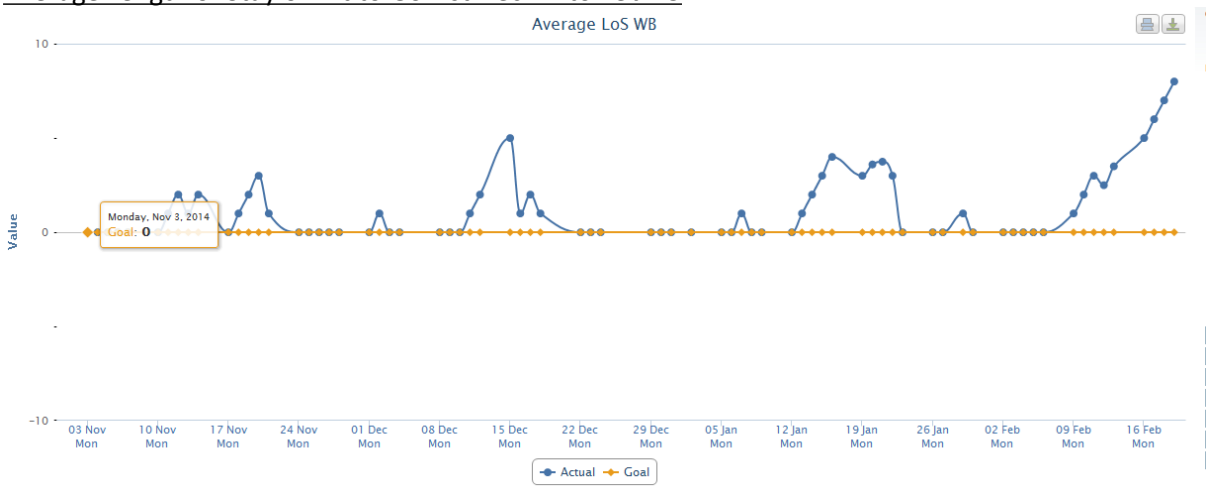
Outcomes and Impact

Numbers on Fit to Go List Dec-14 to Feb-15



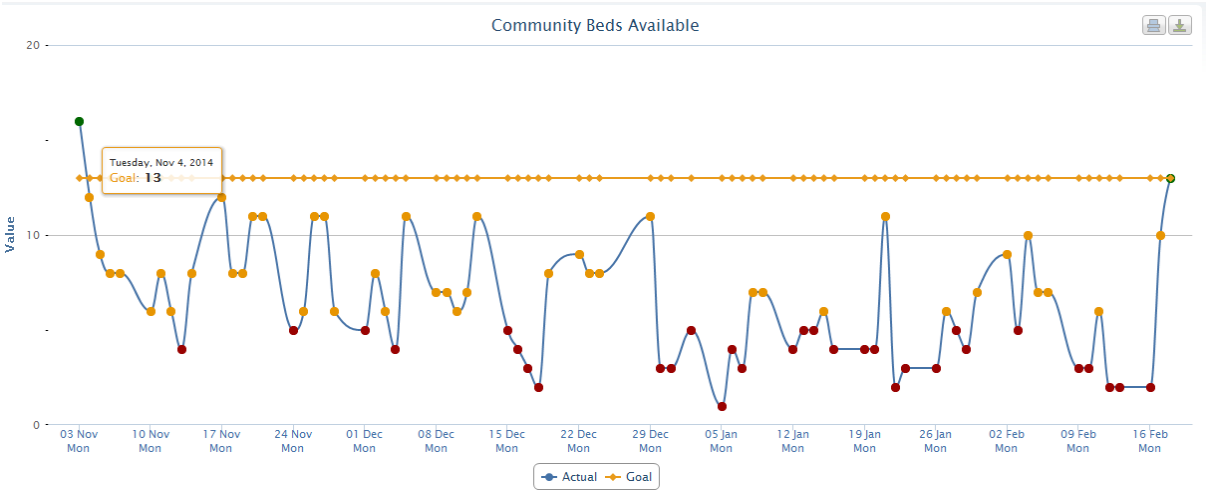
West Berkshire had a target of keeping the maximum number of people on the fit list below 9. Performance on this over the past year has been good so the target has reduced to 5; this has only been possible because of the additional investment provided through resilience funding.

Average Length of Stay on Fit to Go List Dec-14 to Feb-15



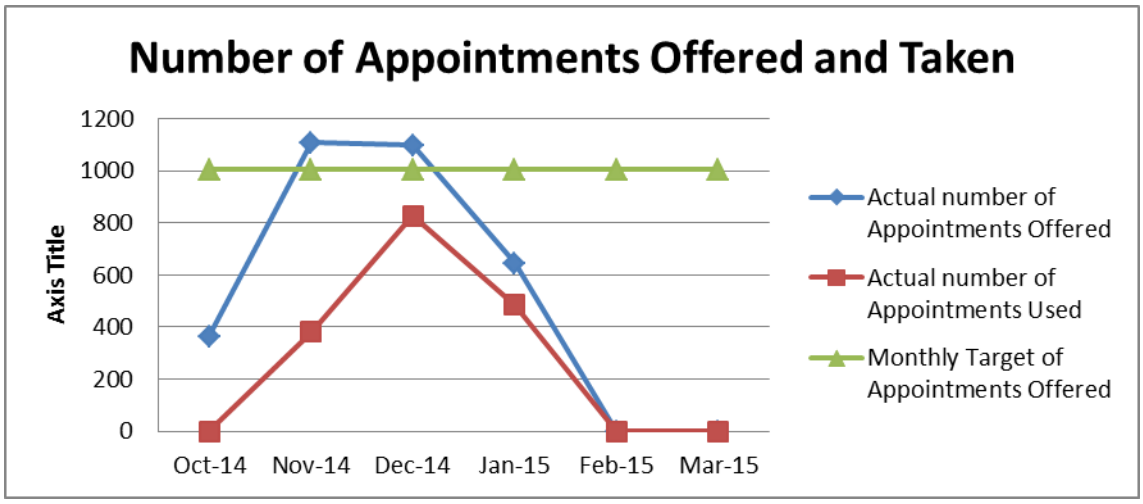
It should be noted that the numbers on the fit list for West Berkshire tend to be low and therefore the rise in average length of stay seen in February related to one individual. More recent data has seen the average length of stay reduce again, there is no target but the monthly average length of stay is 1.5 days.

Community Beds available Dec-14 to Feb-15

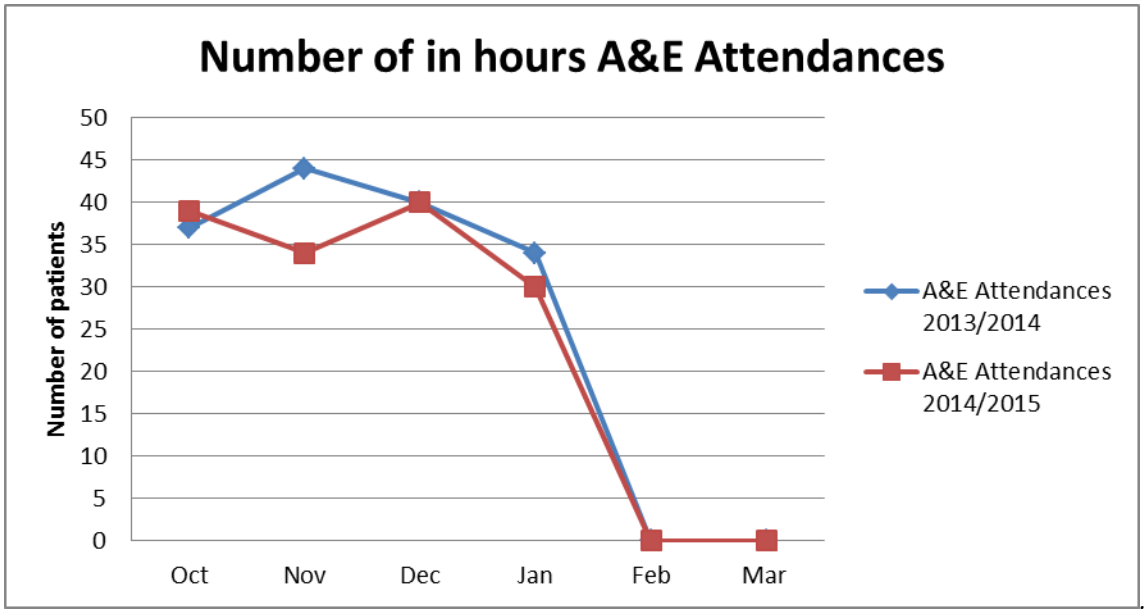


4.2 Primary Care Investment

Newbury & District CCG were allocated £180,990 for investment into additional resilience appointments In Primary Care. This equates to 6036 appointments across the 11 Practices.



In order to understand the impact of the additional appointments, attendance levels at the A&E department, Royal Berkshire Hospital are being monitored to see if there is a decrease in the type of minor attendances that could be seen in Primary Care. The graph below shows A&E attendances for patients with a Newbury & District GP who self referred and were discharged to their GP or home (of left without being seen). The data is also restricted to Monday to Friday 0800 – 1830 as the appointments were to be offered in–hours rather than extended access.



To date Newbury & District GP Practices have offered 3216 additional resilience appointments since October 2014, equating to 53% of their allocation.

In hours A&E attendances appear to be reducing when compared to the same time period in 2013-14 with a 12% reduction in January 2015 and an 8% reduction overall to date.

5. Review of Winter to Date

An initial review of winter to date has been undertaken by the Urgent Care Operational Group and the key messages were as follows;

What worked well
Social Care support immediately up to and post Bank Holidays Use of bridging packages to maintain flow (using Intermediate Care) Integrated Discharge Team Additional staff capacity in BHFT (Westcall GP in ED, additional clinicians on community wards) Hospital Ambulance Liaison officer Senior Triage and Treat process SCAS and Westcall Early Bird GP Additional PTS capacity Dedicated Social Workers based at RBH (especially week-end cover) SOS Night Time bus Additional capacity in Reading Reablement which supported flexing capacity across localities Mental Health Street Triage
What worked less well
Social Care gaps on Bank Holidays (unable to start new packages of care, delays getting

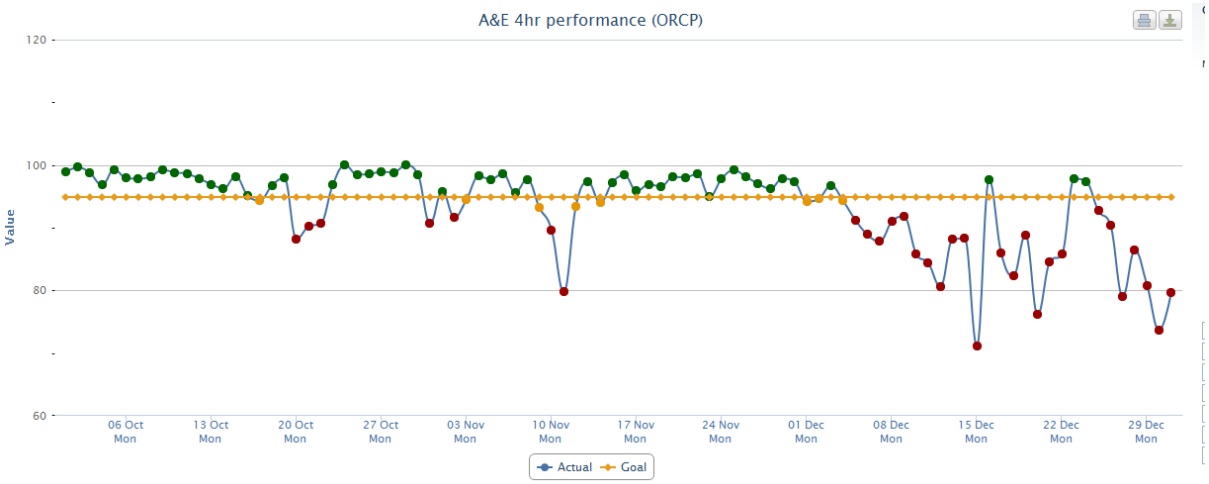
residents back to Care Homes, exacerbated by Bank Holidays being adjacent to week-ends) Early engagement with Provider (agreed actions did not materialise) Lack of planning and mobilisation time for schemes due to late sign off and/or release of monies Staffing challenges (unable to recruit to schemes/issues with agency staff) Communications (potential opportunity for more messages on self care and more system wide comms) NHS 111 issues with call volume predictions
Opportunities
Providers to share On Call Director and other key contact details in advance Ability of junior doctors to write up TTOs at week-ends PTS at week-ends Potential for Councils to select and work with particular Providers and incentivise them to provide during the Christmas period Building on what we know is starting to work (Integrated Teams/Discharge to Assess) Timing and Co-ordination of calls and information flows

A full review of winter will be undertaken in March, building on these initial findings and the post project evaluations on the resilience initiatives.

6. A&E 4 Hour Performance

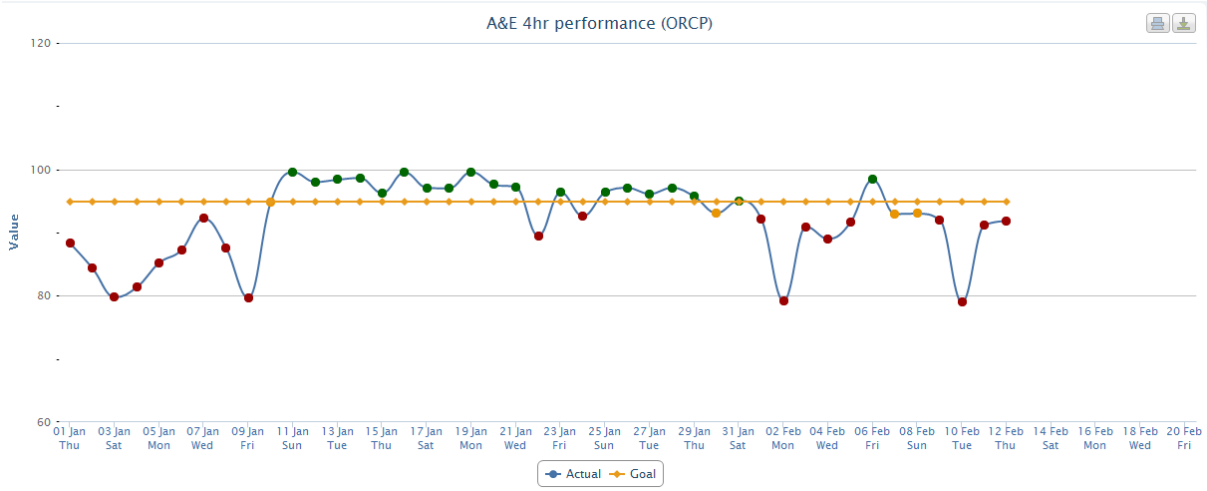
The national measure of success for urgent care performance is the A&E 4 hour standard.

A&E 4 Hour performance Quarter 3



Performance at the start of quarter 3 was very strong but high numbers of non elective admissions led to a significant deterioration in performance during December. The final reported performance for the quarter was 94.53% meaning that the target was narrowly missed. Although the target was not achieved it should be noted that Berkshire West performance was better than the Thames Valley average performance of 93.6% and national average performance of 92.6%.

A&E 4 Hour performance Quarter 4 to date



Performance during quarter 4 has also been challenged and it seems probable that the target will not be achieved. Although this is discouraging, performance for Berkshire West remains above average and the NHS England Area Team have commended Berkshire West on their ability to recover performance rapidly after significant workload challenges. This is a positive reflection on our robust resilience plans and strong partnership working.

7. Next Steps

Resilience monies have now been allocated recurrently and a paper will be prepared for the Urgent Care Programme Board identifying those schemes that are recommended to be funded from these monies.

Carolyn Lawson
Urgent Care Programme Lead
February 2015

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Title of Report:	**Better Care Fund – Progress Report**
Report to be considered by:	Health and Wellbeing Board
Date of Meeting:	26th March 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 Plan schemes and seek approval to the revised NEL targets.

Recommended Action:

Health and Wellbeing Board agree to the revised NEL targets.

Reason for decision to be taken: N/A

Other options considered: None

Key background documentation: None

Contact Officer Details	
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1. Better Care Fund Plan

1.1 The West Berkshire Better Care Fund Plan was finally approved by the Department of Health on the 6th February 2015. No changes were made to any of the original schemes or the financial arrangements.

1.2 No changes were made to any of the original schemes or the financial arrangements. Some very minor rewording was required to evidence to the Department of Health that social care services were being protected using a combination of Better Care Fund monies and changes to the council's 2015/15 budget in order to cover the Care Act funding gap.

1.3 Subsequent to the approval of the BCF plan, an issue has arisen that necessitates a change requiring approval from the Health and Wellbeing Board.

1.4 The table below sets out the original BCF NEL % changes as included in the September submissions. Since these submissions were made the CCGs have reviewed their most recent NEL activity ytd which revises the baseline denominator. We have also got an indication from those improvement intervention schemes approved year to date of those which are expected to have an impact on NEL activity. This has resulted in a shift across all three unitary authority areas.

	Original NEL % Reduction	Revised NEL % Reduction
West Berkshire HWB	1.0%	1.3%
Reading HWB	2.8%	1.1%
Wokingham HWB	2.0%	1.2%

2. Section 75 Agreement

2.1 All of the pooled budget arrangements and transfers of funding from the NHS to Local Authorities will be covered by a Section 75 agreement, this will replace the existing S256 agreements.

2.2 The Integration Finance sub-group is overseeing this process. The West Berkshire Section 75 agreement document is with the Council's Head of Legal and the associated 9 different schedules are in various stages of development..

3. BCF Projects progress

3.1 The following provides a very high level update on the progress of each of the projects;

(1) **Hospital At Home**

The business case has now been reframed to shift the focus to early supported discharge and admission avoidance. Further work has been completed on the costs/benefits assessment and, this is to be reviewed by the Hospital at Home Project Group. The focus is on health provider provision and more discussion is required to understand the impact for social care services. The West Berkshire BCF Plan recognised that costs would fall on both health and social care and therefore appropriate financial provisions were made.

(2) **Integrated Health and Social Care Hub**

Lots of initial work completed to map existing arrangements, practical requirements e.g. technology and the phasing. A new project manager has been appointed and the 'survey monkey' tool has been used to illicit feedback from a wide range of staff across both health and social care.

(3) **Enhanced Care and Nursing homes support**

Progress on this project has stalled but a new project manager has been appointed which should get things back on track. New NICE guidance may result in a shift in focus to include more engagement with local authorities to reflect our new responsibilities under the Care Act.

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

7 work streams have been identified for this project. Emphasis is work stream 1, pathway re-design.

(5) **Personal Recovery Guide**

The council has agreed to act as lead commissioner and its Procurement Board have agreed an exemption from the usual procurement requirements. This flexibility means that a pilot service will be up and running from April/May. Discussions have begun with 3 voluntary sector organisations one of which is Age UK who have a national lead for 'care navigation' and can bring some established good practice to this new service.

3.2 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:	
Officers Consulted:	Toby Ellis
	Paul Coe
	Steve Duffin
	Shairoz Claridge
Trade Union:	Not applicable

Berkshire West 10 Highlight Report

PROGRAMME	Hospital at Home Pathway model	**PROGRAMME & PROJECT MANAGERS**	**Fiona Slevin-Brown, Provider SRO** **Katie Summers, CCG SRO**	**OVERALL RAG STATUS**	
REPORTING PERIOD	01-31 Jan 15	**REPORT ISSUE DATE**	**6th Feb 2015**	**STATUS**	Amber

HOSPITAL AT HOME PATHWAY

The Hospital at Home project is a high profile cross partnership project which is also included within the 3 Better Care Fund plans. It was expected to achieve significant reductions in NEL and savings for the CCGs in 2014/15 however these have not been achieved as the project did not go–live in year.
Following a proof of concept exercise completed in October 2014 it was agreed that there would be benefits to the system in refocusing the Hospital at Home business case and pathway to include early supported discharge of patients deemed medically stable as well as including some admission avoidance activity with the opportunity for improving both patient experience and health outcomes as well as achieving efficiency gains through reductions in length of stay.

PROJECTS/ SCHEMES STATUS

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 Providers developed a reframed business case for Hospital at Home which was presented to QIPP and Finance in December 2014 and was approved formally in January 2015. This re-framed Provider led business case has been developed and shared with key stakeholders from both Health and Social Care. It was agreed that project implementation would commence as soon as possible pending appointment of a new Project Manager. The PM started on the 29th January 2015.

⬅	**Project Status**
⬇	**Finance Status**
⬅	**Activity Status**
⬅	**Milestone Status**

KEY ACHIEVEMENTS

- Implementation Project Manager appointed to commence 29th January 2015.
- Implementation Group reconvened twice monthly, first meeting took place 3rd Feb 2015.
- Implementation work stream and leads agreed 5th February 2015.

NEXT STEPS / PLANNED ACTIVITIES

- Task and finish groups planned for implementation of clinical and pharmacy pathways
- Recruitment and training of new personnel to commence pending formal letter of intent to fund from CCGs to BHFT
- BHFT to develop a formal training plan of its community teams including a review of specialist community nursing, IV therapy and integrated discharge partnership in RBFT and aligned to the locality work being undertaken as part of the Integration projects and BCF schemes
- Procurement of Tele Health equipment

NEW ISSUES RAISED THIS PERIOD

Ongoing funding of interdependent schemes or posts which have been funded to date through Operational resilience funding, e.g. weekend therapists in the RBH

NEW RISKS IDENTIFIED THIS PERIOD

No new issues have been raised at this stage

PLANNED BENEFITS					
	Benefit	**Timescale/date to be realised**	**Responsibility**	**Achieved Yes/No**	**Comment**
	Improving patient flow across the whole health and care system and achieve a reduction in the numbers of delayed transfers of care through co-ordinated discharge planning, and a pull from a community led integrated discharge team. Delivering a reduction in: • *readmission rates – supporting targets in the BCF* • *average length of stay across both acute and community in-patient unit. This is expected to be by at least 4 days in the RBFT and should enable over time an equivalent reduction in in-patient beds of 21.* • *avoidable NELs by 546*	March 2016 fye	Provider transformation Lead	No	Service full go-live from July 2015 with soft launch in May 2015.
	Improve patient's experience through: • *the provision of short-term intensive high acuity care in their normal place of residence through multi-disciplinary case management* • *engagement of patients and carers in individualized planning*	March 2016	Provider Transformation Lead	No	Full evaluation will need to include patient experience surveys
	Create a platform for Integration of Social and Health Services and assist in improving the productivity & responsiveness of community services through: • *building on the services already provided in the community and the plans being developed through local Better Care Fund Schemes* • *the development of the community workforce, providing opportunities for upskilling and career progression* • *the integration of the discharge/service navigation team at the RBH with staff from the community to develop a pro-active and Community led function* • *moving away from isolated specialist care groupings which do not in themselves meet the needs of growing numbers of patients with multiple co-morbidities to generic teams with specialist skills embedded within them*	From April 2015	Provider transformation lead	No	Details to be set out in the implementation plan. First draft due early March 2015.
	To reduce the inconsistency of care and ensure care is safe and equitable through the use of shared documentation, enhanced information sharing and a reduction in handoffs and maximising the effectiveness of the interface between secondary and community care	From April 2015	Provider Transformation lead	No	

RISK LOG					
Risk	*Owner*	*Mitigating Action*	*Impact (1-5)*	*Likelihood (1-5)*	*Rating (R/A/G)*
Inability to recruit and failure to upskill community staff to be able to safely manage higher levels of acuity in the community may impact on the success of the pathway	*BHFT*	*Early notification to BHFT to commence recruitment.* *Inclusion of ANP posts in the model should be attractive to potential applicants* *Training programme to be developed as part of the*	*4*	*2*	*8*

		implementation plan *Q2 commencement of the pathway*			
Interdependency upon other BCF, QIPP and partnership schemes will have an impact on the ability to deliver the revised pathway model	*BHFT/Providers*	*Robust project leadership of the implementation phase, and regular assessment and escalations of risks and issue via the local Integration steering groups*	*3*	*2*	*6*
Refreshed model is not approved by the HWB	*CCGs*	*CCG SRO to provide updated communications to Health and Wellbeing Boards on refreshed model, highlighting benefits.* *.*	*3*	*2*	*6*
Patients may consent not to access the service	*CCGs/Providers*	*Updated communications out to the general public on the model, including the CCG website. Patients to be provided with leaflets about the pathway and their options discussed with the discharge team*	*4*	*2*	*8*
There is a risk that the providers will not agree the revised payment and contracting terms for this pathway	*CCG and Provider DoFs*	*Both Provider finance teams have been involved in and agreement has been sought as part of the business case on the local tariffs and funding in the business case.* *development of a local incentive scheme on potential gain share*	*4*	*3*	*12*
Insufficient leadership capacity and capability to successfully lead the implementation phase of the pathway	*BHFT/RBFT*	*Business case includes funding for ongoing project management support from the Providers. An individual has been identified and can start once funding has been approved*	*3*	*2*	*6*
The pathway is dependent upon the redesign and development of a community led integrated discharge team, and the agreement of providers to positively engage in this work	*BHFT/RBFT*	*Commissioning intentions from the CCGs already include this requirement.* *To be included in the contracting discussions with both RBFT and BHFT* *Transformation lead will oversee and co-ordinate this work*	*3*	*3*	*9*
Clinicians and professionals are culturally slow to change their behaviours and are risk averse, failing to engage in both the development and use of the new pathway	*RBFT/BHFT/LAs*	*Transformation lead will be responsible for ensuring that the individual organisation leads are leading internal work streams which support the success of the pathway.* *Reporting will be through the Provider Steering group*	*3*	*3*	*9*
Access to timely Patient transport and to equipment including monitoring devices will be critical for some patients	*BHFT/BCES/CCG CCIO*	*Equipment funding included in the business case. Any delays will be monitored through a pathway performance framework and actioned with BCES* *Tele-monitoring devices will need to be procured in line with the Connected Care work stream*	*4*	*2*	*8*
A&E attendances may continue to rise if the level of complexity of patients prevents them from accessing the service in sufficient numbers to impact on admissions.	*CCGs*	*NEL activity and A&E attendances will be monitored monthly to evaluate the impact of all the QIPP schemes and the increasing demand pressures both in secondary and primary care*	*4*	*4*	*16*

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West Berkshire Highlight Report

PROGRAMME	WEST BERKSHIRE BCF PROGRAMME	PROGRAMME MANAGER	Tandra Forster & Steve Duffin	OVERALL RAG	
REPORT MONTH END	1 – 31 JANUARY 2015	REPORT ISSUE DATE	6 February 2015	REPORT STATUS	DRAFT

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

PROJECT/ SCHEMES STATUS

Finance - 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 clear what funding will still be available at year end to complete project work.

Milestone Status - some of the service redesign work has slipped into February as a result of a greater than expected level of feedback from staff..

	Project Status
	Financial Status
	Activity Status
	Milestone Status

KEY ACHIEVEMENTS	
Project Level	Draft Comms Strat completed and circulated to WBC Comms Team Revised PID (using new V2 template) circulated to WBC Programme Managers Activity Log prepared to support work package progress
BCF04 Joint Care Provider	**Work Package 1 – 'Care Delivery Redesign'** 1. Glossary of Terms drafted & circulated – ongoing document 2. Revised 'To Be' model re-drafted - issues clarified by team 3. Service Dependency Grid drafted – recognises interfaces between teams 4. Initial rostering conversations completed – to identify differences between shifts/working hours across organisations 5. Provisional 'Duty Manager' daily task list created – to identify function of role
BCF04 Joint Care Provider	**Work Package 2 - 'Workforce'** 1. Pre-Workshop planning completed – presentation for combined staff 2. Workshop held with BHFT & WBC frontline staff to present concept & request feedback 3. Confirmation that staff will not be transferred between organisations & no secondments required 4. Confirmation that co-location of staff across organisations desirable (see next steps)
BCF05 7 Day Services	**Work Package 3 – '7 Day Services'** 1. Initial rostering conversations underway - to identify differences between shifts/working hours across WBC/BHFT organisations 2. Outline review of EDT (Emergency Duty Team) at Bracknell – recognition of current service issues and update requested from WBC regarding contract extension
BCF04 Joint Care Provider	**Work Package 4 – 'Transfer to Long Term Care Proposal'** 1. Existing model to continue in short term – recognition that review & proposals should be delayed until new 'To Be' process and new staffing model have been embedded
BCF04 Joint Care Provider	**Work Package A – 'IT Systems'** 1. Initial meeting held with cross-organisation systems teams – confirmation that manual intervention required and no automated solution available. Confirmation that software integration

	not feasible
BCF01 Community Nurses Directly Commissioning Care / Reablement Services	**Work Package B – 'Trusted Assessor'** **1.** Training Model/Staff 'License' development underway
BCF04 Joint Care Provider	**Work Package C – 'Performance data/measurement'** 1. Decision taken to delay commencement of this work package until 'To Be' model and staffing function agreed

NEXT STEPS / PLANNED ACTIVITIES	
BCF04 Joint Care Provider	**Work Package 1 – 'Care Delivery Redesign'** 1. Process Mapping to be undertaken 2. Agreed standards to be identified 3. Potential patient numbers to be identified – through a staged approach - first factoring in MI & IC functions before widening to AFA function 4. Protocols & Governance to be drafted 5. Activity thus far to be approved at full Project Team meeting (13 Feb)
BCF04 Joint Care Provider	**Work Package 2 'Workforce'** 1. Analysis of staff feedback following 22 Jan workshop 2. Revised staffing model to be further reviewed by staff following additional analysis/review by project team 3. Co-locations to be established 4. Confirmation regarding no requirements for transfers/secondments to be approved at full Project Team meeting (13 Feb) 5. Confirmation regarding decision regarding co-location of staff at full Project Team meeting (13 Feb)
BCF05 7 Day Services	**Work Package 3 – '7 Day Services'** 1. Additional staffing requirements for WBC/BHFT to be considered at at full Project Team meeting (13 Feb) 2. Meet with CCG & RBH(18 Feb) to get greater understanding of organisational working hours and identify barriers to progress
BCF04 Joint Care Provider	**Work Package 4 – 'Transfer to Long Term Care Proposal'** 1. Await next outputs from Work Packages 1 & 2
BCF04 Joint Care Provider	**Work Package A – 'IT Systems'** 1. Seek further understanding of existing manual data capture processes 2. Meet to discuss options
BCF01 Community Nurses Directly Commissioning Care / Reablement Services	**Work Package B – 'Trusted Assessor'** 1. 'As is' Process to be mapped 2. 'To Be' Process to be detailed 3. 'Licence' Requirements to be considered at full Project Team meeting (13 Feb) 3. First draft of 'Trusted Assessor Licence' to be produced

BCF04 Joint Care Provider	**Work Package C – 'Performance data/measurement'** 1. Requirements to be scoped

NEW ISSUES RAISED THIS PERIOD

No new issues raised this period

NEW RISKS IDENTIFIED THIS PERIOD

Risk Ref	Category	Source & Date Raised	Risk Description	Inherent risk score L	I	RR	Required controls and actions to reduce/mitigate risk	Review Dates	SRO and Monitor/ Review body	Residual Risk Score and Rating L	I	RRR
Combined Risks												
COMB 10	Performance	06/01/2015	Different interpretation of terminology across organisations resulting in inconsistencies, assumptions, errors, underestimations, overestimations	3	3	9	Development of common Glossary of Terms authored by all organisations - drafted & circulated 7 Jan	Monthly	Integrated Steering group	1	1	1
COMB 11		06/01/2015	All proposals need to work in tandem with separate WBC Care Act and New Ways of Working projects and initiatives to ensure common direction of travel	3	3	9	Regular sharing of updates and strategic decisions between organisations	Monthly	Integrated Steering group	2	2	4
COMB 12		06/01/2015	Ability of organisations and external providers to retain staff following introduction of new service proposals - concern at loss of expertise if new proposals are not embraced by existing staff	3	3	9	Ensure staff and providers are aware of the opportunities generated by the new service model through updates, workshops, meetings, engagement	Monthly	Integrated Steering group	2	2	4
Joint Care Provider only												
JCP 12	Financial	05/01/2015	Agreement required between BHFT & WBC regarding management of pooled budget. Risk concerning charging to cost centre/authority to spend/invoice queries	2	3	6	BHFT/WBC to agree Pooled Budget mechanism. Project to liaise with BCF finance group and relevant finance teams	Monthly	Integrated Steering group	2	2	4
JCP 13	Performance	06/01/2015	Potential number of service users who might use 'To Be' model not currently known making workforce planning difficult. In addition the % of these patients who will subsequently need long term care not known - estimated at 40%.	3	3	9	Identification of phase one cohort numbers required alongside review of data from recent periods to gain understanding of range of potential users	Monthly	Integrated Steering group	2	2	4
JCP 14	Performance	06/01/2015	Ability of 'Business as Usual' to continue effectively if the proposed model impacts on workforce and existing arrangements.	3	4	12	Current business to be reviewed in light of proposed new model. Existing KPIs - caseload, response times etc - might be negatively affected during transition period	Monthly	Integrated Steering group	3	3	9
JCP 15		06/01/2015	Organisational difference with regards charging model - health - free at point of access, LA - payment upon completion of agreed package - might lead to confusion with new model	2	3	6	clarity required with regards charging model to be captured within process	Monthly	Integrated Steering group	1	2	2

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 work stream 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	Feb	H	Conversion to new (V2) BCF format
Milestone 3: Service Redesign	TE	Jan	Feb	H	Has slipped into February – greater than anticipated staff feedback/contribution
Milestone 4: Work Package Preparation	TE	Jan	Feb	H	Has slipped into February – greater than anticipated staff feedback/contribution
Milestone 5: Work Package Activity	TE	Mar	Mar	H	Work Packages underway
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	

RESOURCE SUMMARY		
Number of Main (FTE) Resources Required	*Number Now In Post*	*Explanation for variance, impact on work stream 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

Project Budget / Cost Summary (£000s) as at 31/1/2015

Funded From:	s256				CTA				Council Funding				Explanation – please use box below if further space is required
Cost Type	Original budget (in Business Case)	Actual spend to date	Forecast to 31st March 2015	Forecast To Completion of scheme	Original budget (in Business Case)	Actual spend to date	Forecast to 31st March 2015	Forecast To Completion of scheme	Original budget (in Business Case)	Actual spend to date	Forecast to 31st March 2015	Forecast To Completion of scheme	
Programme and Project Management costs													
Project Manager					53,200	22,786	34,135	50,668					
Subject Matter Experts (backfill0					55,720	32,251	44,921	65,634					
Project Office Admin Support					4,200	2,436	4,011	6,251					
ICT Equipment					1,050	485	485	485					
Room Hire/ Catering					2,730	1,121	1,400	1,750					
Specialist Support - HR					3,500	0	0	0					
Specialist Support - Legal					3,500	0	2,450	2,450					
Specialist Support - Finance					7,000	630	2,450	2,450					
Training					3,500	0	2,450	2,450					
Other					0	80	2,205	2,240					
Contingency					9,100	0	0	0					
Sub Total	**0**	**0**	**0**	**0**	**143,500**	**59,789**	**94,507**	**134,378**	**0**	**0**	**0**	**0**	
Pump Priming for Go Live													
Sub Total	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**0**	

Totals	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**0**	

FINANCE *Explanation for slippage, impact on work stream and actions being taken. Has any re-planning been approved by appropriate Board?*
The only concern regarding the finance is a suggestion that some of the CTA funding provided will be withdrawn resulting in staff seconded to the BCF programme having to return to their substantive positions with effect from 1st April 2015.

PERSONAL RECOVERY GUIDE / KEY WORKER

PROJECT/ SCHEMES STATUS

The delivery of this project is generally on track however the timetable for having the new service up and running is dependent upon obtaining approval from West Berkshire Procurement Board for an exemption from the usual LA procurement rules. If the exemption is approved at the Board meeting on the 17th February it will enable a pilot scheme to be up and running from April with a far more flexible approach to be taken with voluntary sector providers.

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
	Financial Status
	Activity Status
	Milestone Status

KEY ACHIEVEMENTS

BCF03 Personal Recovery Guide / Keyworker (note project has single work package)	1. 2nd Workshop completed – feedback from stakeholders regarding proposed specification 2. 4th Team meeting – agreement to take draft specification to ICSG, to propose pilot scheme, to propose WBC as Commissioning organisation 3. Agreement from ICSG regarding 12 month Pilot Scheme proposal 4. Agreement from ICSG regarding WBC as Commissioning organisation 5. Meeting with WBC legal regarding pilot 6. Preparation of Paper detailing pilot to be presented at WBC Procurement Board 17 February

NEXT STEPS / PLANNED ACTIVITIES

BCF03 Personal Recovery Guide / Key worker (note project has single work package)	1. Seek approval for pilot from WBC Procurement Board 2. Confirm requirements are synchronised with separate, but related, WBC Voluntary Sector Prospectus scheme 3. Confirm processes, required outcomes, pricing schedule, staffing model, milestones and KPIs with pilot partner organisations 4. Prepare to commence pilot from 1 April with limited initial cohort to be extended over coming months until full capacity achieved

NEW ISSUES RAISED THIS PERIOD

No new issues – progress has been made in dealing with last months issue around the time taken to get the new service up and running. A phased launch – initially targeting a reduced cohort – will be gradually developed until full capacity is achieved.

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 L	I	RR	Required controls and actions to reduce/mitigate risk	Review Dates	SRO and Monitor/ Review body	Residual Risk Score and Rating L	I	RRR
Personal Recovery Guide only												
PRG 10	Delivery	08/01/2015	Implementation timescales incompatible with proposed contract length - early supplier involvement suggests set-up could take between 6-12 months if full tendering process is required	3	3	9	An exemption from the full tendering process is being sought	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 work stream and actions being taken. Has any re-planning been approved by appropriate Board?*
Personal Recovery Guide					
PID Sign-off	TE	Nov	Feb	H	Conversion to new (V2) BCF format
Milestone 2: Assessment of requirements	TE	Dec	Feb	H	Ongoing – perceived overlaps with WBC Voluntary Sector Prospectus scheme to be resolved
Milestone 3: Specification completed	TE	Jan	Feb	H	Delayed due to requirement to seek WBC Procurement Board approval
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	

RESOURCE SUMMARY		
Number of Main (FTE) Resources Required	*Number Now In Post*	*Explanation for variance, impact on work stream 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

Project Budget / Cost Summary (£000s) as at 31/1/15

Funded From:	s256				CTA				Council Funding				Explanation – please use box below if further space is required
Cost Type	Original budget (in Business Case)	Actual spend to date	Forecast to 31st March 2015	Forecast To Completion of scheme	Original budget (in Business Case)	Actual spend to date	Forecast to 31st March 2015	Forecast To Completion of scheme	Original budget (in Business Case)	Actual spend to date	Forecast to 31st March 2015	Forecast To Completion of scheme	
Programme and Project Management costs													
Project Manager					22,800	9,765	14,629	21,715					
Subject Matter Experts (backfill0					23,880	13,822	19,252	28,102					
Project Office Admin Support					1,800	1,044	1,719	2,679					
ICT Equipment					450	208	208	208					
Room Hire/ Catering					1,170	351	600	750					
Specialist Support - HR					1,500	0	0	0					
Specialist Support - Legal					1,500	0	1,050	1,050					
Specialist Support - Finance					3,000	270	900	1,050					
Training					1,500	0	1,050	1,050					
Contingency					3,900	0	0	0					
Sub Total	**0**	**0**	**0**	**0**	**61,500**	**25,460**	**39,408**	**56,604**	**0**	**0**	**0**	**0**	
Pump Priming for Go Live													
Sub Total	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**0**	

Totals	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**0**	

FINANCE *Explanation for slippage, impact on work stream and actions being taken. Has any re-planning been approved by appropriate Board?*
The only concern regarding the finance is a suggestion that some of the CTA funding provided will be withdrawn resulting in staff seconded to the BCF programme having to return to their substantive positions with effect from 1st April 2015.

Berkshire West 10 Integration Portfolio Status Report

Reporting Period: 14 January 2015 to 13 February 2015

Scheme / Programme		Description / Key Achievements	Responsible Lead	Next Steps	BRAG Rating	Issues / Actions/ Item to Note
Frail Elderly	Pathway Activities	• Chief Officers have agreed to support the establishment of a mixed model steering group with senior leadership input from across the partnership with the aim of driving the development of a model and acting as the accountable forum for taking this work forward on behalf of the BW10. • Delivery Group continuing mapping exercises to validate the 'To Be' Blueprint and develop a 'Current' Blueprint by locality • Agreement to ensure the Frailty Network group involved in the national learning programme maintains link into the FEP Steering group once this is established	SRO's Stuart Rowbotham, Lindsey Barker and Bev Searle PM - David Mphanza	• Agree SRO for Pathway and establish Steering group • DG to continue mapping system blueprints, as is and future state	Green	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.
Berkshire West Programmes	Health and Social Care Hub	The Programme Team (Task & Finish Group) is established awaiting a representative from to SCAS join the group. Development of a PID & Business Case is also underway. The Hub Options Appraisal is being developed. As part of the Options Appraisal process, an on-line survey has been circulated to Health and Social Services professionals and Single Point of Access operators within Berkshire West comprising the localities of West Berkshire, Reading and Wokingham. The survey ends on Monday 16th February. The survey includes a preference question about four possible Hub design options; 1. Single telephone number for Health and Social Care referrals, with referral/access point staff co-located in a single building. 2. Single telephone number for Health and Social Care referrals, with referral/access point staff co-located in various buildings across Wokingham, Reading and West Berkshire. 3. Single telephone number for Health and Social Care referrals – Merge of LA single point of access staff with Berkshire Healthcare NHSFT Hub. 4. Status Quo	SRO - Katie Summers / PM John Rourke	Continue to evidence quantifiable data to establish baseline information about current 'Front Door' Hub activity within West Berks, Reading and Wokingham. Build on and develop more detailed information on costs (pay and non-pay), staffing and call volume information provided by each LA. Assess the findings from the electronic survey of health and social care professional and continue to further develop the Options Appraisal Create an on-line survey for patients, carers, service users, voluntary agencies and care home managers and staff.	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 Providers developed a reframed business case for Hospital at Home which was presented to QIPP and Finance in December 2014 and was approved formally in January 2015. This re-framed Provider led business case has been developed and shared with key stakeholders from both Health and Social Care. It was agreed that project implementation would commence as soon as possible pending appointment of a new Project Manager. The PM started on the 29th January 2015. • Implementation Group reconvened twice monthly, first meeting took place 3rd Feb 2015. • Implementation work stream and leads agreed 5th February 2015.	SRO Fiona Slevin-Brown - Providers SRO Katie Summers - CCG PM - Kate Turner	• Task and finish groups planned for implementation of clinical and pharmacy pathways • Recruitment and training of new personnel to commence pending formal letter of intent to fund from CCGs to BHFT • BHFT to develop a formal training plan of its community teams including a review of specialist community nursing, IV therapy and integrated discharge partnership in RBFT and aligned to the locality work being undertaken as part of the Integration projects and BCF schemes • Procurement of Tele Health equipment	Amber	Ongoing funding of interdependent schemes or posts which have been funded to date through Operational resilience funding, e.g. weekend therapists in the RBH
	Enhanced Services for Care Homes (QIPP Scheme)	To improve the quality of care in care homes to prevent non-elective admissions that are deemed avoidable. This is a QIPP scheme that was approved by the QIPP and Finance Committee in December 2013. Key deliverables; • All patients within care homes are assessed by GP within one month of admission and Supportive Care Plan is uploaded onto Adastra and shared with care home staff. GPs will also complete a 6 monthly review of care plans • All care home staff to receive training on health and crisis management • A Speech and Language Therapist to provide an enhanced service to the in-reach team to identify patients with or suspected dysphagia • An enhance Community Pharmacist to review all medicines and prescriptions to reduce costs and polypharmacy	Katie Summers Berkshire West CCGs QIPP Scheme Lead Nina Vinall CSU Support from January 2015.	Key achievements – • 36 out of the 40 General Practice Surgeries have signed up to the CES scheme • Revision of the monitoring HRG codes revised to ensure realistic achievement • Leadership training for care homes to commence in May 2015 provided by Thames Valley Leadership Academy Next Steps - • Training to be reviewed to ensure relevance to avoidable admissions • Review of audit requirements in relation to Supportive Care Plans and service specifications • Review of in-reach service specification • Full review at QIPP and Finance Committee in February 2015	Red	Scheme not realising it's full potential due to the non-appointment of both the Speech and Language Therapist and Community Pharmacist. Stable project mgmt support required, currently 1 day per week provided via the CSU. • SLT at a Band 6 appointed at beginning of February for 2 days a week, remaining 3 days to be advertised • Community Pharmacist interviews to take place in February 2015 • 2 Educators to provide enhanced training to be employed for 2015/16 by BHFT BW10 IP Risk 10
Reading	GREEN	Main risk at present relates to the recruitment of staff which is being closely monitored. Financial status may change next month if agency staff are required. S75: Tool and format identified. S75 sign off confirmed, report now prepared to go to the March 2015 Adult Children's and Education committee. Service specification for reach scheme to be completed. Sign off requirements agreed with Head of Service and Lead Councillor. Further work required on dashboard to map financial elements alongside performance Mental Health Integration: Mental Health Partnership Board now set up - Staff survey to be analysed. First refreshed partnership board to take place				
	Discharge to Assess (DTA)	Recruitment for social care staff remains on track. Recruitment of BHFT staff is in progress. Social work recruitment – in progress Carer recruitment - some success and will continue with ongoing rolling recruitment programme Domestic recruited Transport Operating manual refreshed Developed light touch assessment tool. Continue to run pilot using one of the dementia beds at The Willows – plan to evaluate in Feb.	SRO's Suzanne Westhead & Brigid Day PPM's Melanie O'Rourke	Sign off light touch assessment for hospital Develop pathway awareness session with staff / stakeholders Transport for service users to visit care homes to be negotiated Pharmacy support to be clarified	Green	Risks: Some difficulties recruiting into the Social Care vacancies. Posts being re-advertised – still time to recruit. There may be a requirement to use agency staff for a limited period.
Whole System Whole week	Neighbourhood Clusters	Scoping document presented to Reading Integration Board Map produced to illustrate proposed clusters	SRO Suzanne Westhead & Brigid Day PPM's Melanie O'Rourke / Jan Caulcutt	Take concept through patient journey's to test out Define deliverables of the group Finalise PID	Green	
	7 day access	New provider has been identified who can take admissions onto their schemes at the weekend. Although in place there are still issues about medication and consultant discharges. Further work needed with RBH Linkages now made to the Acute Frailty Network at RBH, to explore issues and opportunities.		Work with key partners to map out the 7 day offers and the dependencies Work with RBH around issues relating to 7 day discharges.		
	GP Access 7/7	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.		

Berkshire West 10 Integration Portfolio Status Report

Reporting Period: 14 January 2015 to 13 February 2015

Scheme / Programme		Description / Key Achievements	Responsible Lead	Next Steps	BRAG Rating	Issues / Actions/ Item to Note
Wokingham	Amber	Financial status amber due to uncertainty regarding DoH funding for change in eligibility criteria and knock on risk to BCF there is funding for 15/16 from Council reserves and further CCG monies, ongoing risk for 16/17. Programme Manager backfill started 110215, handover ongoing.				
	Step up Step Down Beds	Consultation completed with Alexandra Place residents regarding siting SUSD in their scheme. Referral pathway from HLT WISH team for Step Down element of service drafted and circulated. Support service specification drafted, service costs agreed with Optalis, who have secured staff for the scheme. Legal Lease agreement received from landlord awaiting legal advice ref occupancy agreement with service user. 2 flats identified by landlord for piloting the scheme. Check in and out process drafted between partners on site and equipment and furnishings authorised for purchase.	SRO Stuart Rowbotham PM James Burgess	Finalise support service specification and agree referral pathways, and Step Up pathway. Finalise and sign rental agreement with housing provider for units to be used. Furnish and equip 2 units identified. Investigate whether Cockayne Court could be used for additional units if required.	Amber	
	Integrated short term health & social care team		SRO Stuart Rowbotham PM James Burgess	Appoint Project/Development Manager to take forward phase 2 integration	Amber	
	Domiciliary Care Plus	Consulted with Hillingdon's consultant, infrastructure requirements being drafted and discussed with procurement	SRO Stuart Rowbotham PM James Burgess	Draft AT service specification and referral look at procurement options; examine resources needed to progress project, outline project manager requirement for project and secure approval to recruit.	Amber	
	Self-Care and Primary Prevention & Neighbourhood	**Self Care / Primary Prevention:** - Survey for stakeholders regarding maximising independence through prevention and self care launched 04/02/15. 39 online responses by day 2; hard copies also being made available. - Workshop planned for 25/02/15 to understand how people currently 'self care' and how the Co-Production Network can assist in ensuring local people maximise their independence through prevention and self care - Findings reported from Wokingham Healthwatch study (in partnership with Wokingham Information Network (WIN) and the Mobile Information Centre (MICe)); HW planning to develop an agreed Borough Standard around providing information - Work continues to draft updated Prevention strategy; v 4.0 circulated, requires amendment prior to wider consultation **Neighbourhood Cluster teams:** - Further engagement regarding development of options: discussed at GP council meeting (20 Jan), WISP (21 Jan), Practice Managers meeting (22 Jan), Patient Participation Group Forum (22 Jan) WBC executive members meeting (27 Jan) and Place & Community Partnership / Co-production network (29 Jan). Additional engagement planned through 3 x Public events in March - Agreement to develop Neighbourhood teams based on 3 Clusters: North (Wargrave – Twyford – Loddon Vale – Woodley – Parkside – Wilderness Rd), East (Woosehill – Wokingham - Burma Hills – Finchampstead - New Wokingham Road) and West (Brookside – Swallowfield - Shinfield). - Plan is to phase development of a range of highly integrated health and social care teams in the community aligned to clusters of practices. Initially 3 pilots; 1 per Cluster: North – develop role of Generic Primary Care Nurse; West – develop urgent care through a Hub/spoke model for delivering extended access; East – develop Cluster-based Community and Voluntary Sector Coordination - Cluster Team Leader to be recruited for each Cluster – awaiting approval of draft job description then to be advertised.	SRO Stuart Rowbotham PM James Burgess	**Self Care / Primary Prevention** - Survey (re maximising independence through prevention and self care) closing date 18-02-15; results to be analysed by 23-02-15 to feed into Co-production workshop on 25-02-15, where actions to address gaps can be identified - Meeting to refine draft updated Prevention strategy planned for 10-02-15; then out for wider consultation **Neighbourhood Cluster teams:** - Steering group with representation from key stakeholder organisations / professional groups to be established; 1st meeting? end Feb - Cluster Team Leaders to be advertised - Plans for 3 pilot schemes to be further developed in consultation with key stakeholders - 3 x Public events being planned to take place during March; 1 in each cluster. Dates provisionally booked (11th, 14th, 17th March) – will include one evening and one Saturday to allow as many members of the public to attend as possible. Working with CSU / WBC comms to plan events in detail. - Further update and draft business case to WISP 18 -02-15 Work ongoing to develop and refine PID / business case, project plan and service spec as proposals are defined and agreed.	Amber	
	GP Access		SRO Stuart Rowbotham PM James Burgess		Amber	

West Berkshire	Amber	Joint Care Provider - Milestone Status - some of the service redesign work has slipped into February as a result of a greater than expected level of feedback from staff. Finance - 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 clear what funding will still be available at year end to complete project work. Personal Recovery Worker - Dependent upon obtaining approval from West Berkshire Procurement Board for an exemption from the usual LA procurement rules, expected 17th Feb				
	Joint Care Provider (inc 7 day services and direct commissioning)	Care Delivery Redesign: Process Mapping to be undertaken. Agreed standards to be identified. Potential patient numbers to be identified – through a staged approach - first factoring in MI & IC functions before widening to AFA function. Protocols & Governance to be drafted. Activity thus far to be approved at full Project Team meeting (13 Feb). Workforce: Analysis of staff feedback following 22 Jan workshop. Revised staffing model to be further reviewed by staff following additional analysis/review by project team. Co-locations to be established. Confirmation regarding no requirements for transfers/secondments to be approved at full Project Team meeting (13 Feb). Confirmation regarding decision regarding co-location of staff at full Project Team meeting (13 Feb). Transfer to Long Term Care Proposal: Await next outputs from Work Packages 1 & 2. IT Systems: Seek further understanding of existing manual data capture processes. Meet to discuss options Performance data/measurement: Requirements to be scoped 7 Day Services: Additional staffing requirements for WBC/BHFT to be considered at full Project Team meeting (13 Feb). Meet with CCG & RBH(18 Feb) to get greater understanding of organisational working hours and identify barriers to progress. Direct Commissioning: 'Trusted Assessor: 'As is' Process to be mapped. 'To Be' Process to be detailed. 'Licence' Requirements to be considered at full Project Team meeting (13 Feb). First draft of 'Trusted Assessor Licence' to be produced.	Sponsors Shairoz Claridge & Tandra Forster Programme Manager Steve Duffin Project Manager Toby Ellis	Care Delivery Redesign' 1. Process Mapping to be undertaken. and agreed standards to be identified 3. Potential patient numbers to be identified – through a staged approach - first factoring in MI & IC functions before widening to AFA function 4. Protocols & Governance to be drafted. Activity thus far to be approved at full Project Team meeting (13 Feb) Workforce 1. Analysis of staff feedback following 22 Jan workshop 2. Revised staffing model to be further reviewed by staff following additional analysis/review by project team 3. Co-locations to be established. Confirmation regarding no requirements for transfers/secondments to be approved at full Project Team meeting (13 Feb) 5. Confirmation regarding decision regarding co-location of staff at full Project Team meeting (13 Feb) '7 Day Services' 1. Additional staffing requirements for WBC/BHFT to be considered at full Project Team meeting (13 Feb) 2. Meet with CCG & RBH(18 Feb) to get greater understanding of organisational working hours and identify barriers to progress Transfer to Long Term Care Proposal'- Await next outputs from Work Packages 1 & 2 IT Systems'- Seek further understanding of existing manual data capture processes, Meet to discuss options Trusted Assessor' 1. 'As is' Process to be mapped and 'To Be' Process to be detailed 2. 'Licence' Requirements to be considered at full Project Team meeting (13 Feb) 3. First draft of 'Trusted Assessor Licence' to be produced Performance data/measurement'- Requirements to be scoped	Amber	
	Personal Recovery Worker	The delivery of this project is generally on track however the timetable for having the new service up and running is dependent upon obtaining approval from West Berkshire Procurement Board for an exemption from the usual LA procurement rules. If the exemption is approved at the Board meeting on the 17th February it will enable a pilot scheme to be up and running from April with a far more flexible approach to be taken with voluntary sector providers. 1. 2nd Workshop completed – feedback from stakeholders regarding proposed specification 2. 4th Team meeting – agreement to take draft specification to ICSG, to propose pilot scheme, to propose WBC as Commissioning organisation 3. Agreement from ICSG regarding 12 month Pilot Scheme proposal 4. Agreement from ICSG regarding WBC as Commissioning organisation 5. Meeting with WBC legal regarding pilot 6. Preparation of Paper detailing pilot to be presented at WBC Procurement Board 17 February	Sponsors Shairoz Claridge and Ian Mundy Programme Manager Steve Duffin Project Manager Toby Ellis	1. Seek approval for pilot from WBC Procurement Board 2. Confirm requirements are synchronised with separate, but related, WBC Voluntary Sector Prospectus scheme 3. Confirm processes, required outcomes, pricing schedule, staffing model, milestones and KPIs with pilot partner organisations 4. Prepare to commence pilot from 1 April with limited initial cohort to be extended over coming months until full capacity achieved	Amber	

Berkshire West 10 Integration Portfolio Status Report

Reporting Period: 14 January 2015 to 13 February 2015

Scheme / Programme		Description / Key Achievements	Responsible Lead	Next Steps	BRAG Rating	Issues / Actions/ Item to Note
Enabling Programmes						
Connected Care		• Commercial - Hosting contract agreed and signed. Infrastructure build can now commence. SoW received from Orion. CSU review required. • Deployment - BHFT – Orion designing extract from database as opposed to file transfer. RBFT – Orion designing extract from database as opposed to central data repository. Data sets under review prior to distribution to senior users. • IG - Consent and privacy workshop complete, outputs to be reviewed. • Benefits - Completed BCF/connected care benefits mapping completed.	SRO Katie Summers Programme Manager John MacDonald	• Commercial - Ensure PO's are raised for Orion and OCSL. Delays to this may impact on vendor service delivery. • Deployment - Finalise data sets. Build extract model for data based on provider database. • IG - CSU sign off on Orion consent and privacy design. Prepare ISA schedule D's based on exact data extract. Distribute for Caldicott sign off. • Benefits - MIG pre/post surveys to be distributed to MIG user-groups. WestCall MIG reports to be collated.	Green	• Future funding (post pilot) needs to be reviewed as full Digital Care Fund funding was not successful. • Conflicting project priorities at provider organisations may put pressure on availability of key (limited) resources. This could result in delays in related provider-build activities on which the project depends.
	Connected Care - Sub Group NHS Number (BCF National Condition)	• TOR and PID redrafted to accommodate better understanding of sub -group mandate, primary deliverables and BW10 governance structure • Options re. bulk and ongoing acquisition of NHS numbers clearly documented with costs and timescales • NHS number bulk acquisition: Reading - report written to extract data West Berkshire – report written to extract data - 27.5 % of active clients already have an NHS number Wokingham - data has been forwarded to MACS for initial matching - 27.5 % of active records already have an NHS number • IGSOC Level 2 status: Wokingham have been working on the gap between PSN compliance and IGSOC level 2 compliance. Approach and timescales etc. for this work can be shared with other LAs	SRO Katie Summers Programme Manager John MacDonald Project Manager Richard Waller	• BW10CCLA programme governance documents finalised: Finalise TOR, PID and RAID Log • NHS number bulk acquisition progress review: Ascertain match rate and next steps • IGSOC level 2 status : Share Wokingham approach, timescales etc. with other LAs Progress LAs submissions for NHS Connecting for Health reviews and approvals • Benefits identification: Progress benefits identification workshops	Green	Funding to support PM only identified to March 2015 (Phase 1) completion of NHS Number
Market Management		• RBWM signed up to CP feasibility study so we now have the 3 LA's required to proceed • Recruitment of new PM successful	SRO - Stuart Rowbotham Programme Manager - Amina Begum	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 – • Local Authorities to complete data collection for CP study • Wokingham to formally commission Affinity works to undertake study Feb/Mar	Green	New Programme Manager, Amina Begum started 9th Feb 2015
Integrated Carers Commissioning		Carers Needs Assessment • Carers Health Needs Analysis for West Berkshire completed by Public Health. Carer Assessments • Tools refreshed to be Care Act compliant and road tested with carers and carer services in each locality. Governance • BW Partnership Board has approved the BW Carers Commissioning Forum as a reference and advisory group to oversee carers commissioning using Better Care Fund resources. Service development • Project lead appointed (within Healthwatch Reading) to commence delivery of 6m pilot project trialling approaches to developing carer support from a GP practice base.	SRO: Gabrielle Alford Workstream Lead: Janette Searle	Carers Needs Assessment • Wokingham and Reading elements of Carers Needs assessments to be scoped, based on West Berkshire product, to complete the Berkshire West Assessment. BW Carer Information Advice and Support contract. • Negotiations to take place with current provider regarding a possible extension to the jointly commissioned services. • Contingency plans to be developed to ensure continuity of service. • Carer and provider engagement to be planned to inform future re-commissioning.	Green	
Whole System Organisational Development		• Jill/Matt are in the process of undertaking 1-1 interviews with leaders from across the system and have attended a range of meetings to observe the partnership and individual organisations in action.	SRO's Fiona Slevin-Brown & Rachael Wardell	• Jill and Matt to share their findings and recommendations for the development of a programme of work with the Steering Group and the Chief Officers in February. •The Steering group will agree next steps with Jill and Matt at the 12th February meeting to come back to the Partnership Board in March . • Nominees to be agreed by the Steering Group to participate in the learning network to be led by the Kings Fund which is open to participants of the programme	Green	Initial findings to be feedback verbally at the Partnership Board on the 19th February
Integrated Workforce Development		• Dates for Workforce Programme meeting agreed for the year • Agreed next steps with Skills for Health following their report on the current BW10 health and social care workforce. This includes: Scoping a role redesign proposal to support the development of the Generic Support Worker. • Agreed framework for recording and reporting expenditure of HETV funds allocated to workforce programme • Scoping of BW10 programmes with programme leads to assess workforce development implications has started	SRO Brigid Day Programme Manager - Derek Williams	• Prepare summary report of Skills for Care workforce profile highlighting key issues for consideration in the development of the workforce strategy • Agree feedback report to HEETV (meeting 25/2/15) • Continue scoping of BW10 programmes with programme leads to assess workforce development implications • Develop outline project plan for development of Generic Support Worker • Attend HETV Integration workforce learning event 25 February	Green	
7 Day Working including BCF National Condition		• DG, locality programme managers working to develop current blueprint of 7 Day services and functions • 7 Day Clinical Standards included as part of Provider Service Development Improvement Plans • 7 Day Working Sub Group which will utilise the toolkit developed by NHS Improving quality to develop a comprehensive picture across the system, to be established	SRO Gerry Crawford PM TBC	• Sub group to undertake a number of focussed workshops once the current blueprints have been completed by the locality programme managers and the self assessment update from • RBH on how Trust will achieve at least 5 of the 10 clinical standards.	Amber	7 Day working subgroup / Workshops
Integration Programme Delivery Group & Finance Sub Group		• Appointed Market Management Programme Manager, started 9 Feb • First draft of Section 75 and Schedule 1 templates completed, paper developed for Partnership Board on the management of pooled budgets • DG meeting to explore programme wide dependencies and synergies across BCF schemes • Development of Dashboard to report on BCF metrics under development • Attendance at the first King Funds Integrated care Learning Network • Meeting with Locality Care Act programme managers to understand dependencies and links to FEP. Also discussed arrangements for maintaing links into the BW10 Integration Programme post 1st April	Naseema Khan	• Further work with Locality Programme Managers to develop/ review PIDS/ Milestone plans/ Dependencies, Risks etc. • Further development of Blueprints for 7 Day working and FEP expected in next period • Interviews scheduled for Comms Manager Wed 18 Feb • Further development of Section 75 Agreement and programme and scheme Schedule 1's • Field representatives to participate in BCF Implementation Support events, linking in with CCG Ops Directors	Amber	BW10 IP Risk 11 & 05 11Capacity /Engagement

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Title of Report:	**Delivery Plan for the Health and Wellbeing Strategy**
Report to be considered by:	The Health and Wellbeing Board
Date of Meeting:	26th March 2015

Purpose of Report: **To give an update on the arrangements being put in place to coordinate the action plan for the Health and Wellbeing Strategy.**

Recommended Action: **That the Board approve the plans and support the actions ging forward**

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
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Contact Officer Details	
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Executive Report

1. Introduction

1.1 Following the consultation on the Health and Wellbeing Strategy in Oct/Nov 2014 it was agreed by the Health and Wellbeing Board that delivery plans should be developed to support the priorities contained within the strategy. It was also acknowledged that where possible, existing strategic/steering groups could focus their work on demonstrating how the priorities will be addressed. For areas where no group exists, relevant individuals will be asked to come together to develop suitable delivery plans.

1.2 The following proposals are made re the development of delivery plans:

- **Emotional wellbeing of children, health and educational wellbeing of looked after children and educational achievement of children on free school meals.** It is proposed that the action plans for these three priorities, relating to the health and wellbeing of children and young people, are developed by a single group, linking in to other relevant groups such as the Local Children's Safeguarding Board. Possible members of this task and finish group are representatives from Childrens Services, WBC, Children's Commissioning Lead from Commissioning Support Unit, Children and Young peoples lead in Public Health and Wellbeing, Looked After Childrens lead, Children's mental health lead in BHFT, Education services, the community/voluntary sector and WBC**.**

- **Mental Health and Wellbeing in adults** There is an existing group that will be asked to develop the delivery plan for this priority – **The Mental Health Strategy Group.**

- **Health damaging behaviours, healthy weight and physical activity, cardiovascular disease and cancer.** It is proposed that a new group is set up to develop the delivery plans for these three priorities. Possible members of this group are Head of Public Health and Wellbeing, WBC, relevant Public Health and wellbeing leads for smoking, alcohol, physical activity and obesity, representative of Leisure Services, WBC, Operations Director, community/voluntary sector representative and Newbury and District CCG.

- **Carers** There is an existing group that will be asked to develop the delivery plan for this priority – **The Carers Strategy Group**.

- **Long Term Conditions and Falls Prevention** There is considerable work going on in these areas, both on a Berkshire wide and Berkshire West wide basis. There is a Long Term Conditions Programme Board for the Berkshire West Federation and also an End of Life Care group.
  The work of these groups will inform our local delivery plans. The task and finish group who will be asked to lead this work will include representatives from Adult Social Care, WBC, Public Health and Wellbeing, WBC, Enablement Care, WBC and The CCGs. Additional help could be sought from voluntary sector groups.

- **Dementia** It is proposed that a new group be established to develop the delivery plan for this priority. This work will be informed by the work of the Dementia Action Alliance and the Berkshire West Dementia Stakeholders Group. Possible members of this group include the Berkshire West Federation LTC lead, Newbury and

District GP clinical lead, Public Health and Wellbeing dementia lead, Team Manager of the dementia team, WBC, The Beechcroft Team, a dementia carer and the Alzheimer's Society.

1.3 All delivery plans will be published on the website and the public will be able to comment as they feel appropriate.

1.4 A template for the delivery plan will be used by each of the groups and the delivery plans will need to link into the performance monitoring framework.

1.5 A deadline for completion of the delivery plans for year 1 of the Health and Wellbeing Strategy will be decided by the Board.

2. Equalities

2.1 The Health and Wellbeing Strategy priorities were consulted on with the public in October and November 2015. One of the overarching strategy aims is to decrease the gap in healthy life expectancy between the least well off in our district and the most affluent. In addition the strategy targets looked after children, children on free school meals, adults and children with mental health problems, those who are lonely and isolated, carers including young carers, people with long term conditions and disabilities and those with dementia. Thus the Health and Wellbeing priorities will help to decrease inequalities in health for many disadvantaged groups.

Appendices

There are no appendices to this report.

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Title of Report:	**Hot Focus Session Report**
Report to be considered by:	The Health and Wellbeing Board
Date of Meeting:	26/03/2015

Purpose of Report: **To propose an outline of the first Hot Focus Session: Mental health and wellbeing in adults**

Recommended Action: **That the Health and Wellbeing Board agree the agenda for the first Hot Focus Session**

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:	Lesley Wyman
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Executive Report

1. Introduction

At the November 2014 Health and Wellbeing Board it was agreed that during 2015/16 the Health and Wellbeing Board would focus on three of the 11 priorities in more detail and these proposed priorities would be known as 'hot focuses'. The following priorities were agreed:,

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 plan will be to have a three month period where each Hot Focus will be explored, giving an opportunity to bring relevant partners together to have an input, investigate successes and highlight areas where further joint working could take place to achieve against each priority. For each Hot Focus, two key individuals will be nominated to feed ideas and possible solutions that are suggested at the Hot Focus Session into the relevant Delivery Group. It may be that the same individuals are involved in both the session and the delivery plan development.

Feedback will be given to the Health and Wellbeing Board at the end of a three month period.

Initially the first Hot Focus was to have been Looked After Children, however given a change of staffing within WBC Childrens services this has now been changed to promoting mental health and wellbeing in adults.

Each of the Hot Focus sessions will be based on using a continuum approach:

- Prevention and promoting positive mental health and wellbeing
- Early diagnosis and intervention
- Treatment
- Rehabilitation

The proposed agenda is attached as Appendix A

2. Equalities

2.1 The Health and Wellbeing Strategy priorities were consulted on with the public in October and November 2015. One of the overarching strategy aims is to decrease the gap in healthy life expectancy between the least well off in our district and the most affluent. In addition the strategy targets looked after children, children on free school meals, adults and children with mental health problems, those who are lonely and isolated, carers including young carers, people with long term conditions and disabilities and those with dementia. Thus the Health and Wellbeing priorities will help to decrease inequalities in health for many disadvantaged groups.

Appendices

Appendix A – Proposed agenda for Hot Focus 1 – mental health and wellbeing in adults.

Consultees

Local Stakeholders:

Officers Consulted: Rachel Johnson, Senior Public Health Programme Officer

Other:

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Proposed Agenda for the Hot Focus Session 1

We will promote mental health and wellbeing in adults through prevention, early identification and provision of appropriate services.

April 23rd, 9.00am – 12.00pm

Setting the scene for West Berkshire	TBC	15m
Prevention and promoting positive mental health	Rachel Johnson	10m
Mental Health Forum	MHF Chair	10m
Showcasing services within West Berkshire		35m

- Pulling Together
- Friends in Need
- Eight Bells
- Sport in Mind
- CAB
- Talking Therapies
- Berkshire Healthcare Foundation Trust – role of the CPN
- Berkshire Healthcare Foundation Trust – MH triage
- Adult Social Care Representative

Comfort break / Networking	20m

- Dual Diagnosis Nurse — 30m
- Sovereign Housing
- Homestart – Post Natal Depression
- Samaritans
- Mental Health Advocacy Service
- Fountain Gardens
- Counseling in GP practices

Each service will be given 4 minutes to share what the service offers, who it is aimed at, what it is proud of and what are its challenges.

Berkshire Mental Health User Group Chair	15m
Mental Health Strategy Group Chair	15m
Questions/discussion of key points raised	30m

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Title of Report:	**Health and Wellbeing Conference**
Report to be considered by:	Health and Wellbeing Officers Group
Date of Meeting:	
Forward Plan Ref:	

Purpose of Report:

To propose that the Council holds a conference in November of this year which will bring together key partners in order to consider how the wider determinants of health can add value to the overall health and wellbeing strategy..

Recommended Action:

That further work be developed on the detail of the conference and another report be presented to the Board in due course.

Reason for decision to be taken: To ensure that the delivery plans for priorities within the Health and Wellbeing Strategy include input from wider stakeholders reflecting the importance of addressing the wider determinants of health.

Other options considered: N/A

Key background documentation:

Published Works:

The proposals contained in this report will help to achieve the following Council Strategy priority:

X CSP1 – Caring for and protecting the vulnerable

The proposals will also help achieve the following Council Strategy principle(s):

X CSP5 - Putting people first
X CSP7 - Empowering people and communities

Portfolio Member Details	
Name & Telephone No.:	Councillor Marcus Franks
E-mail Address:	mfranks@westberks.gov.uk
Date Portfolio Member agreed report:	

Contact Officer Details	
Name:	Andy Day
Job Title:	Head of Strategic Support
Tel. No.:	01635 519459
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Implications

Policy:	N/A
Financial:	There will be costs associated with holding a conference in relation to the hiring of an appropriate venue and any refreshements that are provided. These will be reported in a subsequent report.
Personnel:	N/A
Legal/Procurement:	N/A
Property:	N/A
Risk Management:	
Corporate Board's Recommendation:	

Is this item subject to call-in?	Yes: ☐	No: X

If not subject to call-in please put a cross in the appropriate box:

The item is due to be referred to Council for final approval	☐
Delays in implementation could have serious financial implications for the Council	☐
Delays in implementation could compromise the Council's position	☐
Considered or reviewed by Overview and Scrutiny Management Commission or associated Task Groups within preceding six months	☐
Item is Urgent Key Decision	☐
Report is to note only	☐

Executive Summary and Report

1. Introduction

1.1 The Health and Social Care Act 2012 introduced Health and Wellbeing Boards and the requirement to publish a Health and Wellbeing Strategy. Up until that point the overarching strategic document for the district would have been the Sustainable Community Strategy (SCS).

1.2 The Local Strategic Partnership (which was known as the West Berkshire Partnership) was established in 2002. LSPs were created as part of the Local Government Act 2000 with the remit of placing a duty on local authorities to prepare a Sustainable Community Strategy for their area, in partnership with other stakeholders, and to create a long term vision to improve the quality of life and services in an area.

1.3 The first Sustainable Community Strategy for West Berkshire was published in 2002. The SCS still remains relevant to West Berkshire in terms of key issues and strategic priorities. However, there is now duplication between the new Health and Wellbeing Strategy (H&WBS) and it was agreed that the two documents should be combined to avoid any confusion and duplication.

1.4 As a result of this decision it was agreed to dissolve the LSP but to retain the Skills and Enterprise Partnership and the Safer Communities Partnership. Both of these partnerships were deemed to be adding value to the "wellbeing" aspects of the Health and Wellbeing Strategy.

1.5 The recent refresh of the Health and Wellbeing Strategy was undertaken in the main by Public Health and Wellbeing, working through the Health and Wellbeing Board. The Board approved the Strategy at the January 2015 meeting, following a public consultation exercise and was adopted by West Berkshire Council on 3 March 2015.

1.6 It was also agreed that priorities around some of the wider determinants of health should include input from a wider range of stakeholders and an annual conference was suggested.

2.0 Proposed Conference

2.1 It is proposed that the Council holds a conference in November of this year. The venue will have to be confirmed but Shaw House presents one possible option to consider.

2.2 Stakeholders to be invited to the conference could include:

Health and Wellbeing Board Members
Representatives from the CCG's
Representatives from Public Health England (Local and Regional)
Representatives from the voluntary and community sector (EWB to co-ordinate)
Representatives from the private sector
Members and officers of the Council
Chair and members of the Safer Communities Partnership (TVP, Probation etc)
Chair and members of the Skills and Enterprise Partnership (EBP, Chamber of Commerce etc) and former members of the LSP.

2.3 The Conference will then focus on a range of wider determinants such as skills and enterprise, housing, community safety and community development etc. It is hoped that this wider discussion will help align the wider determinants of health (formerly articulated in the Sustainable Communities Strategy) more closely with the overall delivery of the Health and Wellbeing Strategy.

2.4 The purpose of the Conference is fundamentally about engaging with a wider range of partners, the community sector and others to help with the delivery of the strategic priorities. The debate will need to focus on what are the *main barriers and challenges* to achieving better outcomes around the wider determinants for residents and directly asking those present to think about possible solutions.

2.5 The benefits of including a broader representation of partners at the Conference such as Sovereign Housing Association, the Royal Berkshire Fire and Rescue Service, Berkshire Youth, Empowering West Berkshire etc, will mean they can each describe their own organisations work and priorities and help find the potential for joint initiatives.

2.6 It is proposed that workshops be held to cover off debates on the wider determinants of health. This will help the HWBB to better understand what initiatives are already in place and how these might contribute to some of the priorities in the Health and Wellbeing Strategy. As part of these workshops the following questions could be asked:

(i) What is the scale of the problem (Priority)?

(ii) Are there specific communities affected?

(iii) What services are available and how much is being spent?

(iv) Who else can help to resolve the problem?

(v) How can communities help themselves?

2.7 This report merely proposes a format for the conference. The detailed planning will need more work and significant input from colleagues in both the Public Health and Wellbeing and Strategic Support Units.

Appendices

There are no Appendices to this report.

Consultees

Local Stakeholders: N/A

Officers Consulted: Jo Naylor, Lesley Wyman, HWB Management Group

Trade Union: N/A

Title of Report:	**West Berkshire Joint Health and Social Care Learning Disabilities Self-Assessment 2014**
Report to be considered by:	Health and Wellbeing Board
Date of Meeting:	26th March 2015
Forward Plan Ref:	N/a

Purpose of Report:

To inform the Health and Wellbeing Board about the Joint Health and Social Care Learning Disabilities Self-Assessment for West Berkshire

Recommended Action:

Reason for decision to be taken: N/A

Other options considered: None

Key background documentation: None

Contact Officer Details	
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Job Title:	Head of Adult Social Care
Tel. No.:	01635 519736
E-mail Address:	tforster@westberks.gov.uk

1. Context

1.1 The Learning Disability Health Self-Assessment began being used in England in 2007/8. It became an important guide for the NHS and Local Authorities helping them to recognise the overall needs, experience and wishes of young people and adults with learning disabilities and their carers. It has made it easier to bring these perspectives into the tasks of determining local commissioning priorities and monitoring services.

1.2 The Framework has helped to improve services for young people with learning disability in many parts of the country by raising awareness of their health needs, driving increased health and local authority resources and improving interagency co-ordination. However, the events at Winterbourne View and subsequent investigations have demonstrated there was more to be done. As a result of this, the signatories to Transforming Care and The Concordat agreed to implement a joint health and social care self-assessment framework

2. Change in approach

2.1 The Joint Health and Social Care Learning Disability Self-Assessment (JHSCSAF) been developed collaboratively by learning disability specialists from the former Strategic Health Authority offices and the Association of Directors of Adult Social Services (ADASS), NHS England and members of the Winterbourne View Joint Improvement Programme Board.

2.2 It is intended to support all commissioners (Local Authorities, Clinical Commissioning Groups and NHS England) to have a shared perspective of the services available across the full spectrum of health and social care in local areas in every part of the country.

3. Joint Health and Social Care Learning Disabilities Self-Assessment 2014

3.1 The framework for 2014 covered three domains:

(i) Staying Healthy

(ii) Keeping Safe

(iii) Living Well

3.2 Localities were asked to RAG rate their performance against a set of pre-defined expectations of what should be in place. It also sought information against a further 5 areas including; demographics, cancer screening, wider health, mortality and general health services.

3.3 The completed self-assessment is attached at Appendix A for review. The assessment highlights that there is still work to be completed with the overall response showing Amber.

3.4 One area has been rated as red under ‘Living Well’, therefore requiring significant improvement; this is supporting people with learning disability into employment. We don’t have a specific service; this gap had already been recognised and has been addressed as part of the new Voluntary Sector Prospectus. It is anticipated that we will be able to evidence improvement next year.

3.5 Two areas were rated as green under 'Staying Healthy'; annual health checks generated which are at over 70% and a designated learning disability liaison function in place in an acute setting.

3.6 All elements of 'Keeping Safe' have been assessed as amber. Areas covered within this domain include reviews and safeguarding.

4. Next Steps

4.1 The feedback will be developed into a joint action plan to address deficits over the coming year.

Appendices

Appendix A – West Berkshire Joint Health and Social Care Self-Assessment 2014

Consultees

Local Stakeholders:

Officers Consulted: Alison Love

Trade Union: Not applicable

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Return to contents

Details

Name of person completing return (for correspondence if necessary)

Alison Love on behalf of Tandra Forster Head of Adult Social Care

Email address of person completing return

As I will be leaving West Berkshire Council can you please send any further corresponence to Tandra Forster tforster@westberks.gov.uk

Local Authority to which the return relates (from dropdown list)

West Berkshire

Staying Healthy

GP registers

The Learning Disabilities Quality and Outcomes Framework register in primary care.

LD registers reflect prevalence data AND data stratified in every required data set (e.g. age / complexity / Autism diagnosis / black and minority ethnicities etc.).

LD registers reflect prevalence data but are not stratified in every required data set (e.g. age / complexity).

The numbers of people on LD registers reflect the requirements outlined in QOF.

If you have provided supporting evidence on your website, enter the URL here

If you want to add further notes about this rating do so here: (max 1000 characters)

489 people with a learning disbility are on the Learning Disability QOF Register. The register contains information related to age, ethnicity and autism.

Long Term Health Conditions

Finding and Managing Long Term Health Conditions: obesity, diabetes, cardiovascular disease, epilepsy.

We compare treatment and outcomes for all four conditions between people with learning disabilities and others in: the area and at local GP level.

We compare treatment and outcomes for some of the conditions between people with learning disabilities and the general population in the area.

No comparative data available.

If you have provided supporting evidence on your website, enter the URL here

If you want to add further notes about this rating do so here: (max 1000 characters)

CCG uses the information to identify people that are eligible and track those that have been screened.

Annual health checks
This RAG question is based on coverage numbers and will be completed by the Learning Disabilities Observatory

If you have provided evidence about this programme locally on your website, enter the URL here

If you want to add further notes about the likely rating do so here: (max 1000 characters)

275 people had an Annual Health Check

Health Action Plans
Health Action Plans are generated at the time of Annual Health Checks (AHC) in primary care.
70% or more than of Annual Health Checks generate specific health improvement targets (Health Action Plan).
50% - 69% of Annual Health Checks generate specific health improvement targets (Health Action Plan).
Fewer than 50% of Annual Health Checks generate specific health improvement targets (Health Action Plan).

If you have provided supporting evidence on your website, enter the URL here

If you want to add further notes about this rating do so here: (max 1000 characters)

Nearly all people have had an Annual Health check. The CCG operates a Direct Enhanced Service.

Cancer Screening
This RAG question is based on coverage numbers and will be completed by the Learning Disabilities Observatory

If you have provided evidence about this programme locally on your website, enter the URL here

If you want to add further notes about the likely rating do so here: (max 1000 characters)

Primary / Secondary care communication
Primary care communication of LD status to other healthcare providers

Secondary care and other healthcare providers can evidence that they have a system for identifying LD status on referrals based upon the LD identification in primary care and acting on any reasonable adjustments suggested. There is evidence that both an individual's capacity and consent are inherent to the system employed.

There is evidence of a local area team/clinical commissioning group wide system for ensuring LD status and suggested reasonable adjustments if required, are included in referrals. There is evidence that both an individual's capacity and consent are inherent to the system employed.

There is no local area team/clinical commissioning group wide system for ensuring LD status and suggested reasonable adjustments are included in the referrals.

If you have provided supporting evidence on your website, enter the URL here

If you want to add further notes about this rating do so here: (max 1000 characters)

Information related to the person's disability is communicated to other health providers to make reasonable adjustments. The Royal berkshire Hospital confirmed that a LD Liason Manager supports people through outpatient, in-patient and emergency services.

Acute LD liaison function

Learning disability liaison function or equivalent process in acute settings

Designated learning disability function in place or equivalent process, aligned with known learning disability activity data in the provider sites and there is broader assurance through executive board leadership and formal reporting /

Designated learning disability liaison function or equivalent process in place and details of the provider sites covered has been submitted. Providers are not yet using known activity data to effectively employ LD liaison function against

No designated learning disability liaison function or equivalent process in place in one or more acute provider trusts per

If you have provided supporting evidence on your website, enter the URL here

If you want to add further notes about this rating do so here: (max 1000 characters)

Learning Disability Manager in place at the Royal Berkshire Hospital

Reasonable Adjustments in primary care

Considering NHS commissioned primary care services - dentistry, optometry, community pharmacy and podiatry.

All people with learning disability accessing/using service are known and patient experience is captured. All of these services are able to provide evidence of reasonable adjustments and plans for service improvement.

Some of these services are able to provide evidence of reasonable adjustments and plans for service improvements.

People with learning disability accessing/using these services are not flagged or identified. There are no examples of reasonable adjusted care.

If you have provided supporting evidence on your website, enter the URL here

If you want to add further notes about this rating do so here: (max 1000 characters)

People with learning disabilities report reasonable adjustments are in place in some of these services. Dental services make reasonable adjustments. Optometry and pharmacy are less certain.

Offender Health and the Criminal Justice System

Local Commissioners have and act on data about the numbers and prevalence of people with a learning disability in the criminal justice system.

· Local commissioners have a working relationship with regional, specialist prison health commissioners AND

· There is good information about the health needs of people with LD in local prisons and wider criminal justice system and a clear plan about how such needs are to be met AND

· Prisoners and young offenders with LD have had an annual health check which generates a health action plan, or are scheduled to have one in the coming 6 months AND

· Evidence of 100% of all care packages including personal budgets reviewed at least annually.

In the absence of the above (or elements of the above) An assessment process has been agreed to identify people with LD in all offender health services e.g. learning disability screening questionnaire. Offender health teams receive LD awareness training to know how best to support individuals to meet their health needs AND There is easy read accessible information provided by the criminal justice system.

There is no systematic collection of data about the numbers of people with LD in the criminal justice system. There is no systematic learning disability awareness training for staff within the criminal justice system. The local offender health team does not yet have informed representation of the views and needs of people with learning disability.

If you have provided supporting evidence on your website, enter the URL here

If you want to add further notes about this rating do so here: (max 1000 characters)

There is no local prison therefore no local offender health team. However the local Learning Disability Trust and the CTPLD teams do keep data on the number of people in prison and do work with prison staff to ensure that their needs are being met.

Keeping Safe

Individual health and social care package reviews

Commissioners know that all funded individual health and social care packages for people with learning disability, across all life stages, are reviewed regularly.

Evidence of 100% of all care packages including personal budgets reviewed within the 12 months covered by this self

Evidence of at least 90% of all care packages including personal budgets reviewed within the 12 months covered by this self assessment.

Less than 90% of all care packages including personal budgets reviewed within the 12 months covered by this self

If you have provided supporting evidence on your website, enter the URL here

If you want to add further notes about this rating do so here: (max 1000 characters)

Local Authority LD services did complete 100% of their reviews last year. The local authority employed additional staff to do this. However not all CHC and Section 117 reviews were completed.

Learning disability services contract compliance

Contract compliance assurance for services primarily commissioned for people with a learning disability and their

Evidence of 100% of health and social care commissioned services for people with learning disability: 1) have had full scheduled annual contract reviews; 2) demonstrate a diverse range of indicators and outcomes supporting quality assurance and including un announced visits . Evidence that the number regularly reviewed is reported at executive

Evidence of at least 90% of health and social care commissioned services for people with learning disability: 1) have had full scheduled annual contract reviews; 2) demonstrate a diverse range of indicators and outcomes supporting quality assurance. Evidence that the number regularly reviewed is reported at executive board level in both health & social care.

Less than 90% of health and social care commissioned services for people with learning disability: 1) have had full scheduled annual contract reviews; 2) demonstrate a diverse range of indicators and outcomes supporting quality

If you have provided supporting evidence on your website, enter the URL here

If you want to add further notes about this rating do so here: (max 1000 characters)

Berkshire Healthcare Trust is compliant with contract and the CCG receives monthly updates. The CCG does not make unannounced visits. West berkshire Council is also compliant with all contracts receiving an annual contract review.

Monitor Assurances

Assurances given regularly in Monitor Risk Assessment Framework for Foundation Trusts

Commissioners review Monitor returns and review actual evidence used by Foundation Trusts in agreeing ratings. Evidence that commissioners are aware of and working with non-Foundation Trusts in their progress towards Monitor

Commissioners review Monitor returns of Foundation Trust providers. Evidence that commissioners are aware of and working with non-Foundation Trusts in their progress towards Monitor compliance.

Commissioners do not assure themselves of the on-going compliance, via Monitor returns, for each Foundation Trust - OR - for non-Foundation Trusts, commissioners are not aware of the Trust's position in working towards Monitor standards and Foundation Trust status.

If you have provided supporting evidence on your website, enter the URL here

If you want to add further notes about this rating do so here: (max 1000 characters)

Adult Safeguarding

Assurance of safeguarding for people with a learning disability.

Evidence of robust, transparent and sustainable governance arrangements in place. in all statutory organisations including Local Safeguarding Adults Board(s), Health & Well-Being Boards and Clinical Commissioning Executive Boards. The provider can demonstrate that delivery of Safeguarding Adults within the current Statutory Accountability and Assurance Framework includes people with learning disabilities. This assurance is gained using DH Safeguarding Adults Assurance (SAAF) framework or equivalent. Every learning disability provider service has assured their board and others that quality, safety and safeguarding for people with learning disabilities is a clinical and strategic priority within all services. Key lessons from national reviews are included. There is evidence of active provider forum work addressing the

Regular Board reporting and key points and lessons learned are included in action plans. Evidence that Learning Disability Partnership Board(s) and/or health sub group(s) are involved in reviewing progress. The provider can demonstrate that delivery of Safeguarding Adults within the current Statutory Accountability and Assurance Framework includes people with learning disabilities. This assurance is gained using DH Safeguarding Adults Assurance (SAAF) framework or equivalent. Every learning disability provider service has assured their board that quality, safety and safeguarding for people with learning disabilities is a clinical and strategic priority within all services.

No Board assurance and learning points not identified. Action plan(s) either not in place, or not yet discussed with

If you have provided supporting evidence on your website, enter the URL here

If you want to add further notes about this rating do so here: (max 1000 characters)

Safeguarding has been embedded across partnerships, Boards and providers locally and there are a number of mechanisms set up to quality assure training etc. Through the Safeguarding Adults Partnership Board for Berkshire West.

Involvement of Self-Advocates and Carers in training and recruitment

In Learning Disability specific services there is evidence of all of services involving people with learning disabilities and families in recruitment and training.

Commissioners of universal services can provide evidence of contracting for Learning Disability awareness training (for example as part of Disability Equality Training).

In Learning Disability specific services there is evidence of some services involving people with learning disabilities and families in recruitment and training.

Commissioners of universal services can provide evidence of contracting for Learning Disability awareness training (for example as part of Disability Equality Training).

No evidence of involvement in recruitment and training and appropriate levels of disability equality training.

If you have provided supporting evidence on your website, enter the URL here

If you want to add further notes about this rating do so here: (max 1000 characters)

In most Learning Disability services there is evidence of service users and their families being involved in recruitment and some training. Learning Disability awareness training is provided by both the Local Authority and the Healthcare Trust and all staff and providers of ajny service can access this.

Compassion, dignity and respect

This item is answered by family carers and self advocates. Family carers and people with a learning disability agree that providers treat people with compassion, dignity and respect.

Family carers and people with a learning disability agree that all providers do.

Family carers and people with a learning disability agree that some providers do.

Family carers and people with a learning disability agree that few or no providers do.

If you have provided supporting evidence on your website, enter the URL here

If you want to add further notes about this rating do so here: (max 1000 characters)

The people with learning disability we spoke were very positive about being treated with compassion, respect and dignity by service users. Carers were critical of how some providers treated the people they provide a service to.

Commissioning strategy Impact Assessments

Commissioning strategies for support, care and housing are the subject of Impact Assessments and are clear about how they will address the needs and support requirements of people with learning disabilities

Up to date commissioning strategies and Impact Assessments are in place.

Up to date commissioning strategies and Impact Assessments are in place.

Not all commissioning strategies and Impact Assessments are in place.

If you have provided supporting evidence on your website, enter the URL here

If you want to add further notes about this rating do so here: (max 1000 characters)

Impact Assessments are not in place for Commissioning strategies in the local authority but are for the CCG.

Complaints lead to changes

Commissioners can demonstrate that all providers change practice as a result of feedback from complaints, whistleblowing experience

90 % or more of commissioned services can demonstrate improvements, based on the use of feedback from people who use services (for example complaints, surveys, quality checking),. There is evidence of effective use of a whistleblowing policy where appropriate.

50-89% of commissioned services can demonstrate improvements, based on the use of feedback from people who use services (for example complaints, surveys, quality checking),. There is evidence of effective use of a whistleblowing policy where appropriate.

Less than 50% of commissioned services can demonstrate improvements, based on the use of feedback from people who use services (for example complaints, surveys, quality checking),. There is evidence of effective use of a whistleblowing policy where appropriate

If you have provided supporting evidence on your website, enter the URL here

If you want to add further notes about this rating do so here: (max 1000 characters)

We have had several incidents of whistleblowing from both service users and staff about providers we have used this to plan improvement via our Care Quality team. We have also had several examples of service users complaining to our Learning Disability team that we have managed to resolve satisfactorily and changed our process as a result.

Mental Capacity Act and Deprivation of Liberty Safeguards

Appropriate use of the Mental Capacity Act (MCA) and Deprivation of Liberty Safeguards (DoLS).

Commissioners can evidence that all relevant providers have well understood policies in relation to the MCA and DoLS in place and routinely monitor their implementation.

Commissioners have limited evidence about the adoption and implementation of policies in relation to MCA and DoLS by relevant providers.

Commissioners cannot produce any evidence about the adoption and implementation of policies in relation to MCA and DoLS by relevant providers.

If you have provided supporting evidence on your website, enter the URL here

If you want to add further notes about this rating do so here: (max 1000 characters)

There was evidence of slowly increasing knowledge by providers of the adoption and implementaion of policies re MCA and DoLS. This has increased rapidly more recently due to the Chester West judgement.

Living Well

Effective joint working

Effective joint working across health and social care.

There are well functioning formal partnership agreements and arrangements between health and social care organisations. There is clear evidence of single point of health and social care leadership, joint commissioning strategies and or pooled budgets, integrated health and social care teams.

There are some examples of functioning formal partnership agreements and arrangements between health and social care organisations. There is clear evidence of at least on of the following:

· single point of health and social care leadership,
· joint commissioning strategy and/ or pooled budgets and,
· integrated health and social care teams.

Joint working has not met either of the above measures.

If you have provided supporting evidence on your website, enter the URL here

If you want to add further notes about this rating do so here: (max 1000 characters)

There is is a formal partnership for Winterbourne Improvement and Learning Disability joint commissioning. There is an integarted Community Team for People with Learning Disability and a commissioning strategy for people with challenging behaviour.

Local amenities and transport

Extensive and equitably distributed examples of people with learning disability having access to reasonably adjusted local transport services, changing places and safe places (or similar schemes) in public venues and evidence that such schemes are communicated effectively.

Local but not widespread examples of all of these types of schemes.

Reasonably adjusted levels of support in these schemes do not reach any of the standards above.

If you have provided supporting evidence on your website, enter the URL here

If you want to add further notes about this rating do so here: (max 1000 characters)

Rail and bus services locally have made adjustments to signage and assistance available to people with a learning disability and the Council's Transport officer attends the LDPB. However this mostly applies in urban areas. Rural areas have poor public transport and so is not readily accessible.

Arts and Culture

Extensive and equitably distributed examples of people with learning disabilities having access to reasonably adjusted facilities and services that enable them to use amenities such as cinema, music venues, theatre, festivals and that the accessibility of such events and venues are communicated effectively.

Local but not widespread examples of people with learning disabilities having access to reasonably adjusted facilities in these amenities. The accessibility of such events and venues are communicated effectively.
Reasonable adjustments of these amenities do not reach any of the standards above.

If you have provided supporting evidence on your website, enter the URL here

If you want to add further notes about this rating do so here: (max 1000 characters)

Some people we spoke to talked about attending music,drama and singing groups and one person attended a knitting group in the library. However other people were not aware of such groups.

Sport and leisure Sport and leisure

Extensive and equitably geographically distributed examples of people with learning disability having access to reasonably adjusted sports and leisure activities and venues for example use of local parks, leisure centres, swimming pools and walking groups. Designated participation facilitators with learning disability expertise are available. There isevidence that such facilities and services are communicated effectively.
Local but not widespread examples of people with learning disability having access to reasonably adjusted sports and leisure activities and venues for example use of local parks, leisure centres, swimming pools and walking groups. Designated participation facilitators with learning disability expertise are available. There is evidence that such facilities and services are communicated effectively.
Reasonable adjustments of these amenities do not reach any of the standards above.

If you have provided supporting evidence on your website, enter the URL here

If you want to add further notes about this rating do so here: (max 1000 characters)

Some people reported attending swimming and the gym and this included one person in a wheelchair who was hoisted into the pool. Other people did not use sports facilities and were not aware of what was available.

Employment
Supporting people with learning disability into and in employment

Clear published local strategy for supporting people with learning disabilities into paid employment. Relevant data is available and collected and shows the strategy is achieving its aims.
Clear published strategy for supporting people with learning disabilities into paid employment but limited evidence of aims being met or outcomes achieved.
Not meeting either of the above measures.

If you have provided supporting evidence on your website, enter the URL here

If you want to add further notes about this rating do so here: (max 1000 characters)

Due to financial constraints for the Council and the current economic situation there is no current strategy for supporting people into employment. We refer people to the local DEA and Progress to work services.

Transition to Adulthood

Preparing for Adulthood in Education, Health and Social Care

There is a monitored strategy, service pathways and multi-agency involvement across education, health and social care.
There is evidence of clear preparing for adulthood services or functions that have joint health & social care scrutiny and ownership across children and adult services.
There is some evidence of clear preparing for adulthood services or functions that have joint education, health & social care scrutiny and ownership across children and adult services..
There is no evidence of clear preparing for adulthood services or functions that include joint education, health & social care scrutiny and ownership across children and adult services.

If you have provided supporting evidence on your website, enter the URL here

If you want to add further notes about this rating do so here: (max 1000 characters)

There are clear protocols in place and much work has been done by social care and SEN services to improve the transition process for families. However the NHS were not fully engaged in these changes.

Involvement in service planning and decision making

People with learning disability and family carers are involved in service planning and decision making.

For the purposes of this assessment Co Production means that people with learning disabilities and family carers are actively involved in discussion and decision making about service planning and strategy.

Clear evidence of co-production in universal services and learning disability services. The commissioners use this to inform commissioning practice.

Clear evidence of co-production in all learning disability services that the commissioner uses to inform commissioning practice. Inconsistent or no evidence of co-production in universal services.

There is no evidence that people with learning disability and families have been involved in co-production of service planning and decision making.

If you have provided supporting evidence on your website, enter the URL here

If you want to add further notes about this rating do so here: (max 1000 characters)

There is evidence of local commissioners involving service users and their families in service changes, contracting processes and some universal services.

Carer satisfaction rating

This measure should be rated by family carers.

Most carers are satisfied that their needs were being met.

Most carers were neither satisfied nor dissatisfied that their needs were being met

Most carers thought that their needs were not being met.

If you have provided supporting evidence on your website, enter the URL here

Add brief notes about how this rating was undertaken: (max 1000 characters)

From discussions with carers.

A.Demographics

How many people have learning disability?

Aged 0-13

17

Aged 14-17

28

Aged 18-34

157

Aged 35-64

246

Aged 65 & over

41

Add a comment about these numbers if you wish

How many people have LD with complex or profound disability?

Aged 0-13

3

Aged 14-17

4

Aged 18-34

15

Aged 35-64

30

Aged 65 & over

10

Add a comment about these numbers if you wish

How many people have LD with autistic spectrum disorder

Aged 0-13

3

Aged 14-17

11

Aged 18-34

27

Aged 35-64

15

Aged 65 & over

2

Add a comment about these numbers if you wish

How many people have learning disability?ONLY ANSWER THIS IF YOU WERE UNABLE TO PROVIDE A FULLER AGE BREAKDOWN IN Q27 (above)

Aged 0-17

2

Aged 18 & over

5

Add a comment about these numbers if you wish

How many people have LD with complex or profound disability? ONLY ANSWER THIS IF YOU WERE UNABLE TO PROVIDE A FULLER AGE BREAKDOWN IN Q28 (above)

Aged 0-17

Aged 18 & over

Add a comment about these numbers if you wish

How many people have LD with autistic spectrum disorder?ONLY ANSWER THIS IF YOU WERE UNABLE TO PROVIDE A FULLER AGE BREAKDOWN IN Q29 (above)

Aged 0-17

Aged 18 & over

Add a comment about these numbers if you wish

How many people have learning disability: All ages ONLY ANSER THESE QUESTIONS IF YOU ARE NOT ABLE TO PROVIDE ANY AGE BREAKDOWN IN THE QUESTIONS ABOVE

How many people have learning disability: All ages

How many people have LD with complex or profound disability: All ages

How many people have LD with autistic spectrum disorder: All ages

Add a comment about these numbers if you wish

B.Cancer screening

Cervical cancer screening: In each case enter the number of women are there in the age range 25 to 64 inclusive who have not had a hysterectomy

Eligible women aged 25-64 - all whether or not they have a learning disability

37460

Eligible women aged 25-64 - all whether or not they have a learning disability -who have had a cervical screening test within the prescribed period.

23152

Eligible women with learning disability aged 25-64

147

period.

36

Add a comment about these numbers if you wish

Breast cancer screening

How many women are there in the age range 50-69 inclusive (includes women with and without learning disability)?

18370

How many eligible women are there in the age range 50-69 inclusive (includes women with and without learning disability) who have been screened in past three years?

11197

How many women are there in the age range 50-69 inclusive with learning disability?

52

How many eligible women are there in the age range 50-69 inclusive with learning disability who have been screened in past three years?

25

Add a comment about these numbers if you wish

Bowel cancer screening

How many people are there in the age range 60 to 69 inclusive (includes people with and without learning disabilities): Eligible people aged 60-69

16634

How many people are there in the age range 60 to 69 inclusive (includes people with and without learning disabilities): Eligible people aged 60-69 and screened in past two years

9286

How many people are there in the age range 60 to 69 inclusive with learning disabilities?

40

years

17

Add a comment about these numbers if you wish

C.Wider Health

General health and healthcare

BMI recorded

On the 31st March 2014 - How many people are there aged 18 and over with learning disabilities who have a record of their body mass index?

331

BMI 30 and over

On the 31st March 2014 - How many people are there aged 18 and over with learning disabilities who have a body mass index in the obese range (30 or higher)?

144

BMI less than 18.5

On the 31st March 2014 How many people are there aged 18 and over with learning disabilities who have a body mass index in the underweight range (where BMI is less than 18.5)? (Note threshold changed from SAF 2014 to align with national obesity observatory work and international standards)

1

Coronary Heart Disease

How many people with learning disabilities aged 18 and over are known to their doctor to have coronary heart disease? As per the QOF Established Cardiovascular Disease Primary Prevention Indicator Set

1

Diabetes

On the 31st March 2014 - How many people of any age with learning disabilities are known to their doctor to have diabetes (include both type I and type II diabetes here)? As per the QOF Established Diabetes Indicator Set?

31

Asthma

On the 31st March 2014 - How many people of any age with learning disabilities are known to their doctor to have asthma? As per the QOF Established Asthma Indicator

51

On the 31st March 2014 - How many people of any age with learning disabilities are known to their doctor to have dysphagia?

2

Epilepsy

On the 31st March 2014 - How many people of any age with learning disabilities are known to their doctor to have epilepsy? As per the QOF Established Epilepsy Indicator Set?

76

Add a comment about these numbers if you wish

D.Mortality

How many people with a learning disability died in the year to March 2014?

Aged 0-13

0

Aged 14-17

0

Aged 18-34

0

Aged 35-64

2

Aged 65 & over

1

Add a comment about these numbers if you wish

F.General Hospital Services

General Hospital Services

How many HOSPITAL PROVIDER SPELLS of inpatient Secondary Care were been received under any consultant specialty EXCEPT the psychiatric specialties (Specialty codes 700-715) between 1st April 2013 and 31st March 2014? Persons with LD

39

How many HOSPITAL PROVIDER SPELLS of inpatient Secondary Care were been received under any consultant specialty EXCEPT the psychiatric specialties (Specialty codes 700-715) between 1st April 2013 and 31st March 2014? All persons

27684

How many Secondary Care Outpatient ATTENDANCES were been received by people under any consultant specialty EXCEPT the psychiatric specialties (Specialty codes 700-715) between 1st April 2013 and 31st March 2014? Persons with LD

56

Outpatient attendances
How many Secondary Care Outpatient ATTENDANCES were been received by people under any consultant specialty EXCEPT the psychiatric specialties (Specialty codes 700-715) between 1st April 2013 and 31st March 2014? All persons

88409

A & E attendances
How many ATTENDANCES at Accident & Emergency between 01 April 2013 - 31 March 2014? Persons with LD

45

A & E attendances
How many ATTENDANCES at Accident & Emergency between 01 April 2013 - 31 March 2014? All persons

11811

A & E people with 3 or more attendances
How many PEOPLE have attended Accident & Emergency 01 April 2013 - 31 March 2014 more than 3 times? (only required for persons with LD) Persons with LD

Add a comment about these numbers if you wish

Figures for people with 3 or more attendances not available

Continuing Health Care and Section 117 after care

Continuing Health Care
How many people with learning disabilities are in receipt of Continuing Health Care (CHC)?

22

Section 117
How many people with learning disabilities are in receipt of care funded through an arrangement under Section 117 of the Mental Health Act?

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Title of Report:	**Report of FGM Task and Finish Group**
Report to be considered by:	The Health and Wellbeing Board
Date of Meeting:	26th March 2015

Purpose of Report:

The findings of LSCB Task & Finish Group are that FGM be a matter raised at the Health & Wellbeing Boards in order to ensure that addressing FGM is a priority for all agencies and that it is seen as a family and community issue.

Recommended Action:

Health & Wellbeing Board to take forward the recommendations of the report and to initiate a quarterly FGM delivery and safeguarding partnership meeting.

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 The LSCB set up a Task & Finish Group in 2014. The aim of the group was to scope local statutory responses to FGM and to develop recommendations for action based upon policy recommendations from the intercollegiate document Tackling FGM in the UK 2013. This will support a robust multi-agency and community approach to safeguarding children at risk of FGM across Berkshire West.

1.2 The action plan contained in the intercollegiate document was used as a starting point to review the local response to FGM. This is attached at appendix 1.

1.3 The task and finish group has established that across Berkshire West there is some awareness of FGM amongst local agencies and that some agencies are developing good practice to recognise and respond to women who have suffered FGM.

1.4 However, there is much still to be done locally. The key policy recommendations contained in the 2013 document are not fully addressed locally. A summary document is contained at appendix 1.

2. Equalities

2.1 It is known that the number of communities affected by FGM is growing and with increased migration from the countries where FGM is widely practised, more girls in the UK are at risk of undergoing FGM.

2.2 Local implementation of the recommendations in the report will actively promote the protection of girls living in Berkshire West who are identified as being at risk of FGM.

Appendices

Appendix A – FGM Report

Consultees

Local Stakeholders:

Officers Consulted:

Other:

Berkshire West LSCB Report

Report of FGM Task and Finish Group to LSCBs

In February 2014 the Designated Nurse Safeguarding for the four CCGs in Berkshire West brought to the attention of the LSCBs, an intercollegiate report published by the Royal College of Midwives (2013) entitled Tackling FGM in the UK. Multi Agency Practice Guidelines published in 2011 by HM Government, identified Reading as an area of potential high prevalence of women and girls who might have suffered, or are at risk of suffering, FGM. This is because of the diverse population of Reading.

The chair of the LSCBs requested a task and finish group be formed to review the 2013 report with reference to the three areas across Berkshire West. Members of the LSCBs were requested to identify representation on the task and finish group from their agency.

West of Berkshire Female Genital Mutilation (FGM) Task and Finish Group:

The group consisted of members from Children's Social Care Services, Thames Valley Police, Reading LSCB Business Manager, Royal Berkshire Hospital, Berkshire Healthcare Foundation Trust, Schools Safeguarding Children Lead from West Berkshire Council and Berkshire West CCGs. The group was chaired by the Designated Nurse Safeguarding and met on five occasions between May and October.

The aim of the group was to scope local statutory responses to FGM and to develop recommendations for action based upon policy recommendations from the 2013 document. This will support a robust multi-agency and community approach to safeguarding children at risk of FGM across Berkshire West.

The action plan contained in the intercollegiate document was used as a starting point to review the local response to FGM. This is attached at appendix 1.

Actions Identified by the Task and Finish Group:

Child Protection Procedures

Berkshire LSCBs Child Protection Procedures were amended in June 2014 to reflect the 2013 Intercollegiate Document. The procedures were reviewed by the task and finish group. It was the decision of the group that further clarity is required for frontline practitioners about the need to refer all female children in cultures where FGM is known to be practised to Children's Social Care Services. This must be done with respect and sensitivity to enable a professional assessment of risk to female children within that family.

Suggested amendment to Section 5 of the Berkshire LSCBs Child Protection Procedures.

If a girl or woman is a mother or a prospective mother, her child/ren or unborn child should be considered at risk of significant harm. The professional should consult with their designated child protection advisor and should make a referral to Children's Social Care services. (Adapted from London LSCB Guidance).

The addition of a flow chart to supplement the child protection procedures is also recommended to provide clarity for practitioners.

It is of note that during the course of the task and finish group two families from cultures in which FGM is known to be practiced, were referred to Children's Social Care Services, because the families contained female children who might have been at risk of FGM. The Berkshire LSCBs Child Protection Procedures were followed and the children, at that time, were not considered to be at immediate risk of FGM. However, this raised the question within the group about how professionals could be assured that at some point in the future the risk of FGM for such children would not resurface. This is because there is no process for 'monitoring' such children. The issue reminded the group that communities and all statutory agencies, especially schools and GPs, must, at every contact with families, be alert to recognise and respond to girls at risk of FGM.

Local Health Services:
The Royal Berkshire Hospital NHS Foundation Trust (RBH) has encompassed routine questioning about FGM into all pregnancy bookings. Guidelines for midwives including a referral flowchart for midwives, following identification of pregnant women who have suffered FGM, have been developed for use within midwifery services.

It is apparent that whilst FGM is recognised within RBH maternity services, there is potential to increase recognition and response throughout other departments within the hospital. In particular, key clinical environments such as Urology, Gynaecology and the Emergency Department.

A form adopted from the Bolton FGM Assessment Tool, has been developed at RBH to be used to support referrals to Children's Social Care Services. The form is currently being reviewed within RBH internal governance processes.

The RBH is not currently listed on NHS Choices as a hospital where services for women who have suffered FGM, can be accessed. This is likely to be because there is not a specific FGM clinic at RBH. This is an issue for consideration by CCGs as commissioners of local health services, and also Directors of Public Health.

Other local healthcare providers:
The group was unable to find evidence that routine enquiries about FGM are made in other healthcare settings. There are opportunities for health care professionals to make sensitive enquiries about FGM at every contact with patients. Healthcare professionals need to follow the **'one chance rule'.** This states that the attending professional may only have one chance to speak to the victim and prevent future harm.

Schools:
LSCB members did not provide representation from schools on the task and finish group. This is unfortunate because it is well documented that schools have a crucial part to play in recognising and responding to girls at risk of FGM. Peer support and education within schools will contribute to protecting and preventing girls suffering FGM. The group is unable to comment if any action is being taken in schools to identify girls at risk of FGM.

Data collection:
Since April 2014 all NHS hospitals are required to record:

- If a patient has had Female Genital Mutilation
- If there is a family history of Female Genital Mutilation
- If a Female Genital Mutilation-related procedure has been carried out on a patient.

From September 2014 all acute hospitals are required to submit this data centrally to the Department of Health on a monthly basis. This is the first stage of a wider ranging programme of work in development to improve the way in which the NHS will respond to the health needs of girls and women who have suffered FGM and actively support prevention.

It has not been possible to establish the exact numbers of women and girls living in Berkshire West who have suffered or are at risk of suffering FGM. This is because the data is not collected by any source.

The task and finish group has identified the following possible sources to enable collection of local data:

- Use of school census information
- Thames Valley Police data
- Children's service data
- Maternity data set
- Primary care read codes
- Office of National Statistics Registration System

These sources will provide data on actual incidences and allow for predicted incidence according to local demographics.

Raising awareness and preventing FGM:
Although individual organisations attempt to raise awareness of FGM there appears to be a lack of a co-ordinated and consistent approach.

The group suggests that leaflets containing information about FGM and additional resources for help and support should be developed and made available within professional and community settings. This literature should be made available in a range of languages. This will require a commitment for funding.
There is also a wealth of on line resources.

Training:
The Home Office has recently circulated free web based training. This has been advertised within individual agencies. National conferences specific to FGM are available but it is apparent that information about FGM is not currently contained in the LSCBs training programme.

It is recommended that recognition and response to FGM is included in the LSCB training programme.

Community Approach:
One member of the task and finish group met with representatives from two community groups in Reading, ACRE (Alliance for Cohesion and Racial Equality) and Utilivu Woman's Group, to learn more about their response to FGM.

Addressing FGM is seen as a priority within both of these organisations who have emerged as key partners in addressing the issue with those affected.

It has not been possible to locate representatives from affected groups or community based groups in Wokingham or West Berkshire.

Recommendations for future practice:
The group recommend emulating the 'Bristol Model' to address the issues relating to FGM. Key components of this approach include:

- The empowerment of affected communities utilising an educative approach
- Collective ownership – commitment from all key stakeholders
- A strategic overview –how does this fit in with existing violence against women and girls strategies
- Service development and commissioning of support services eg. specialist FGM clinics for women and girls who have suffered FGM can be referred or self- refer, for discussion about surgical interventions and where psychological support can be made available.
- Training and resource development – websites, guidelines, lesson plans and leaflets to support learning and campaigning

Conclusion:
The task and finish group has established that across Berkshire West there is some awareness of FGM amongst local agencies and that some agencies are developing good practice to recognise and respond to women who have suffered FGM. The Berkshire LSCBs Child Protection Procedures support practitioners in referring girls at risk of FGM to Children's Social Care Services who then inform Thames Valley Police.

However, there is much still to be done locally. The key policy recommendations contained in the 2013 document are not fully addressed locally. A summary document is contained at appendix 1.

A co-ordinated strategic direction is required to progress local developments that will ensure girls living in Berkshire West who might be at risk of FGM are identified and protected. Most successful models of addressing FGM currently existing within the UK are based upon the recognition that tackling FGM warrants a co-ordinated approach, from statutory and voluntary organisations as well as representatives from community groups of those affected. Without such co-ordinated strategic direction it will be difficult to progress key policy recommendations locally.

Recommendations (from the task and finish group) to the LSCBs:
The group suggests that the local response to FGM should be a matter raised at the Health & Wellbeing Boards in order to ensure that addressing FGM is a priority for all agencies. Thereafter, in each of the three areas of Berkshire West quarterly FGM delivery and safeguarding partnership meetings are initiated to include developing policy and practice, awareness- raising, intelligence gathering and sharing and data monitoring. This will require commitment from Directorates of Public Health. It is essential that affected communities are represented from the start.

This will inform commissioning of local services for women and girls who have suffered, or might be at risk of suffering FGM.

Amendments are made to section 5 of the Berkshire LSCBs Child Protection Procedures.

Training courses to raise awareness about FGM is made available through the LSCBs training group

Sources of funding are explored to progress the development of literature explaining about the consequences of FGM. Such literature needs to be available in a variety of relevant languages.

References:

RCM, RCN, RCOG, Equality Now, UNITE (2013) Tackling FGM in the UK: Intercollegiate Recommendations for Identifying, Recording and Reporting. London: Royal College of Midwives. (Available at www.rcm.org.uk)

HM Government (2011) Multi-Agency Practice Guidelines: Female Genital Mutilation. (Available at www.gov.uk)

Berkshire Local Safeguarding Children Boards Child Protection Procedures. (Available at http://berks.proceduresonline.com/index.htm)

Appendix 1 Key Policies Recommendations (contained in Tackling FGM in the UK 2013)

Target Audience	Policy Recommendations/Rationale	Expectations of Action to carry out recommendation	Berkshire West Progress
All Agencies	**Treat FGM as Child Abuse** and integrate it into to all safeguarding procedures across the 4 countries of the UK (England, Northern Ireland, Scotland and Wales) outlined in Working Together to Safeguard Children (2013) (England), Co-operating to Safeguard Children (2010) (Northern Ireland), Child Protection in Scotland (2010) (Scotland) and All Wales Child Protection procedures (2008)	• NICE should revise their guidance on 'When to suspect Child Maltreatment' (Clinical Guidance CG89) to include FGM. • Girls born to mothers who have had FGM should be considered at risk of significant harm. They require monitoring through the child protection system until they are at an age when they can speak about FGM and are able to seek protection for themselves. • Lead Social Work agencies should urgently work to revise and clarify referral thresholds when risk of FGM is a concern or suspicion, including conducting assessments and monitoring of the child at risk. Referral pathways must be developed so that all health and social care agencies are aware of their respective roles and responsibilities.	Berkshire LSCBs Child Protection Procedures updated July 2014. Suggested amendment to be made to Policy and Procedure Group. When agreed, accompanying flow chart to be incorporated. Need to develop generic risk assessment tool. RBH have developed one for use in maternity services.
NHS	**Document and collect information on FGM and its associated complications in a consistent and rigorous way:** Good documentation is important for planning and commissioning services on FGM, providing quality care for girls and women affected, for research and for monitoring trends of FGM in the UK.	• The Health and Social Care Information centre should develop specifications to code FGM in hospital episode statistics and in maternity and child health datasets. • Every woman from practicing community who books for maternity care should be asked in a sensitive manner about FGM and the discussion recorded in paper based and electronic records, to include action taken or referral to the appropriate professional. • All new patient registrations in primary and secondary care, including A&E of young girls/women, should include detailed enquiry about country of origin. If the family is from FGM practicing community, document any presence of FGM to establish a baseline for monitoring and sharing information with relevant agencies.	Since September 2014 RBH submit monthly returns re FGM to DH. Routine questioning about FGM at all antenatal bookings. Guidelines and referral flowchart for pregnant women developed and implemented for midwives to use at RBH.

		• This information should be captured at all pregnancy bookings • The Royal College of Paediatrics and Child Health (RCPCH) should update the specifications for the 'Personal Child Health Record' (the Red Book) to include a code for the mother having FGM. This should include FGM in the electronic 'Red Book' (Personal Child Health Record) • Health practitioners in maternity services should ensure FGM is coded in electronic records and information shared with child health teams. • Adequate language translation services are required in areas of high prevalence.	Midwives record risk of FGM in maternity discharge records that are sent to GPs and Health Visitors. RBH staff have access to interpreter services via Prestige Network. Information Sharing processes re FGM requires further exploration and development. PCHR is not currently used to document risk of FGM.
Health, Social Care, education and the Police	**Share information on FGM systematically:** There is a need to develop information sharing protocols between health, the police and other relevant agencies such as social care and education.	• The NHS should develop protocols for sharing information about girls at risk – or girls who have already undergone FGM with other health and social care agencies, the Department for Education and the police. • These protocols should be based on national guidance and should regularly be reviewed for their effectiveness by public health directors and GP commissioners.	Information sharing processes re FGM requires further exploration and development.
Healthcare Professionals	**Develop the competence, knowledge and awareness of frontline health professionals to ensure prevention and girls' protection of girls at risk of FGM:** Ensure that health professional know how to provide quality care for girls who suffer complications of FGM.	• Health and Social Care staff must work to the WHO guidelines for nurses and midwives, the UK multi-agency practice guidelines and CPS legal guidance. www.who.int/reproductivehealth/publications/fgm/en/index.html • On the opening and re-suturing of women with Type III FGM, WHO guidelines should be followed. Guidelines can be accessed from the WHO website as follows: www.who.int/reproductivehealth/publications/maternal_perinatal_health/RHR_01_03/en/index.html • Refer all women identified with FGM for support and further	FGM guidelines in place at RBH. FGM awareness incorporated in ingle agency safeguarding children training. Access to Home Office FGM e-learning course circulated to the LSCB

		medical and psychological assessment as appropriate. This must be done very sensitively. • A multi-agency and multi-professional approach should include the Medical Royal Colleges, professional organisations and trade unions for incorporating FGM into pre-registration education/undergraduate level training and continue professional development appropriate to the individuals' levels of responsibility and accountability. This should include a mix of face to face and the development of e-learning resources on FGM, which all relevant frontline professionals can access. • A lead agency should be involved in producing e-learning materials for healthcare and other practitioners. This agency should inv9olve the main health professional bodies such as the relevant medical royal colleges and health trade unions in developing training materials. • High quality information on the effects of FGM (health, psychological and rights-based) should be provided to all women identified as having FGM. • Healthcare practitioners need to consider the needs of both the future child as well as any other female children who may already be born or resident in the household with the woman. • Healthcare practitioners need to follow the 'one chance' rule. This states that the attending professional may only have one chance to speak to the victim and prevent future harm.	Training Group with the request to consider provision of multi-agency training about FGM. RBH has developed a leaflet for pregnant women. BHFT have developed a leaflet about diversity and cultural norms.
Health, Social Care, Education and the Police	**Identify girls at risk and refer them as part of the safeguarding children obligation:** Early identification of risks of FGM to girls, referral, planned and sustained information and support to families are needed to protect girls from undergoing FGM.	• Professionals should identify girls at risk of FGM as early as possible. All suspected cases should be referred as part of existing child safeguarding obligations. Sustained information and support should be given to families to protect girls at risk. • In cases where FGM is identified in a woman who presents at maternity services, the implications for the woman and her future child should be discussed by the midwife or doctor and a clear plan of action including communication with relevant agencies detailed in paper and electronic records. • Professionals should refer all women identified as having undergone	Incorporated in Berkshire LSCBs Child Protection procedures. RBH have developed a flow chart to support decision making and referral. Midwives inform health

		FGM who give birth the female children to the Multi-Agency Safeguarding Hub (MASH) for discussion and review. A home visit should be made by social services and further information on the law on FGM and support provided to women. This has been tried in Waltham Forest before the FGM Services closed down. Such visits have been welcomed by women. • It is important to share this information with the GP, the health visitor, school nurse and safeguarding leads in Schools so that they can engage in continuous dialogue and provide information to parents about illegality of FGM and monitor girls at risk. • Health practitioners offering travel vaccinations to children from practising communities for travel to countries where FGM is prevalent must be sensitive to the possible risk of FGM. • Girls from FGM practising communities who are put on child protection registers for other forms of abuse and those who come into contact with youth offending teams and CAMHS should be asked about their risk or experiences of FGM by trained professionals. • All responsible agencies should promote and sign post at risk girls and women to age appropriate information and support services such as the NSPCC helpline and specialist FGM clinics. • Refer all girls and women identified with FGM for support and further medical and psychological assessment as appropriate. Referral pathways must be developed so that all health and social care agencies are aware of their respective roles and responsibilities.	visitors and GPs of pregnant women who have suffered FGM.
All Agencies	**All girls and women presenting with FGM within the NHS must be considered as potential victims of crime and should be referred to the police and support services.** FGM is illegal in the UK. All professionals to be aware of the	Protocols for information sharing between health, the police and other relevant agencies such as social care and education should be developed. These protocols should be based on national guidance and should regularly be reviewed for their effectiveness by public health directors and GP commissioners.	Requires further development. Currently referrals are made to CSC who then convenes a strategy meeting with the police.

	FGM Act (2003) and able to act on cases of FGM where a crime has been committed. All girls and women who were UK residents since March 2004 and have had FGM are victims of crime, with rights to redress, regardless of whether FGM was committed in the UK or abroad.		
Local Authorities, Service Commissioners and Social Services	**The NHS and local authorities should systematically measure the performance of frontline health professionals against agreed standards for addressing FGM and publish outcomes to monitor progress of implementing these recommendations.** Directors of Public Health, Health and wellbeing Board and Clinical Commissioning Groups to consider the needs of people affected by FGM with Joint Strategic Needs Assessment (JSNA) and local strategies (e.g. Violence against Women and Girls strategies) particularly in areas where communities affected by FGM reside. Local Safeguarding Children Boards should be charged with leading a preventative response to FGM, including ensuring that information on girls at-risk is	• Directors of Public Health, Directors of Social Care and Children's Services, Clinical Commissioning Groups, Health and Wellbeing Boards should include FGM in the Strategic Needs Assessments (JSNA) and Violence against Women and Children strategies. • JSNAs should inform preventative strategies led by the Local Safeguarding Children Boards in collaborations with the local authority and Health and Wellbeing Boards. • In the absence of local prevalence data, local authorities to use socio-demographic data; e.g. Primary Level Annual Schools Census (PLASC), to map communities affected by FGM in their local area, and to plan for services to meet those needs. • In all areas, training on FGM should be integrated into all safeguarding training conducted by LSCBs. • Practitioners should be aware of their role in prevention during the life-course of the girl at risk and be able to sensitively discuss FGM and prevention of harm with them. • In areas with high densities of communities affected by FGM, preventions should be explicit in local child protection policies. • LSCBs should publish and share their strategies in high density areas. • Preventative agendas should consider the need for empowering girls at risk to prevent harm, as well as support services for those affected by FGM. • The NSPCCs dedicated FGM helpline service is promoted across all settings, including health, social care and education as a resource	Refer to Health and wellbeing Boards

	shared across health, social care and education with information sharing protocols based on national guidance, and regular reviews of how information is shared and used. Practitioners should refer all women from FGM affected communities who have had FGM and who have female children to the Multi-Agency Safeguarding Hub (MASH) for discussion, review and assessment	for practitioners with concerns and girls at risk to claim their rights to protection. • Some practitioners – teachers, school nurses, GPs – are well placed to talk with girls at risk about prevention of harm. LSCBs should support such interventions. • Strategies for early identification of girls at risk should be put in place: At national level – health, Social Care and education performance in these areas should be monitored against the CQC and Ofsted inspections regime which are published. At local level – Develop FGM into quality standards for commissioning, by which health and social care institutions/service providers can be judged.	
UK departments for education	**Empowering and supporting affected girls and young women should be a priority consideration.** Many girls are too young to understand the implications of FGM for them. Young people may support FGM because they lack fact about it.	• In areas where affected communities reside, schools should explicitly include discussions and information on FGM within Personal, Social and Health Education (PSHE) curriculum. Teachers, School Nurses, Health Visitors, Counsellors and Safeguarding Leads in schools should provide time for 1:1 conversations and information to girls from practising communities. These could be integrated into other messages (MSPCC Pants Campaign), encouraging girls and young women to report harm such as in the preventions of physical and sexual abuse. Young people should be signposted to the MSPCC FGM Helpline on 0800 028 3550 for advice, information and counselling.	Refer to Schools
Home Office, UK Public Health Authorities and Social Services	**Develop and implement national public health and legal awareness campaigns in FGM, similar to previous campaigns on domestic abuse and HIV.** Current information provision about the health consequences is not reaching the affected communities and the general	Well-designed public health and legal awareness campaign about FG<, targeted at women and girls from at risk communities about the health and legal implications of FGM. These campaigns should also emphasise to the general public that FGM is illegal in the UK, a message endorsed by key professional organisation and NGOs.	

	public is not aware of the illegality of FGM. There is support for stringer and effective action by the governments, particularly among young women from affected communities, who want to see the practice stopped.		

Title of Report:	**Pharmaceutical Needs Assessment**
Report to be considered by:	The Health and Wellbeing Board
Date of Meeting:	26th March 2015

Purpose of Report:

This report sets out the outline of the Pharmaceutical Needs Assessment (PNA). It states what will be included in the PNA, the methodology that has been used and the timeline for delivery of the project. The Consultation period for the PNA in West Berkshire ended 16th January and this report now includes the key issues identified form the consultation and the final amended PNA to be agreed and published.

Recommended Action:

To approve the final document following consultation and revisions

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: x

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Executive Report

1. Policy Context

1.1 PNAs are useful for the NHS to help make decisions on which NHS funded services need to be provided by local community pharmacies. Their services are part of the local healthcare provision, Public Health and affect NHS budgets.

1.2 Each Health and Well-being Board must in accordance with Department of Health regulations —

(a) assess needs for pharmaceutical services in its area, and

(b) publish a statement of its first assessment and of any revised assessment

1.3 The PNA will provide information on the current pharmaceutical services in Berkshire and identify gaps in the current service provisions, taking into account any known future needs.

2. Purpose of the PNA

2.1 The PNA will be used by the NHS to commission pharmaceutical services in Berkshire. It will also be used by the Public Health and Wellbeing team in West Berkshire Council to commission local services.

3. PNA Consultation in West Berkshire

3.1 Each of the six unitary authorities across Berkshire has developed a PNA for its area and have gone out to consultation. The formal second consultation period West Berkshire commenced In September 2014 and ended on the 16th January 2015.

3.2 It should be noted that the PNA included in its development a survey of users, which informed the draft recommendations of the PNA. In total there were 2048 user responses across Berkshire – with 275 from West Berkshire. The second stage of consultation was focussed on getting views on the document.

3.3 The consultation in West Berkshire broadly consisted of:

1. The PNA and the consultation were published on West Berkshire Council's website in October/November 2014 and on the West Berkshire Health Watch Website.

2. From November 2014, letters were sent to West Berkshire's GPs - signed by the Head of Public Health and Wellbeing for West Berkshire, and circulated by the Manager of Newbury & District Clinical Commissioning Group - inviting them to complete the survey.

3. In November 2014, letters were sent to West Berkshire Pharmacies - signed by Head of Public Health and Wellbeing West Berkshire for circulation to the pharmacies by the Berkshire Local Pharmaceutical Committee – inviting them to complete the survey.

4. In December 2014, letters were sent to neighbouring chairmen of Health and Wellbeing Boards - signed by Chairman of the West Berkshire Health and Wellbeing Board, encouraging them to complete the survey.

5. Liaison with Health Watch by West Berkshire Head of Public Health and Wellbeing to promote the survey to increase uptake.

4. What to expect in the PNA

4.1 There is one PNA document for each Unitary Authority in Berkshire.

4.2 The document contains:

1. Existing pharmaceutical services in Berkshire mapped against population
2. A review of the demography and Joint Strategic Needs Assessment (JSNA) - used to identify health needs of the population
3. Users' views obtained through a questionnaire for the public using pharmacy services.
4. Professional views obtained through questionnaire for the pharmacists
5. Key stakeholders input through steering group

4.3 The Draft report was sent to the Health and Wellbeing Board for approval before sending it out for stakeholder consultations.

4.4 The final report with recommendations is presented to the Health and Wellbeing Boards in Berkshire for approval before publication.

4.5 The following stakeholders were consulted:

- Local Pharmaceutical Committee for Berkshire
- Berkshire Local Medical Committee
- Berkshire CCGs
- Any persons on the pharmaceutical lists and any dispensing doctors list for Berkshire population
- Any (Local Pharmaceutical Services) LPS chemist with whom NHS England has made arrangements for the provision of any LPS for Berkshire population
- Local Health Watch organisations and other patient, consumer or community groups with an in interest in the provision of pharmaceutical services in Berkshire
- NHS Trusts
- Thames Valley NHS England Area Team
- Neighbouring Health and Wellbeing Boards

5. Timelines:

Milestones	Deadline	Completed?
User and pharmacist surveys	Summer 2014	Summer 2014
Writing first draft and outline paper to HWBB	September 2014	September 2014
Consultation period	September - December 2014	Completed mid-January 2015
Analysis of consultation results	January 2015	January 2015
Final report	January 2015	January 2015

6. Consultation responses

Whilst the number of written responses were very limited - only 16 responses were received from major stakeholders (e.g Local Medical Committee, Local Pharmaceutical Committee, neighbouring Health and Wellbeing boards. The major areas highlighted in the responses were:

- Need to identify and publish the individual opening hours of pharmacies in the area and map against local GP opening hours – *this has been included in the final document (see appendix 3)*
- Need to give further description on the population growth and specific housing developments - *amendments to demographic profile undertaken*
- Need to clarify future needs and any gaps that may occur – *addressed in recommendations*
- Need to clarify that the assessment covers community pharmacy, appliance contractors and dispensing doctors – *page 3 amended*

7. References:

1. Department of Health: Pharmaceutical Needs Assessment Information Pack May 2013 https://www.gov.uk/government/publications/pharmaceutical-needs-assessments-information-pack (last accessed on 5th November 2013)

2. UK Legislations: National Health Service (Pharmaceutical and Local Pharmaceutical Services) Regulations 2013 http://www.legislation.gov.uk/uksi/2013/349/regulation/8/made (last accessed on 5th November 2013)

Appendices

Appendix A - Detailed Consultation responses
Appendix B - Pharmaceutical Needs Assessment document for West Berkshire (circulated electronically only)

Appendix A

Detailed Consultation responses
Only 16 respondents -

Is the purpose of the PNA explained sufficiently within the draft PNA document (section 1)?
93 - yes - no response 7%

One detailed response suggested that further clarity that dispensing doctors were also part of this survey was needed - the scope of the document is clarified by an amendment on page 3

Does the document clearly set out the scope of the PNA (section 4)? -
75% agreed - the comments were focussed on clarifying the range of services addressed in this document and the purpose - both of these issues have been addressed by minor amendments on page 3

Does the document clearly set out the local context and the implications for the PNA (section 5)?

74% agreed that the document did this - the comments suggested that the document should strengthen the potential fro pharmacy to improve services and also identify the impact of future housing. Whilst housing growth is not a major issue in West Berkshire the document now included a revised section on population growth and an assessment of pharmacy provision against the national England average

Does the information provide a reasonable description of the services which are provided by pharmacies and dispensing appliance contractors in your local authority (section 8)?

Only 33% of respondents though that the document gave an accurate reflection on the level of services - the major concern was that the document did not include a description of opening hours by pharmacy - this has now been included.
There was concern that the range of services provided by dispensing doctors was under described - again this has been strengthened.
One area of concern was raised regarding the provision of care home support by medicine management in the CCG rather than community pharmacy – this was not addressed in the final document as the document does not set out to evaluate different forms of services but does set out to describe potential impact of community pharmacy. It is the role of the commissioner to decide the most appropriate response to a community need.

Are you aware of any pharmaceutical services currently provided which have not been included within the PNA?
50% of respondents identified that the New medicines review (NMS) service had not been included in the advanced service section - this has now been included.

Do you think the pharmaceutical needs of the population have been accurately reflected throughout the PNA

In this section 10 respondents felt that the needs were not addressed as there was not an accurate reflection of population growth and that access times needed further description - this has now been included in the final document.

Do you agree with the recommendations?
Essential and advanced services - 40% agree - main issue is lack of information on opening hours does not allow any gap in service provision to be identified - final document includes this information.
Local service recommendations - 60% agree - main issue raised in lack of commitment to commissioning the services identified.

Appendix B

Draft

Pharmaceutical Needs Assessment

West Berkshire Council

2015-18

Public Health Services for Berkshire
Six Local Authorities working together for the health and wellbeing of residents in Berkshire

Pharmaceutical Needs Assessment
West Berkshire Council
2014

Contents

Introduction

What is a Pharmaceutical Needs Assessment (PNA)?

PNA is the statement for the needs of pharmaceutical services of the population in a specific area - this includes services provided by community pharmacies, dispensing doctors and appliance contractors. It sets out a statement of the pharmaceutical services which are currently provided, together with when and where these are available to a given population.

From 1 April 2013 every Health and Wellbeing Board (HWB) in England has a statutory responsibility to keep an up to date statement of the PNA.

This PNA describes the needs of the population of West Berkshire Council and is different from the previous PNA which was Berkshire West focussed, but it will also give a view across Berkshire as people move between Local Authorities for work and health care.

Purpose of a PNA:

The PNA has several purposes:

- To provide a clear picture of community pharmacy services currently provided
- To provide a good understanding of population needs and where pharmacy services could assist in improving health and wellbeing and reducing inequalities
- To deliver a process of consultation with local stakeholders and the public to agree priorities
- An assessment of existing pharmaceutical services and making recommendations to address any identified gaps if appropriate and suggesting improvements to address future needs
- It will be used by NHS England when making decisions on applications to open new pharmacies and dispensing appliance contractor premises or applications from current pharmaceutical providers to change their existing regulatory requirements.
- It will inform interested parties of the pharmaceutical needs in Berkshire and enable work to plan, develop and deliver pharmaceutical services for the population.
- It will influence commissioning decisions by local commissioning bodies including Local Authorities (Public Health services from community pharmacies), NHS England and Clinical Commissioning Groups (CCGs) in the potential role of pharmacy in service redesign.

Background: Statutory Requirements

Section 126 of the NHS Act 2006 places an obligation on NHS England to put arrangements in place so that drugs, medicines and listed appliances ordered via NHS prescriptions can be supplied to persons. This section of the Act also describes the types of healthcare professionals who are authorised to order drugs, medicines and listed appliances on an NHS prescription.

The first PNAs were published by NHS Primary Care Trusts (PCTs) according to the requirements in the 2006 Act. NHS Berkshire West and East published their first PNA in 2010.

The Health and Social Care Act 2012 amended the NHS Act 2006. The 2012 Act established the Health and Wellbeing Boards (HWBs) and transferred to them the responsibility to publish and keep up to date a statement of the needs for pharmaceutical services of the population in its area, with effect from 1 April 2013.

The 2012 Act also amended the Local Government and Public Involvement in Health Act 2007 to introduce duties and powers for HWBs in relation to Joint Strategic Needs Assessments (JSNAs). The preparation and consultation on the PNA should take account of the JSNA and other relevant local strategies in order to prevent duplication of work and multiple consultations with health groups, patients and the public.

The development of PNAs is a separate duty to that of developing JSNAs. As a separate statutory requirement, PNAs cannot be subsumed as part of these other documents.

The PNA must be published by the HWB by April 2015, and will have a maximum lifetime of three years. The PNA will be used by NHS England when making decisions on applications to open new pharmacies and dispensing appliance contractor premises or applications from current pharmaceutical providers to change their existing regulatory requirements. Such decisions are appealable to the NHS Litigation Authority's Family Health Services Appeal Unit (FHSAU) and decisions made on appeal can be challenged through the courts.

PNAs will also inform the commissioning of enhanced services from pharmacies by NHS England and the commissioning of services from pharmacies by the local authority and other local commissioners for example CCGs.

The 2013 Regulations list those persons and organisations that the HWB must consult. This list includes:

- Any relevant local pharmaceutical committee (LPC) for the HWB area.
- Any local medical committee (LMC) for the HWB area.

- Any persons on the pharmaceutical lists and any dispensing GP practices in the HWB area.
- Any local Healthwatch organisation for the HWB area and any other patient, consumer and community group which in the opinion of the HWB has an interest in the provision of pharmaceutical services in its area.
- Any NHS trust or NHS foundation trust in the HWB area.
- NHS England.
- Any neighbouring HWB.

Definition of Pharmaceutical services

The pharmaceutical services to be included in the pharmaceutical needs assessment are defined by the reference to the regulations governing pharmaceutical services provided by community pharmacies, dispensing doctors and appliance contractors.

Pharmaceutical services are provided through the national pharmacy contract which has three tiers:

- Essential Services
- Advanced services – currently Medicines Use Reviews and Appliance Use Reviews
- Locally commissioned services (Enhanced Services)

Essential Services- set out in 2013 NHS Pharmaceutical Services Regulations 2013 include:

- Dispensing
- Dispensing appliances
- Repeat dispensing
- Disposal of unwanted / waste drugs
- Public Health (Promotion of healthy lifestyles)
- Signposting
- Support for self care
- Clinical governance

All contractors must provide the full range of essential services.

Advanced Services - set out in 2013 NHS Pharmaceutical Services Regulations 2013 include:

- Medicines Use Review and Prescription Intervention (MURs)
- New medicine service (NMS)
- Appliance Use Reviews (AURs)
- Stoma Appliance Customisation Services (SACs)

Enhanced Services - set out in Directions made subsequent to the NHS Pharmaceutical Services Regulations 2013 include:

- Anticoagulant monitoring service
- Care home service
- Disease specific medicines management service
- Gluten free food supply service
- Home delivery service
- Language access service
- Medication review service
- Medicines assessment and compliance support service
- Minor ailments service
- Needle syringe exchange service
- On demand availability of specialist drugs service
- Out of hours service
- Patient group directions service
- Prescriber support service
- Schools service
- Screening service
- Stop smoking service
- Supervised administration service
- Supplementary prescribing services

Whilst the National Pharmacy Contract is held and managed by the NHS England, local Thames Valley Area Team, and can only be used by NHS England, local commissioners such as West Berkshire Council and Newbury and District CCG can commission local services using other contracts such as local government contracts and the standards NHS contracts to address additional needs.

Process for developing the PNA

The PNA is a key tool for identifying what is needed at a local level to support the commissioning intentions for pharmaceutical services and other services that could be delivered by community pharmacies.

The scope will include recommendations for action to meet the current needs of West Berkshire and across Berkshire highlighting any areas of current provision which could be improved and potential areas for development that could assist the HWB in its duty to improve the health of the population and reduce inequalities.

A key part of the process for this PNA is to summarise the health needs of the local population using the joint strategic needs assessments and the findings of the HWB Board.

The PNA has five main objectives:

1. Identifying local needs
2. Mapping current provision

3. Consultations with partners, patients and the public
4. Obtaining clinical input from clinical commissioning groups (CCGs) and the Local Pharmaceutical Committee (LPC)
5. Identifying services that are not currently provided or need to be improved in the local area.

The PNA summarises the national vision for community pharmacy and also summarises the key priorities in the Health and Wellbeing Strategy which details the local priorities for our community.

Principles of Development

The PNA will be published on the West Berkshire Council website once agreed and is a public facing document communicating to both an NHS and a non-NHS audience.

The key stages involved in the development of this PNA were:

- Survey of public to ascertain views on services - web and paper based surveys.
- Survey of community pharmacies to map current service provision.
- Public Consultation on the initial findings and draft PNA.
- Agreement of final PNA by the West Berkshire Health and Wellbeing Board.

The process for the development of the PNA was agreed with the HWB Board. A small task and finish group was set up to over see the development of the PNA Member included.

- Director of Public Health
- Medicines Management – CCG
- NHS England pharmaceutical commissioner
- Representative from the Local Pharmaceutical Committee
- Public Health Informatics Advisor

During the consultation the following stakeholders have been included in addition to the public consultation:

- The Local Authorities within Berkshire
- The Clinical Commissioning Groups in Berkshire
- The Local Pharmaceutical Committee (LPC)
- The Local Medical Committee (LMC)
- The persons on the pharmaceutical list (pharmacy contractors) and its dispensing doctors list
- Healthwatch
- NHS Foundation Trusts in Berkshire

National Pharmacy Commissioning

Commissioning Arrangements

NHS England is the only organisation that can commission NHS Pharmaceutical Services through the national Pharmacy contract. They are therefore responsible for managing and performance monitoring the Community Pharmacy Contractual Framework. This is a regulatory framework based on the Terms of Service set out in the NHS (Pharmaceutical and Local Pharmaceutical Services) Regulations 2013 and the Pharmaceutical Services (Advanced and Enhanced Services) (England) Directions 2013.

Pharmaceutical Services are those services set out in the NHS Pharmaceutical and Local Pharmaceutical Services) Regulations 2013 and the Pharmaceutical Services (Advanced and Enhanced Services) (England) Directions 2013:

- Essential services - set out in Part 2, Schedule 4 of the Regulations
- Advanced services - set out in the Directions
- Enhanced services - set out in the Directions

There are four ways in which pharmaceutical services are commissioned:

NHS England

- Sets legal framework for system, including regulations for pharmacy
- Secures funding from HM Treasury
- Determines NHS reimbursement price of medicines & appliances.

NHS England Area Team (AT)

- securing continuously improving quality from the services commissioned, including community pharmacy enhanced services.

Local Authority

- Provision of public health services in line with the local Health and Well being Strategy.

CCGs

- Locally commissioned in line with local needs and CCG strategy

This ensures that the public have access to comprehensive pharmaceutical services.

Local Professional Networks

In addition as part the National changes in the NHS in 2013 Local Professional Networks (LPNs) for pharmacy, optometry and dentistry were established within each Area Team (AT). They are intended to provide clinical input into the operation of the AT and local commissioning decisions

In general they:

- support the implementation of national strategy and policy at a local level
- work with other key stakeholders on the development and delivery of local priorities, which may go beyond the scope of primary care commissioning providing local clinical leadership

The specific functions of the Pharmacy LPN include:

- supporting LAs with the development of the Pharmaceutical Needs Assessment (PNA)
- considering new programmes of work around self-care and long term conditions management in community pharmacy to achieve Outcome 2 of the NHS Outcomes Framework
- working with CCGs and others on medicines optimisation
- 'holding the ring' on services commissioned locally by LAs and CCGs, highlighting inappropriate gaps or overlaps *(PSNC Pharmacy Commissioning 2013).*

Contribution of Pharmacy

Pharmacists play a key role in providing quality healthcare. They are experts in medicines and will use their clinical expertise, together with their practical knowledge, to ensure the safe supply and use of medicines by the public. There are more than 1.6 million visits a day to pharmacies in Great Britain (*General Pharmaceutical Council Annual Report 2012/13*).

A pharmacist has to have undertaken a four year degree and have worked for at least a year under the supervision of an experienced and qualified pharmacist and be registered with the General Pharmaceutical Council (GPhC). Pharmacists work in a variety of settings, this includes in a hospital or community pharmacy such as a supermarket or high street pharmacy. See NHS Choices at http://www.nhs.uk/Pages/HomePage.aspx for your local ones.

In December 2013 NHS England held a Call to Action for community pharmacy that aimed through local debate, to shape local strategies for community pharmacy and to inform NHS England's strategic framework for commissioning community pharmacy (http://www.england.nhs.uk/wp-content/uploads/2013/12/community-pharmacy-cta.pdf).

The aim was to uncover how best to develop high quality, efficient services in a community pharmacy setting that can improve patient outcomes delivered by pharmacists and their teams

Pressures on primary care as a whole are increasing and the vision is for the community pharmacy to play a full role in the NHS transformational agenda by:

- providing a range of clinical and public health services that will deliver improved health and consistently high quality
- playing a stronger role in the management of long term conditions
- playing a significant role in a new approach to urgent and emergency care and access to general practice
- providing services that will contribute more to out of hospital care and
- supporting the delivery of improved efficiencies across a range of services

The call to action consultation has now finished and the response is awaited from the Department of Health.

National Outcomes frameworks

Pharmacy has a key role in supporting the achievement of the NHS outcomes Framework. This framework measures the success of the NHS in improving the health of the population.

NHS Outcomes Framework

Domain 1	Preventing people from dying prematurely
Domain 2	Enhancing quality of life for people with long-term conditions
Domain 3	Helping people to recover from episodes of ill health or following injury
Domain 4	Ensuring people have a positive experience of care
Domain 5	Treating and caring for people in a safe environment and protecting them from avoidable harm

And similarly contributes to the success against the Public Health Outcomes framework.

Public Health Outcomes Framework

Domain 1	Life expectancy and healthy life expectancy
Domain 2	Tackling the wider determinants of Health
Domain 3	Health Improvement
Domain 4	Health Protection
Domain 5	Healthcare and preventing premature mortality

Control of Market Entry

The regulations that govern the provision of pharmacy places an obligation on NHS England to put arrangements in place so that drugs, medicines and listed appliances ordered via NHS prescriptions can be supplied to persons.

It is not possible for a community pharmacy to be set up without agreement from NHS England. From 1 April 2013, pharmaceutical lists are maintained by NHS England and so applications for new, additional or relocated premises must be made to the local NHS England Area Team.

NHS England must ensure that they have arrangements in place for:

- the provision of proper and sufficient drugs, medicines and listed appliances which are ordered on NHS prescriptions by doctors;
- the provision of proper and sufficient drugs, medicines which are ordered on NHS prescriptions by dentists;
- the provision of proper and sufficient drugs, medicines and listed appliances which are ordered on NHS prescriptions by other specified descriptions of healthcare professionals; and
- such other services that may be prescribed.

In April 2013 there was a change in how pharmacy applications are controlled. Applications for inclusion in pharmaceutical lists are now considered by NHS England (through their Area Teams) and the 'market entry test' is now an assessment against the pharmaceutical needs assessment. The exemptions introduced in 2005 have been removed (other than the exception for distance selling pharmacies) (*Regulations under the Health and Social Care Act 2012: Market entry by means of Pharmaceutical Needs Assessments - Medicines, Pharmacy and Industry – Pharmacy Team).*

The market entry test now assesses whether an application offers to:

- meet an identified current or future need or needs
- meet identified current or future improvements or better access to *pharmaceutical services* or
- provide unforeseen benefits, i.e. applications that offer to meet a need that is not identified in a PNA but which NHS England is satisfied would lead to significant benefits to people living in the relevant HWB area (*Policy for determining applications received for new or additional premises under the NHS (Pharmaceutical and Local Pharmaceutical Services) Regulations 2013*).

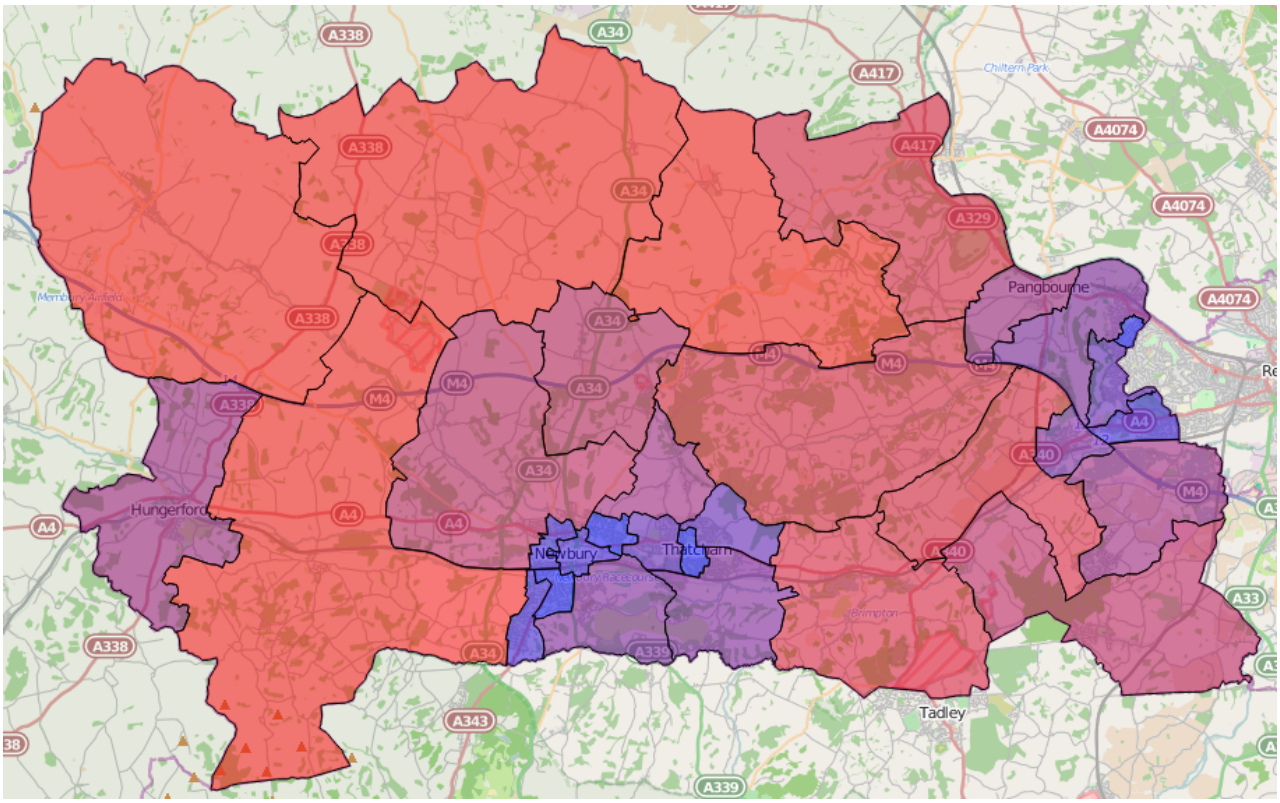
The change in the market entry test means that it is no longer necessary to have exemptions to the test for the large out of town retail developments, the one stop primary medical centres, or the pharmacies undertaking to provide pharmaceutical services for at least 100 hours per week. These exemptions therefore cannot be used by an applicant (although existing pharmacies and those granted under the exemption continue). The regulations make it clear that 100 hour pharmacies granted under old exemptions cannot apply to reduce their hours.

The only exemption that now exists is for distance selling pharmacies, as it is argued they provide a national service and so their contribution cannot be measured adequately by a local pharmacy needs assessment.

Geography Covered by West Berkshire PNA

Each PNA has to define its geographic scope. This year the West Berkshire PNA is following the boundaries of the Local Authority, as is each PNA for the Berkshire Local Authorities. The services are mapped for each Local Authority, although a composite picture is given for Berkshire. Results are also compared by Local Authority versus the whole of Berkshire. See Appendix 1 for a map of West Berkshire pharmacies.

Figure 1: Map of West Berkshire showing ward boundaries



The wards in West Berkshire are:

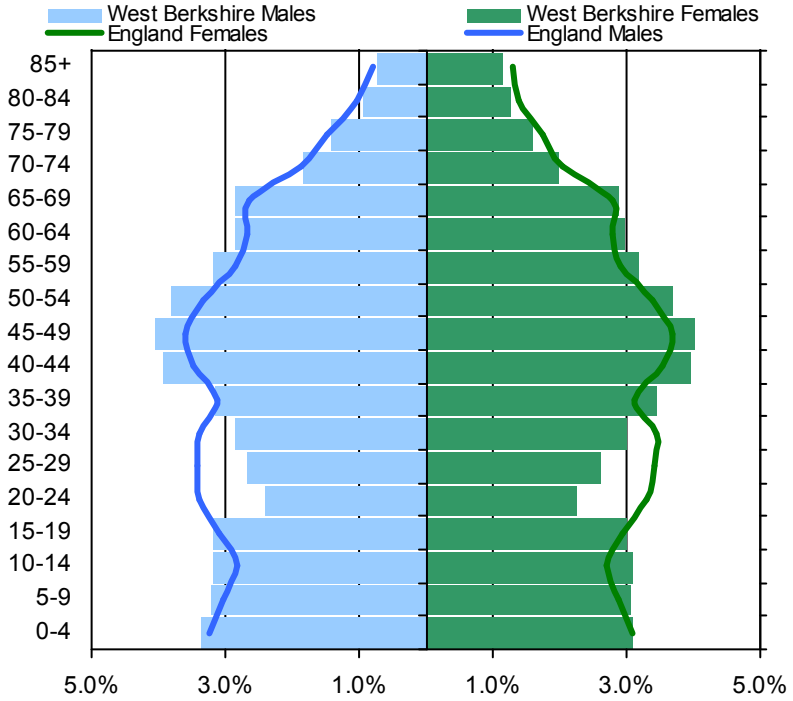
Aldermaston	Downlands	Speen
Basildon	Falkland	Sulhamstead
Birch Copse	Greenham	Thatcham Central
Bucklebury	Hungerford	Thatcham North
Burghfield	Kintbury	Thatcham South and Crookham
Calcot	Lambourn Valley	Thatcham West
Chieveley	Mortimer	Theale
Clay Hill	Northcroft	Victoria
Cold Ash	Pangbourne	Westwood
Compton	Purley on Thames	

West Berkshire Demographics

The population of West Berkshire is now 157,147.

As a proportion of the total population, there are fewer adults aged 20 to 34 than the national average. However, there are a larger proportion of adults aged 40 to 69.

Figure 2: West Berkshire Council's Population pyramid, compared to the national profile



Source: Annual Mid-Year Population Estimates for the UK, Office for National Statistics 2014

The registered population differs to resident as this is the number of people registered with GP practices based in West Berkshire.

Figure 3: Resident and registered population of West Berkshire and other Berkshire Local Authorities

Local Authority	Resident population	Registered population
West Berkshire	**155,392**	**148,126**
Bracknell Forest	116,567	110,216
Reading	159,247	205,209
Slough	143,024	145,848
Windsor & Maidenhead	146,335	165,936
Wokingham	157,866	156,123

Source: Office for National Statistics (2014)

Figure 4: Ethnic Origin of resident population in West Berkshire and other Berkshire Local Authorities (Census 2011)

	West Berkshire	Bracknell Forest	Reading	Slough	Windsor and Maidenhead	Wokingham
All Usual Residents	**153,822**	113,205	155,698	140,205	144,560	154,380
English/Welsh/Scottish/Northern Irish/British, Irish, Gypsy or Irish Traveller, White Other	**94.8**	90.6	74.8	45.7	86.1	88.4
Mixed/Multiple Ethnic Groups: White and Black Caribbean, White and Black African, White and Asian, Mixed Other	**1.6**	2.1	3.9	3.4	2.3	2.0
Asian/Asian British: Indian, Pakistani, Bangladeshi, Chinese, Asian Other	**2.4**	5.1	13.6	39.7	5.5	7.5
Black/African/Caribbean/Black British: African, Caribbean, Black Other	**0.9**	2.0	6.7	8.6	6.6	1.4
Other Ethnic Group	**0.2**	0.5	0.9	2.6	0.8	0.7

Source: Office for National Statistics (2011)

Figure 5: Life Expectancy for men and women in West Berkshire and other Berkshire Local Authorities (2010-12)

Local authority	**Males**	**Females**
West Berkshire	**80.8**	**84.6**
Bracknell Forest	80.8	84.0
Reading	78.4	82.7
Slough	78.5	82.7
Windsor and Maidenhead	81.1	84.6
Wokingham	81.6	84.5

Source: Office for National Statistics (2014)

Population Growth

Current population is 157,147 in 2014
Population growth is driven by natural demographic changes (ONS calculations) but also planned housing developments - in West Berkshire planned housing accounts for the smallest growth across Berkshire.

Over the 3 years of this strategy there is an estimated 3 % rise in the population

Total growth - Cumulative				
UA_Name	2015	2016	2017	2018
West Berkshire	**158,105**	**160,136**	**162,434**	**164,836**
Bracknell Forest	120,036	124,044	127,906	131,879
Reading	161,515	164,824	167,923	171,364
Slough	149,811	154,078	157,768	160,764
Windsor and Maidenhead	151,166	154,216	156,460	158,568
Wokingham	162,695	166,547	171,417	177,112

Children

Children in poverty

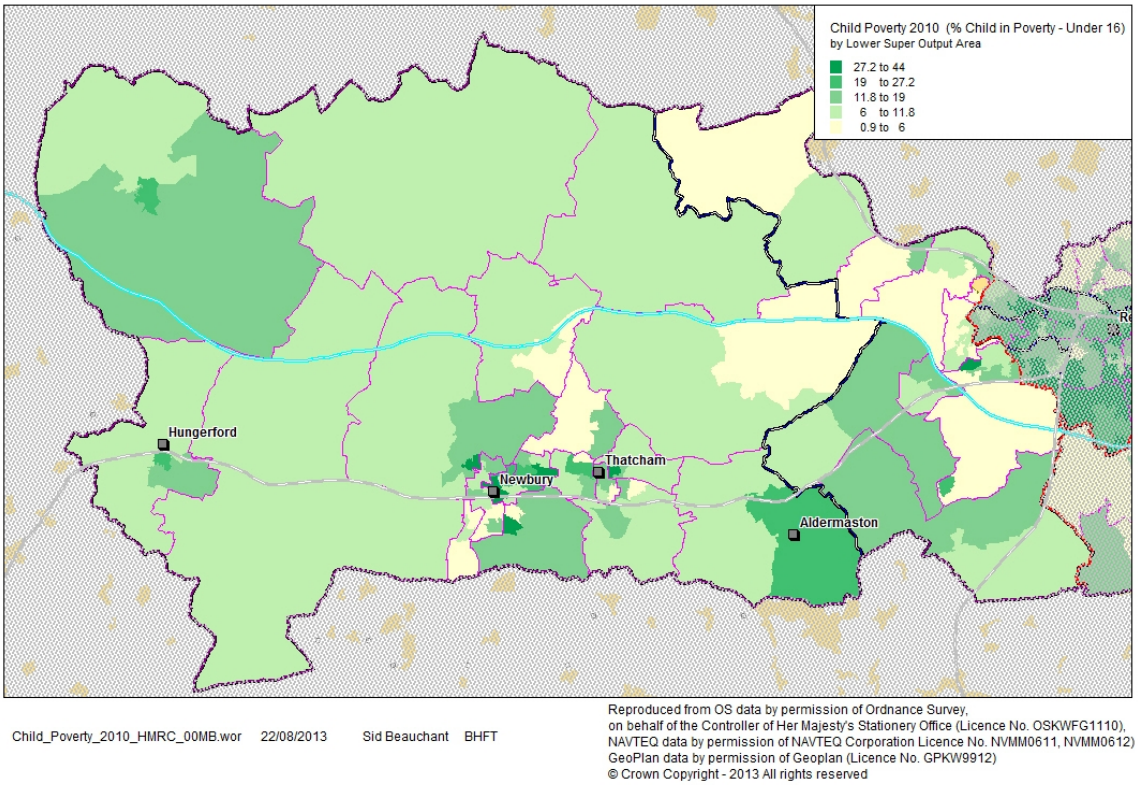
Child poverty and deprivation can be measured in a number of different ways. Figure 6 shows the percentage of children (dependent children under the age of 20), who live in households where income is less than 60% of average household income. This is termed as living in 'relative poverty'. Figure 6 also shows the Income of Deprivation Affecting Children Index score (IDACI score), which measures the proportion of under 16s living in low income households. A higher score indicates higher levels of child deprivation in an area.

Figure 6: Level of Child Poverty in West Berkshire and other Berkshire Local Authorities (2010-12)

Local Authority	% of Children in "Poverty"	IDACI score
West Berkshire	**10.8%**	**0.10**
Bracknell Forest	11.7%	0.11
Reading	20.7%	0.21
Slough	22.2%	0.26
Windsor & Maidenhead	9.4%	0.09
Wokingham	6.9%	0.06

Source: HM Revenue and Customs (2011) and Department for Communities and Local Government (2010)

Figure 7: Map to show level of Child Poverty in West Berkshire at a Lower Super Output Area (2010)



Source: Department for Communities and Local Government (2010)

Teenage Pregnancies

Figure 8: Under 18 conceptions and conception rates in West Berkshire and other Berkshire Local Authorities (3 year aggregates: 2010-2012)

Area of usual residence	Number of Conceptions	Conception rate per 1,000 women in age group	Percentage of conceptions leading to abortion
West Berkshire UA	**217**	**23.0**	**48.8**
Bracknell Forest UA	127	18.4	57.5
Reading UA	260	36.9	47.3
Slough UA	196	25.3	64.8
Windsor and Maidenhead UA	117	14.5	70.9
Wokingham UA	122	13.8	46.7

Source: Office for National Statistics (2014)

Educational Attainment

Figure 9: Percentage achieving 5+ A*-C GCSE grades, including English and mathematics

Percentage achieving 5+ A*-C grades inc. English & mathematics GCSEs	
Area	%
West Berkshire	**61.3**
Bracknell Forest	63.4
Reading	63.6
Slough	71.4
Windsor and Maidenhead	68.3
Wokingham	70.6

Source: Department for Education (2012/13)

Figure 10: Key Stage 2 results – Percentage achieving level 4 or above by Local Authority

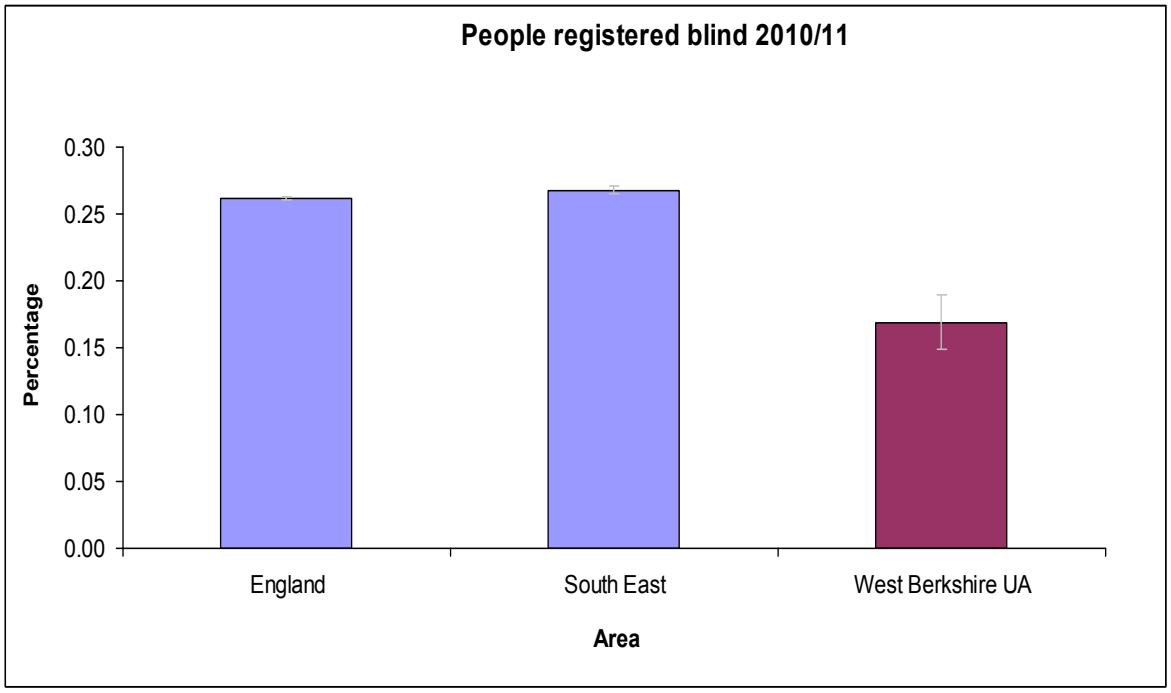
Percentage achieving level 4 or above	
West Berkshire	**77%**
Bracknell Forest	78%
Reading	69%
Slough	74%
Windsor and Maidenhead	79%
Wokingham	81%

Source: Department for Education (2013)

Physical disability and sensory impairment

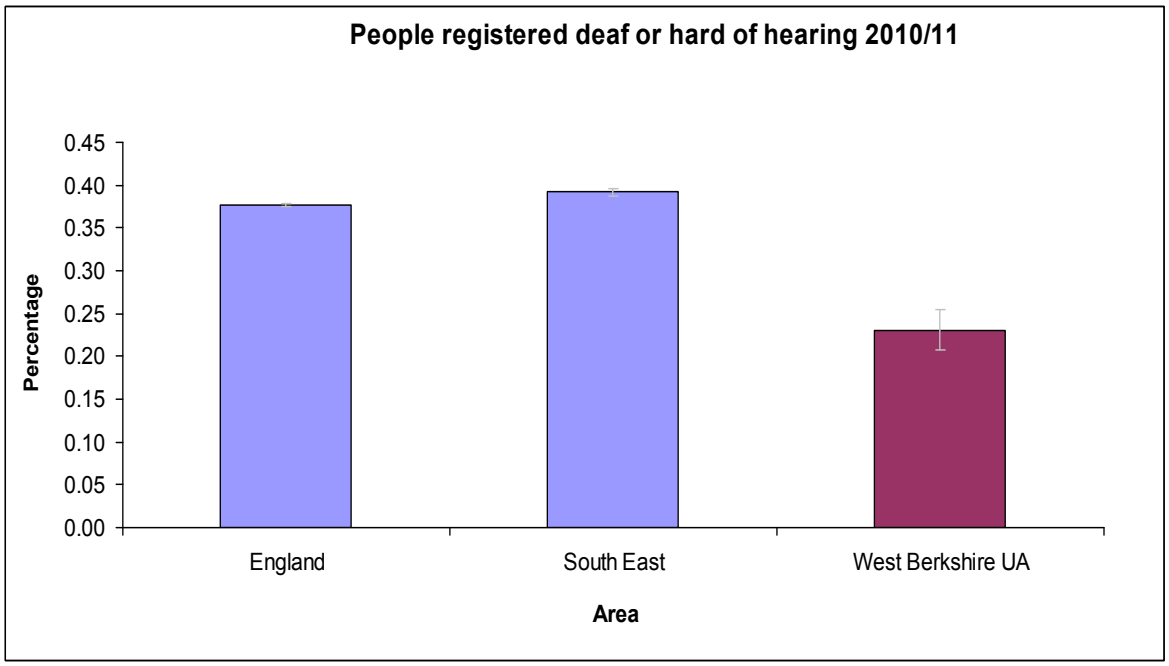
Figures 11 and 12 shows the number of people receiving certification as being blind, partially sighted, deaf or hard of hearing as a proportion of the total population. Fewer people in West Berkshire are registered as having a sensory impairment than the national and South East Region averages.

Figure 11: Percentage of people registered as blind in West Berkshire (2010/11)



Source: Health and Social Care Information Centre (2011)

Figure 12: Percentage of people registered as deaf or hard of hearing in West Berkshire (2010/11)



Source: Health and Social Care Information Centre (2011)

The Projecting Adult Needs and Services Information System uses Office for National Statistics population projections and the number of people estimated to have a physical disability to project how many people aged 18 to 64 will have a physical disability from 2012 to 2020. Around 7,600 people in West Berkshire are estimated to have a moderate physical disability in 2012 with just under 2,300 estimated to have a serious physical disability. These figures are estimated to rise to around 8,050 and 2,460 by 2020.

Carers

9.3% of West Berkshire's respondents stated that they provided unpaid care to a family member, friend or neighbour in the 2011 Census. Figure 13 provides a breakdown to show the levels of unpaid care provided.

Figure 13: Percentage of people providing unpaid care in West Berkshire and other Berkshire Local Authorities (Census 2011)

Local Authority	All categories: Provision of unpaid care	Provides no unpaid care	Provides 1 to 19 hours unpaid care a week	Provides 20 to 49 hours unpaid care a week	Provides 50 or more hours unpaid care a week
West Berkshire	**153,822**	**139,534**	**10,313**	**1,466**	**2,509**
Bracknell Forest	113,205	103,531	6,719	1,098	1,857
Reading	155,698	143,383	8,074	1,642	2,599
Slough	140,205	128,579	7,058	1,977	2,591
Windsor and Maidenhead	144,560	131,325	9,604	1,432	2,199
Wokingham	154,380	140,478	10,190	1,397	2,315

Source: Office for National Statistics (2012)

West Berkshire Needs Assessment

Residents of West Berkshire have good levels of health in general - both men and women in West Berkshire are expected to live longer on average and benchmarked indicators of health show West Berkshire in a favourable light.

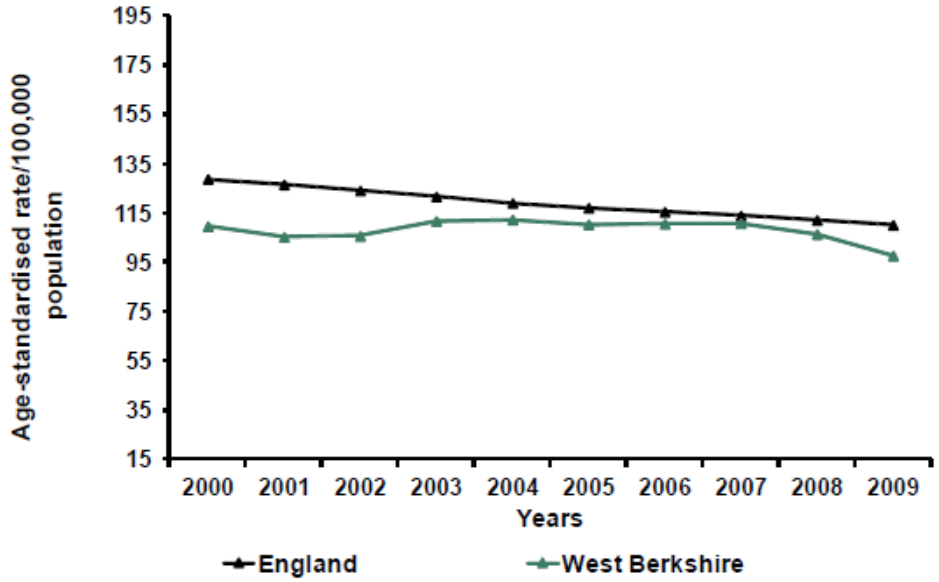
Between 2001 and 2011, the number of people aged over 65 has risen by just under 4,500 (23%). This continued increase in numbers of residents aged over 65 in the next 10 years will see more people with long term conditions including diabetes, heart failure and dementia

Like neighbouring Boroughs, the commonest cases of early deaths are cancer, heart disease and stroke, lung disease and liver disease.

Cancer

Death rates from cancer are reducing, as they are nationally, however cancer is still the leading cause of premature death in West Berkshire causing 130 deaths per 100,000 people (*Longer Lives, Public Health England*).

Figure 14: Rate of deaths from cancer for people aged under 75 in West Berkshire (2000-2009)



Source: Association of Public Health Observatories, 2012 Local Health profile

Screening is a key health intervention that will allow earlier detection of cancer or its precursors. In West Berkshire whilst uptake of breast and cervical cancer screening is above the England average, bowel cancer screening uptake needs improvement to reach the expected target.

Heart Disease and stroke

The modelled prevalence of heart disease and stroke in West Berkshire is shown in Figure 15.

Figure 15: Recorded and estimated prevalence of heart disease and stroke in West Berkshire

Disease	GP recorded prevalence (2012/13)	Modelled/ Estimated (2011)
Hypertension (high blood pressure)	28.4%	28%
Coronary heart disease	2.5%	5%
Stroke	2%	2%

Source: Health and Social Care Information Centre (2013)

Heart disease is caused by a range of risk factors - lifestyle and modifiable risk factors can be influenced to reduce an individual's risk of heart disease. The NHS Health Checks programme is a risk assessment and management programme aimed at preventing and delaying the onset of cardiovascular diseases such as heart and kidney disease, diabetes and stroke.

Developing well

West Berkshire has lower than average rates of obesity in children, though adults are becoming increasingly overweight.

Teenage conception rates are decreasing, though reported access to sexual health advice is an ongoing issue.

Living Well - Lifestyle

Smoking

Smoking has long been known to be a major risk factor in many diseases including cardiovascular disease, respiratory diseases, and many cancers.

Tobacco use is the single most preventable cause of death in the England – killing over 80,000 people per year. This is greater than the combined total of preventable deaths caused by obesity, alcohol, traffic accidents, illegal drugs and HIV infections (*Action on Smoking and Health, 2013*).

Whilst smoking prevalence in West Berkshire is close to the England average (18.8%) and in routine and manual workers is higher than the national average (31% v 30% nationally) approximately 230 per 100,000 people aged over 35 years will die due to smoking related illnesses. In addition 900 people will be admitted to hospital with smoking related illnesses (*Local Tobacco Control Profile, 2013*).

Alcohol

Alcohol consumption above the recommended levels is associated with numerous health and social problems. This includes several types of cancer, gastrointestinal and cardiovascular conditions and psychiatric and neurological conditions. The social effects of alcohol have been associated with road accidents, domestic violence, antisocial behaviour, crime, poor productivity and child neglect.

The ongoing trend of a reduction in alcohol consumption by young people in West Berkshire continues.

Estimates of binge drinking behaviour suggest in West Berkshire fewer than 18% of the population aged over 18 years of age engage in binge drinking, which is close to the national and regional averages of 20% and 18% respectively.

Higher risk drinking is the level of drinking that has the greatest risk of health problems and is quantified as more than 50 units a week for men and more that 35 units a week for women. Modelled estimates suggest that 7% of the West Berkshire LA population engage in higher risk drinking, which translates to almost 9000 people in West Berkshire seriously damaging their health through alcohol misuse (*LAPE, 2013*).

Flu Immunisation

Flu immunisation is a key public health programme that reduces the mortality and morbidity from this common condition. Whilst West Berkshire was one of a minority of areas that achieved the 75% target for patients aged over 65, the at risk groups had significant gaps in uptake.

Figure 16: Recorded and estimated prevalence of heart disease and stroke in West Berkshire

	Aged 65 years and over		Aged 6 months to 64 years in clinical risk groups		Pregnant women	
Target uptake	75% (2012/13)	Distance from 2013/14 target of 75%	70% (2012/13)	Distance from 2013/14 target of 75%	70% (2012/13)	Distance from 2013/14 target of 75%
West Berkshire	76.7%	1.7%	59.4%	-15.6%	46.9%	-28.1%
Berkshire West	75.9%	0.9%	56.4%	-18.6%	48.3%	-26.7%
England	73.4%	-1.6%	51.3%	-23.7%	40.3%	-34.7%

Source: NHS Thames Valley Local Area Team (2013)

Mental Health

Depression and anxiety disorders are common throughout the UK population. However whilst 125 people in every 100,000 people living in West Berkshire are admitted to hospital due to mental ill health, this is lower than the national and regional average. In West Berkshire, about 7 people in every 100,000 commit suicide (or injury of undetermined intent) and this is mirrored by the fact that fewer people in West Berkshire are recorded as having severe and enduing mental health issues. However 13 % of patients on GP registers are recorded as having depression - more than the England average (*West Berkshire JSNA*).

Ageing Well

In West Berkshire, the percentage of the population aged 65+, 75+ and 85+ is significantly higher than the England average.

The population of people over 65 years is forecast to increase from 25,100 in 2012 to 31,200 in 2020 and those aged 85 years from 3,200 in 2012 to 4,300 in 2020.

- 3,500 people aged 65 to 74 and 5,500 people aged 75 and over living in West Berkshire are estimated to be living alone.
- Around 2,150 people aged 65 and over living in West Berkshire are estimated to have depression in 2012 with numbers rising slightly year on year.
- West Berkshire has a higher rate of delayed transfers of care than would be expected against the national and regional benchmarks. This is also the case for delayed transfers of care that are attributable to adult social care.

Wider Determinants and Vulnerable groups

There is a higher percentage of households in rural areas of West Berkshire that are estimated to be living in 'fuel poverty'

Around 40 people in every 100,000 are killed or seriously injured on West Berkshire's roads each year which is the only benchmarked indicator where West Berkshire is significantly worse than the England average.

The significant amount of rurality within West Berkshire which requires outreach or transport solutions for services in rural wards.

Monitoring against the Public Health Outcomes Framework

The Public Health Outcomes Framework includes over 60 indicators, which measure key aspects of public health within a Local Authority area. In August 2014, West Berkshire was seen to be "significantly worse" than the England figures on five of these measures:

1.02ii	School readiness - % of Year 1 pupils with FSM status achieving the expected level in the phonics screening check
1.18i	Social isolation - % of adult social care users who say they have as much social contact as they want
2.21vii	Access to Diabetic Eye Screening
2.22v	NHS Health Checks - % of eligible population who received and NHS Health Check
3.02ii	Chlamydia diagnoses (15-24 year olds)

Local Commissioning Strategies

West Berkshire Health and Wellbeing Strategy

The Health and Wellbeing Vision for West Berkshire is:

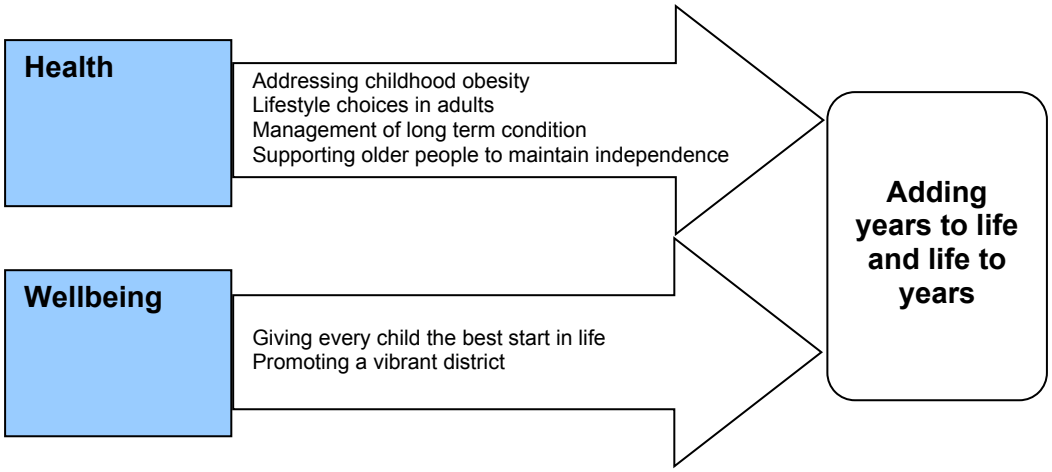
We aim to add years to life and life to years for the residents of West Berkshire

A number of key values have been adopted in producing the strategy that include the following:

- We aim to reduce the unacceptable inequalities in health across West Berkshire.
- We will promote independence and reduce social exclusion.
- We will address underlying environmental and economic determinants of health.
- We will get the best value from our resources.
- We will invest in prevention and early intervention.
- We will use evidence of effectiveness to inform everything that we do.
- We will deliver cost effective health and care services as close to people's homes as is possible.

The Strategy commits to the following objectives:

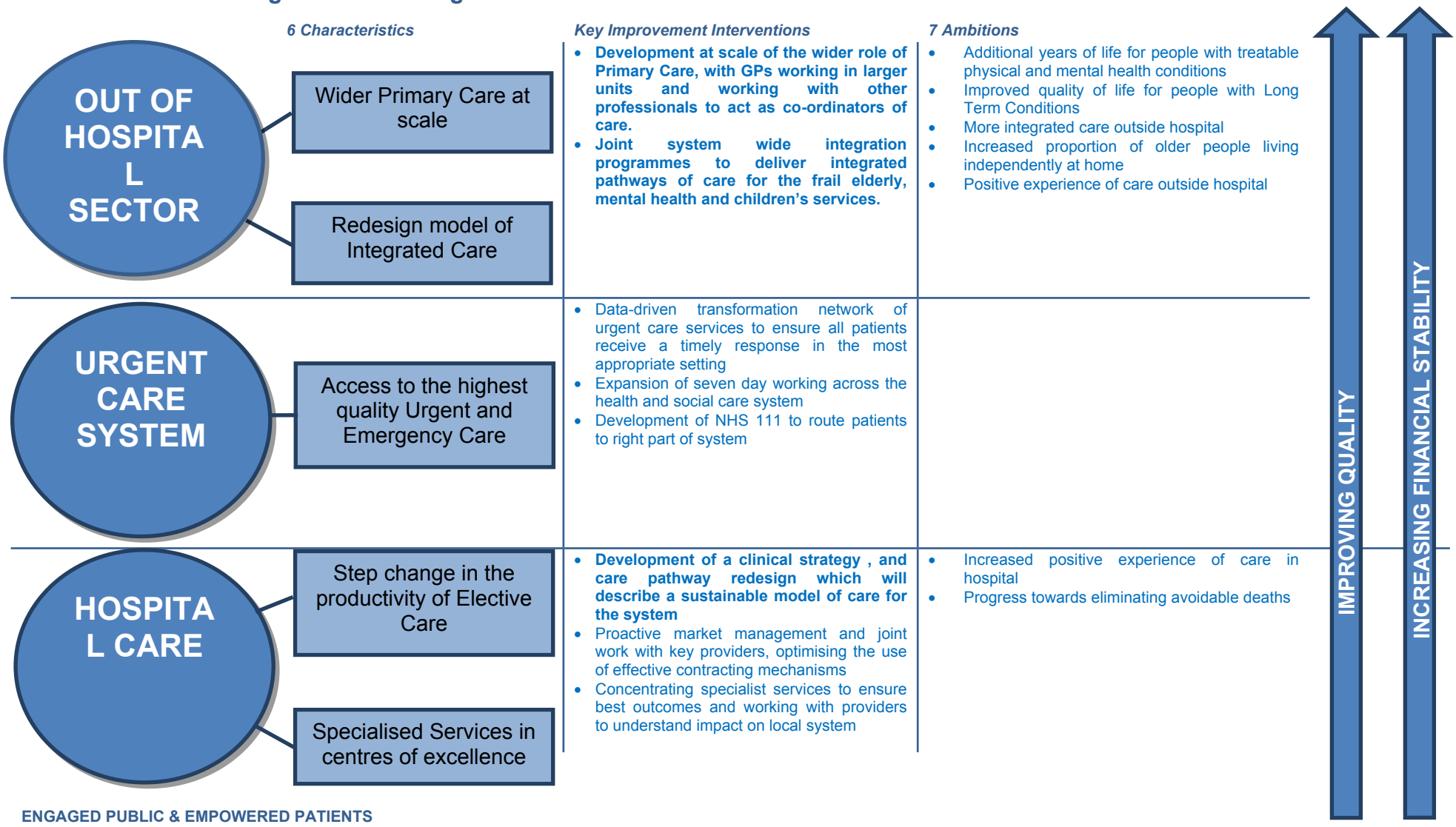
- To offer all children in West Berkshire the best start in life.
- To prolong life expectancy whilst maintaining a high quality of life in later years.
- To promote healthier lifestyles and positive mental health throughout the life course.
- To sustain thriving and supportive communities.
- To improve access to services through transport and opportunities to walk and cycle.
- To ensure the highest possible standards of health and social care service provision.
- To support programmes which support sustainable development.
- To focus activities on key settings for health, such as schools, workplaces, health and care establishments.



CCG Strategy

The local NHS commissioners in West Berkshire are Newbury and District CCG. This CCG works collaboratively with 2 CCGs in Reading and Wokingham CCG. This collaboration encompasses their strategic planning function and the recent produced strategic plan is included below, which summarises their key priorities.

Figure 17: Berkshire West CCGs Strategic Plan on a Page



Current Pharmacy Provision

As detailed above the core Pharmaceutical services are provided through the National Pharmacy Contract which has three tiers:

- Essential Services
- Advanced services
- Enhanced Services

This contract is managed by NHS England (Thames Valley Area Team locally).

However in addition community pharmacy can be commissioned by:

- CCGs - local commissioned services to support local needs and service transformation
- Local Authorities - locally commissioned services to support local needs

There are currently 29 pharmacies in West Berkshire and 162 across Berkshire. These provide the essential services and arrange of advanced and enhanced services. The types of business vary from multiple store organisations to independent contractors. There are two100 hour pharmacies in West Berkshire.

Pharmacy of course is also available at our Hospital sites across Berkshire: There are pharmacies at Wexham Park Hospital, Royal Berkshire Hospital and Frimley Park Hospital. These are open to 6pm on weekdays and limited hours at weekends. However, they only dispense hospital prescriptions and will not dispense FP10 Prescriptions (prescriptions that can be taken to any community pharmacy to be dispensed. They do not sell any products and do not offer any additional services to the public.

Essential Services

The following services form the core service provision required of all 29 West Berkshire pharmacies as specified by the NHS Community Pharmacy Contract 2013.

- **Dispensing** - Supply of medicines and devices ordered through NHS prescriptions together with information and advice to enable safe and effective use by patients. This also includes the use of electronic RX (electronic prescriptions). Community pharmacies support people with disabilities who may be unable to cope with the day-to-day activity of taking their prescribed medicines.
- **Repeat dispensing** – Management of repeat medication in partnership with the patient and prescriber.
- **Disposal of unwanted medicines** – acceptance (by community pharmacies) of unwanted medicines which require safe disposal from households and individuals.

- **Signposting** - The provision of information to people visiting the pharmacy, who require further support, advice or treatment which cannot be provided by the pharmacy.
- **Public Health promotion** – Opportunistic one to one advice given on healthy lifestyle topics such as smoking cessation.
- **Support for self care** - Opportunistic advice and support to enable people to care for themselves or other family members.
- **Clinical governance** – Requirements include use of standard operating procedures, ensuring compliance with the Disability Discrimination Act and following quality frameworks to ensure safe delivery of services.

Advanced Services

Currently the only Advanced Services which are commissioned nationally are Medicine Use Review (MUR), Appliance Use Review (AUR) and Prescription Intervention Service. The MUR and AUR services provided by pharmacists are to help patients in the use of their medication and appliances. An MUR includes what each medicine is used for, side effects and if the patient has any problem taking them. The Prescription Intervention Service is in essence the same as the MUR service, but conducted on an ad hoc basis, when a significant problem with a patient's medication is highlighted during the dispensing process.

Enhanced Services

The following enhanced services that are currently commissioned, as at August 2014 by:

Public Health within the council:

- **Supervised consumption** - This service requires the pharmacist to supervise the consumption of opiate substitute prescribed medicines at the point of dispensing in the pharmacy so ensuring that the dose has been administered to the patient.
- **Needle exchange** - The pharmacy provides access to sterile needles and syringes, and sharps containers for return of used equipment. The aim of the service is to reduce the risk of blood borne infections that are prevalent in people who inject drugs.
- **Chlamydia Screening** – Pharmacists supply Chlamydia Screening Postal Kits to any person aged between 15 and 24 upon request and will opportunistically offer Chlamydia Screening Postal Kits to young people attending the pharmacy who may be sexually active. This service aims to improve access to Chlamydia screening and so reduce the prevalence of Chlamydia.
- **Emergency Hormonal Contraception** - Pharmacists supply Emergency Hormonal Contraception (EHC) also known as the

'morning after pill', when appropriate to patients in line with the requirements of a locally agreed Patient Group Direction (PGD).

- **Smoking Cessation Services** – Working with the main provider of Smoking cessation services pharmacies provide a range of support including medication to people who want to give up smoking.
- **NHS Health Checks** - Pharmacies are commissioned to deliver NHS health checks to anyone aged 40 – 74, who does not have an existing cardiovascular condition. This provides the individual with an assessment of their risk on developing heart disease and allows signposting to GP follow up or health promotion services e.g. weight management/ smoking cessation

By the CCGs within Berkshire:

- **Palliative Care Urgent Drugs Scheme** - making available locally a list of medication that may be required urgently for palliative care patients. A number of pharmacies ensure they keep the items in stock and can be accessed out of hours if required.

Advice to care homes is not available through community pharmacy but is provided by the medicines management teams in each CCG. This service provides support to staff within care homes, over and above the Dispensing Essential Service, to ensure the proper and effective ordering of drugs and appliances and their clinical and cost effective use, their safe storage, supply and administration and proper record keeping. This service is to improve patient safety within the care home and to ensure the safe storage, supply and administration of medicines.

By NHS England:

- Flu Immunisation - A pilot scheme was developed to increase flu vaccination availability in high risk groups through community pharmacy. In 2014 this scheme is being extended across Berkshire.

Private Services**:**
Some pharmacies offer private services, which are not commissioned, but are available to customers for additional payment e.g. diabetes screening.

Pharmacy provision - current

Identified Health Needs	Current service provision Community pharmacy
Adults Self care	Signposting is part of core contract
	Medicine utilisation reviews
	Health promotion campaign part of core contract
Smoking	Solutions 4 Health sub contract
Alcohol	Pilot programme in pharmacies raising awareness of alcohol units
Cancer	Health promotion campaigns - bowel screening as part of core contract.
Cardiovascular disease	NHS health checks
Chronic Obstructive Pulmonary Disease (COPD)	Medicine utilisation reviews
Older people Winter excess death Winter warmth Flu Immunisations Falls	 Pilot of Flu immunisation to at risk groups
Dementia	Dementia Friends trained
Sexual Health	Emergency hormonal contraception Access to condoms - C Card scheme Signposting to Chlamydia screening
Substance misuse	Needle exchange Supervised consumption

Current Pattern of Enhanced services

For more details see Appendix 2.

Dispensing Practices

In addition to community pharmacies, to ensure access in defined rural areas (controlled localities) - GPs may provide dispensing services to patient who live more than 1.6km from a pharmacy. Across the UK nearly 3.8 million of these patients live remotely from a community pharmacy and at the patient's request dispensing doctors are allowed to dispense the medicines they prescribe for these patients. In total in the UK around 7% of all prescription items are dispensed by doctors.

Dispensary standards for doctors in England and Wales are set out in the Dispensary Services Quality Scheme (DSQS) which was agreed by the NHS, the General Practitioners' Committee and the Dispensing Doctors' Association, and introduced in 2006/07.

West Berkshire has 7 dispensing practices :

1. Lambourn Surgery, Brockhampton
2. Kintbury and Woolton Hill Surgery, Newbury Street
3. The Downland Practice, East Lane Surgery, Chieveley
4. Mortimer Surgery, Victoria Road, Mortimer
5. Theale Medical Centre, Englefield Road, Theale
6. Chapel Row Surgery, The Avenue, Bucklebury
7. Pangbourne Medical Practice, Boathouse Surgery, Pangbourne

There is one Essential small pharmacy local pharmacy service (ESPLPS) in West Berkshire:

- Downland Pharmacy, East Lane, Chieveley, Newbury, RG20 8UY

An ESPLPS pharmacy is open in a neighbourhood where it is not 'financially viable' to be open but it is in an area where it is believed that the local population require access to pharmacy services. The contract allows a subsidy to the pharmacy to remain open in that area depending on the level of prescriptions dispensed. The arrangements finish in March 2015.

Outside of area service providers

Residents can of course access pharmacies in other areas, and West Berkshire border with the following authorities:

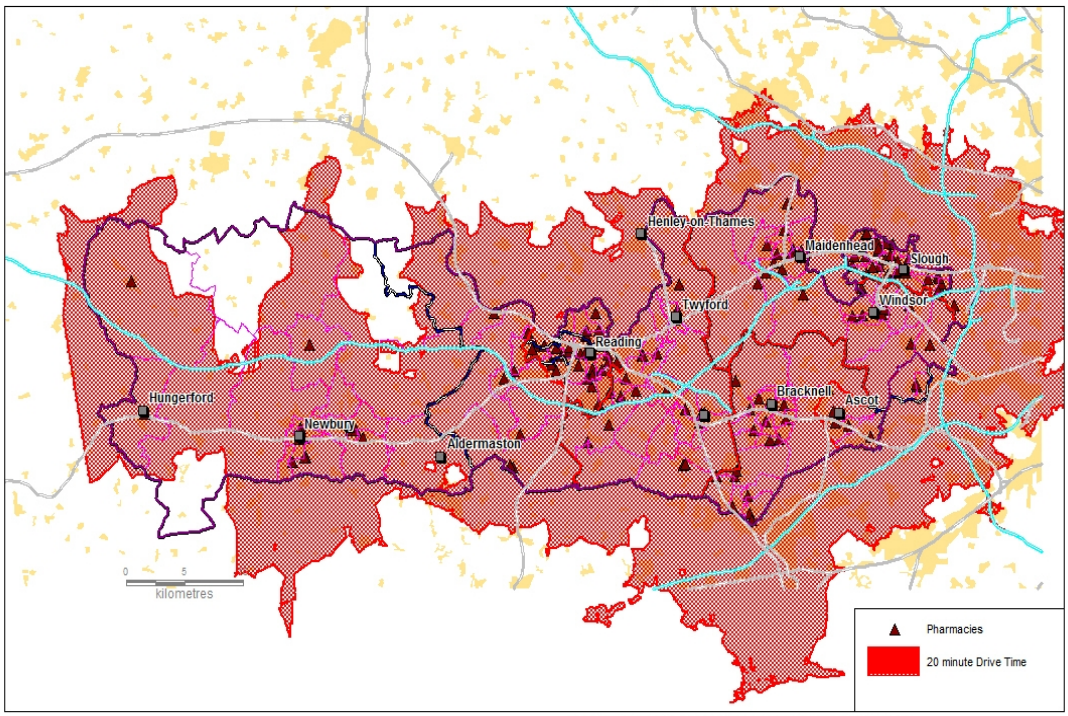
- Reading
- Hampshire
- Wiltshire
- Wokingham
- Oxfordshire

The map of provision shows the neighbouring pharmacies which are accessible to local residents. Information has been gathered on cross border services Appendix 1and appendix 3 .

Pharmacy Access and Services

One measure of accessibility is the number of patients that can get to a pharmacy or dispensing doctor within 20 minutes driving time (drive time calculated by software Chronomap)) see Figure 18. For West Berkshire it can be seen that not all of the population can access a pharmacist within this time. This reduced access typifies the challenges of a rural community.

Figure 18: Population of Berkshire that can get to a pharmacy within a 20-minute drive time



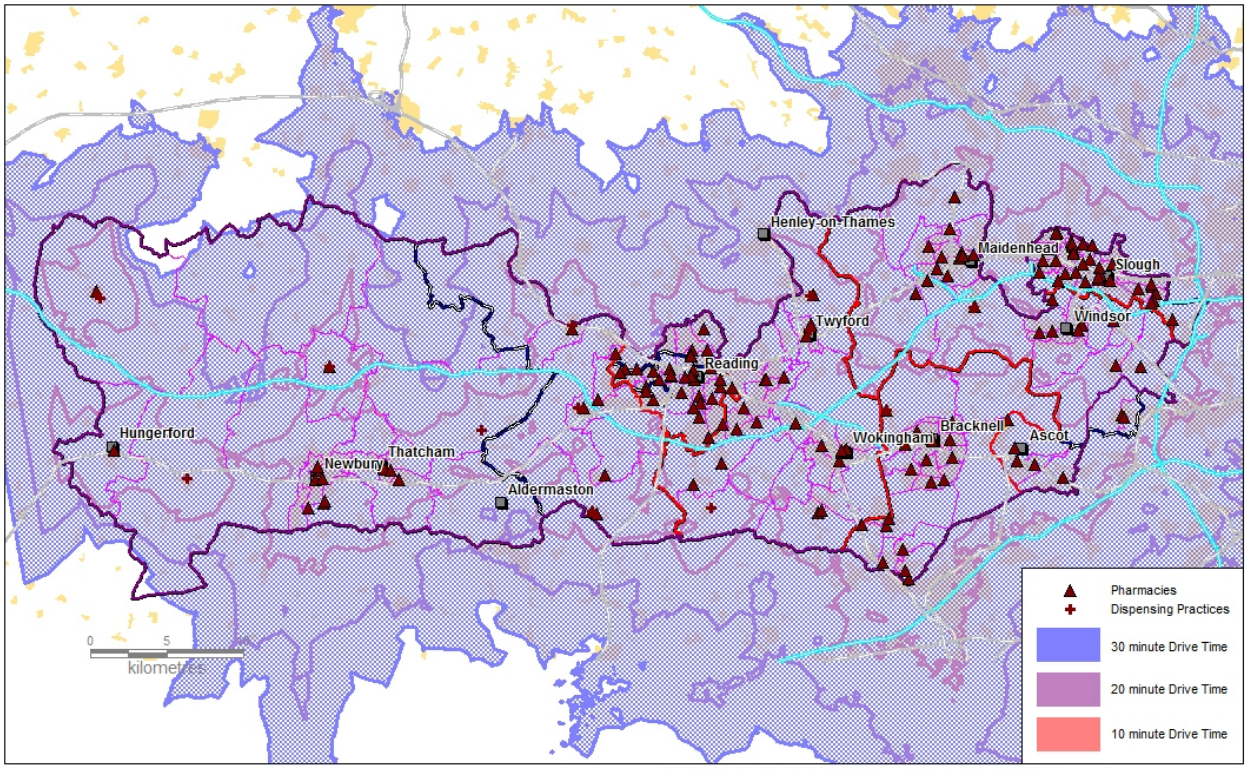
Berks_PNA_Apr14_v1.wor 15/05/2014 Sid Beauchant BHFT

The total population of West Berkshire in 2013 was 157,147 . If we model the numbers that might be affected by access issues then the estimated population affected is approximately 3,100 residents. The centres of population that are possibly not covered are places that are either within the gaps of 20 minute coverage, or on the border of them:

- Aldermaston - AWE
- Aldworth
- Ashampstead
- Brightwalton
- Combe
- Compton
- Frilsham
- Hampstead Norreys
- Welford
- Yattendon

Figure 19 shows the coverage of 30 minute drive times. The remaining gaps appear to have an estimated population of less than 100.

Figure 19: Population of Berkshire that can get to a pharmacy / dispensing doctor within a 30-minute drive time

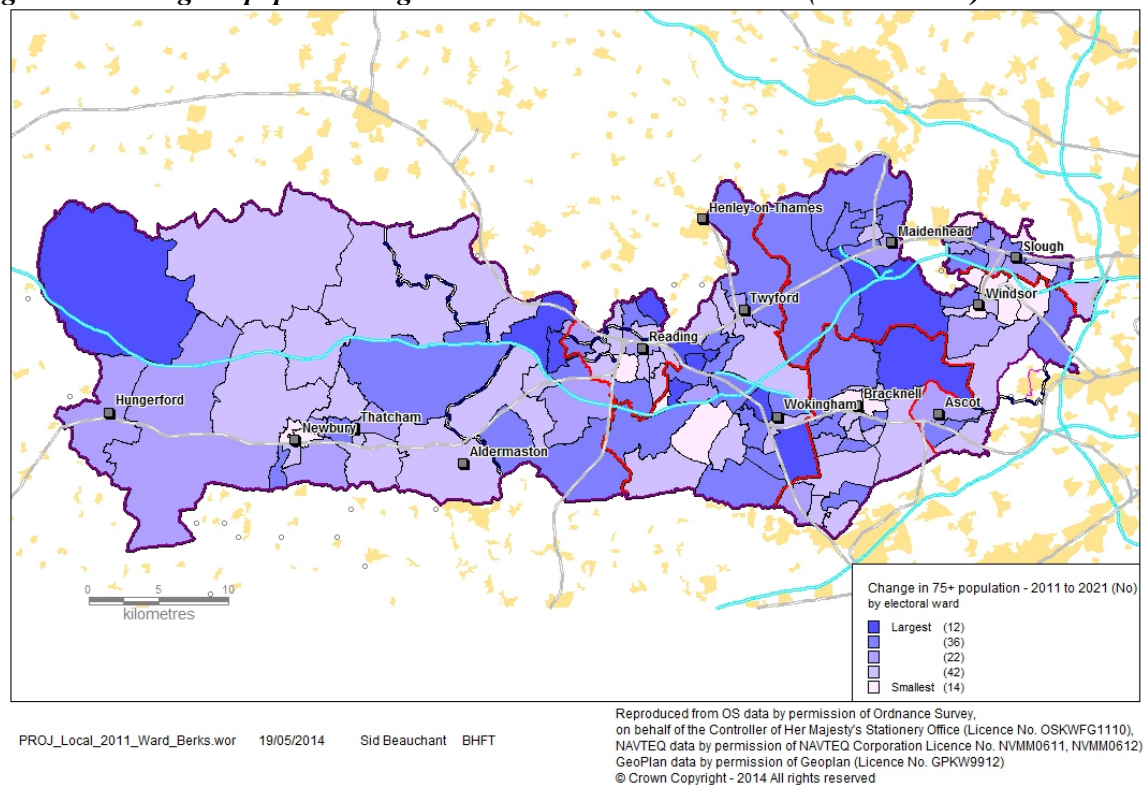


Berks_PNA_Jul14_v1.wor 14/07/2014 Sid Beauchant BHFT

Since access is usually more difficult for older residents we have mapped the wards where the largest percentage increase in residents over the age of 75 years is likely to occur. It should be noted that the limited access in the north boundary does impact on this ward.

(Appendix 3 - shows Berkshire access for a variety of drive times)

Figure 20: Change in population aged 75 and over within Berkshire (2011 to 2021)



Source: Office for National Statistics (2014)

Opening Hours

A survey was undertaken of all pharmacists in West Berkshire. 19 providers out of 29 providers took part on this survey. The following information is taken from the survey.

All providers are open Monday to Friday between 6 am and 11 pm depending on the day of the week. All bar one of the community pharmacies are open on Saturdays, with 6 open on a Sunday. In addition West Berkshire has two '100 hour per week' pharmacists. (See appendix 3 for full list of pharmacies with opening hours).

Consultation Facilities

To deliver the advanced services e.g. medicines utilisation reviews and to potentially support patients with more knowledge on their illnesses and increase patient confidence in self care, the pharmacist will need an area to provide this level of support in a confidential setting.

In West Berkshire 74% of providers have wheel chair accessible consultation facilities, an additional 22% have a consultation space however it is not wheel chair accessible. Only 4% do not have consultation space available.

Advanced Services

Within West Berkshire all respondents provide advanced services for medicines, though this is not the case for appliance care and customisation services.

Figure 21: West Berkshire Pharmacy response to question about the provision of advanced services

	Yes	Soon	No
Medicines Use Review service	19 (100%)	0 (0%)	0 (0%)
New Medicine Service	19 (100%)	0 (0%)	0 (0%)
Appliance Use Review service	3 (15.8%)	0 (0%)	16 (84.2%)
Stoma Appliance Customisation service	1 (5.3%)	0 (0%)	18 (94.7%)

Additional language availability

There are only a few additional languages spoken in West Berkshire.

Collection and Delivery Services

Many patients with long term conditions have ongoing medication requirements. For them collection and delivery services may be crucial for accessing their prescriptions – having the prescription collected from the GP surgery and then delivered to their home.

95% of pharmacists in West Berkshire offer free prescription collection from the surgery services. In addition 85% of community pharmacies offer free delivery to patients when requested usually to patients with limited mobility.

IT connectivity

IT connectivity refers to the ability of the pharmacy to link to the NHS information systems so allowing easier transfer of information e.g electronic prescriptions

Moving forward service integration will require sharing of information and so it will become increasingly important for pharmacy to have IT connectivity if they are to play a role in transformed services. 95% of pharmacies in West Berkshire have IT connectivity with additional 5% planning connectivity in the next year.

Analysis of user survey

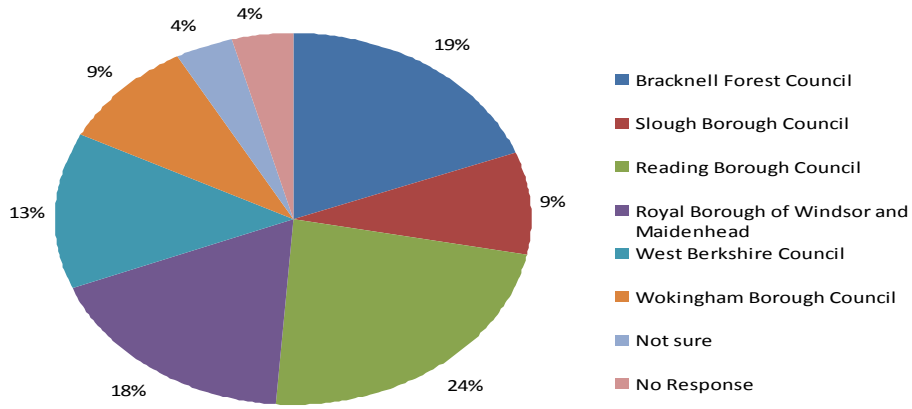
A key part of the PNA is to obtain the views of residents who use our community pharmacy and dispensing doctor services.

The survey was circulated in a number of ways. The survey was available at all of the local community pharmacists; the anonymous paper based surveys were then collected from these locations by courier. In addition the survey was available electronically on the Council's website. Posters in the pharmacies and press releases in the local papers tried to increase local awareness of the survey and to encourage participation.

Respondents

The survey was sent out across Berkshire, with 2,048 people responding. The responses by Local Authority are shown below.

Figure 22: Which local authority area do you live in?



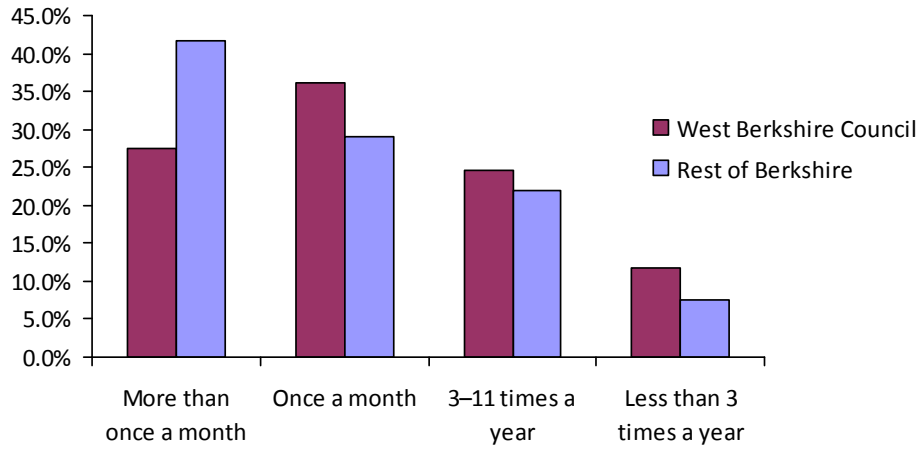
In West Berkshire there were 275 responses making up 13% of the total replies. Of these 93% were from respondents that classed themselves as white British and 3% as white other. The most common age groups that responded in West Berkshire was 45-54 year (27%) and 22% being aged 55-64 years. 17% of respondents were aged over 65 years

Pattern of use

Residents were asked what services they used: 93% replied that they used community pharmacy, 3% a dispensing appliance supplier (someone who supplies appliances such as incontinence and stoma products) and 4% internet pharmacy. These results show a similar pattern of use to the rest of Berkshire.

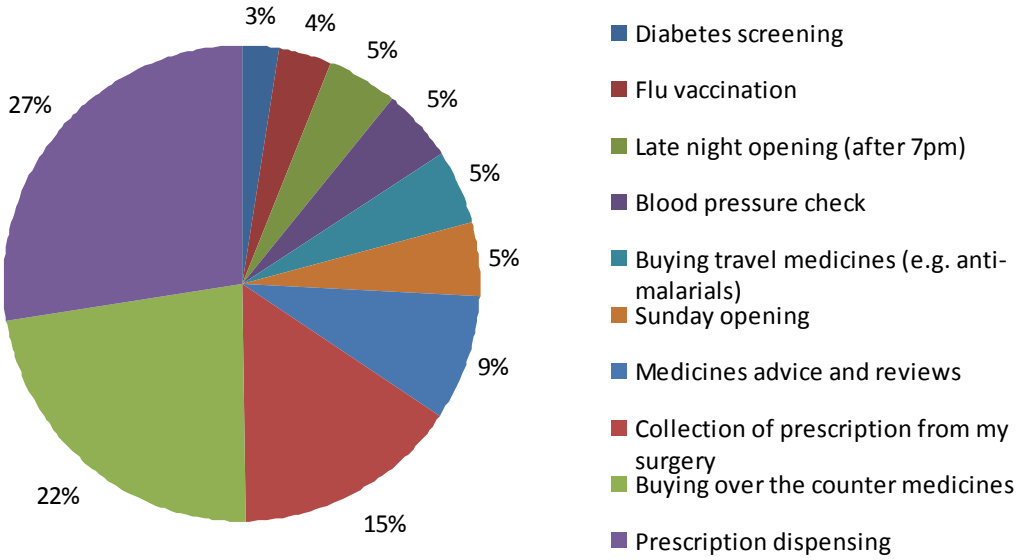
When residents were asked how often they used a community pharmacy they gave the following replies, which shows a lower usage in the "more than monthly" category than the rest of Berkshire.

Figure 23: How often do you use a pharmacy?



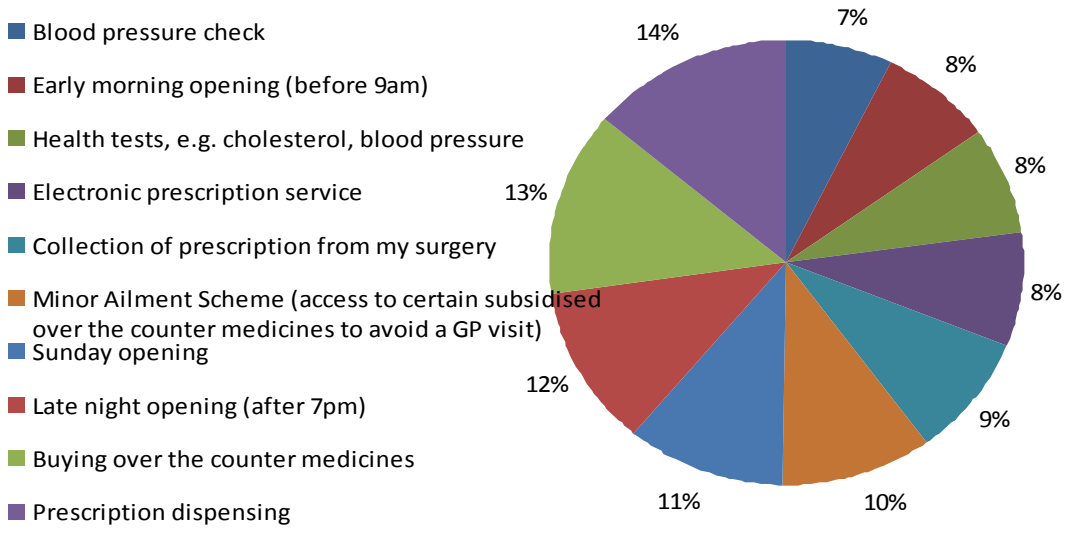
Additionally residents were asked about the type of services they currently use at their local pharmacy: As could have been expected the most common reason is to get prescriptions dispensed (27%) and buying over the counter medicines (22%). The results show how the respondents value to (voluntary) collection of prescription service provided by pharmacists (15%)

Figure 24: Which of the following service do you currently use at a pharmacy?



We also asked respondents' about the type of services they would like to see at a community pharmacy, whilst dispensing and medicines are still important and respondents wish to see extended opening times, 12% would like to see late night opening, 8% early morning opening and 11% Sunday opening.

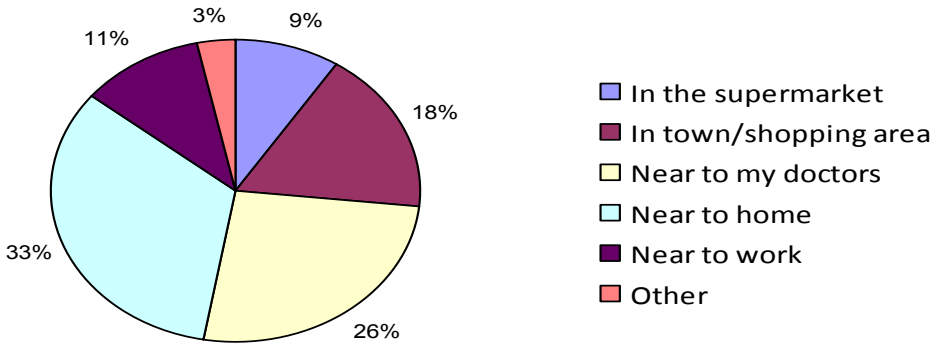
Figure 25: Which of the following services would you use at a pharmacy, if available? (Top 10 responses)



Access to pharmacy

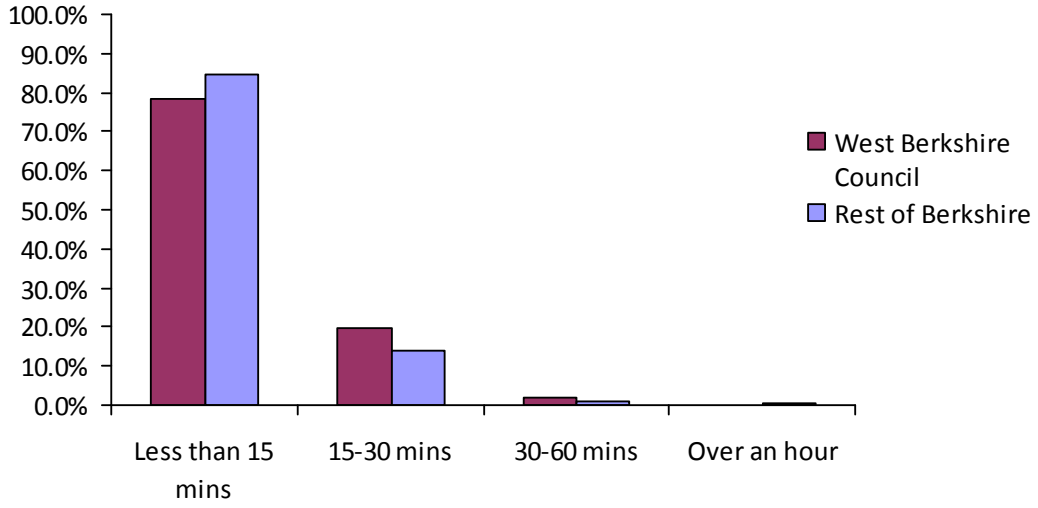
Respondents state they have good access to services with 97.5% being able to access the pharmacy of their choice. The commonest reason for choice of pharmacy service was proximity to home (33%) with 26% stating that proximity to GP was the key factor , however respondents in West Berkshire show the highest response in the town centre access category being important in comparison to the rest of Berkshire (18%).

Figure 26: Reason for choice of pharmacy



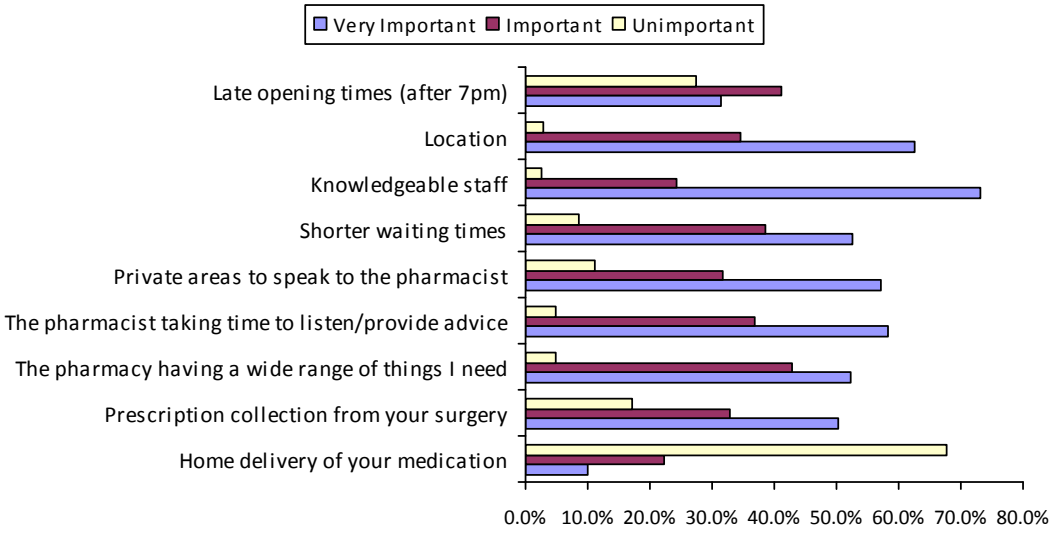
More respondents' access pharmacy on foot (52%) with 40% using the car. 79 % of respondents can access services within 15 minutes and 20% within 15-30 minutes.

Figure 27: How long does it take you to travel to your pharmacy?



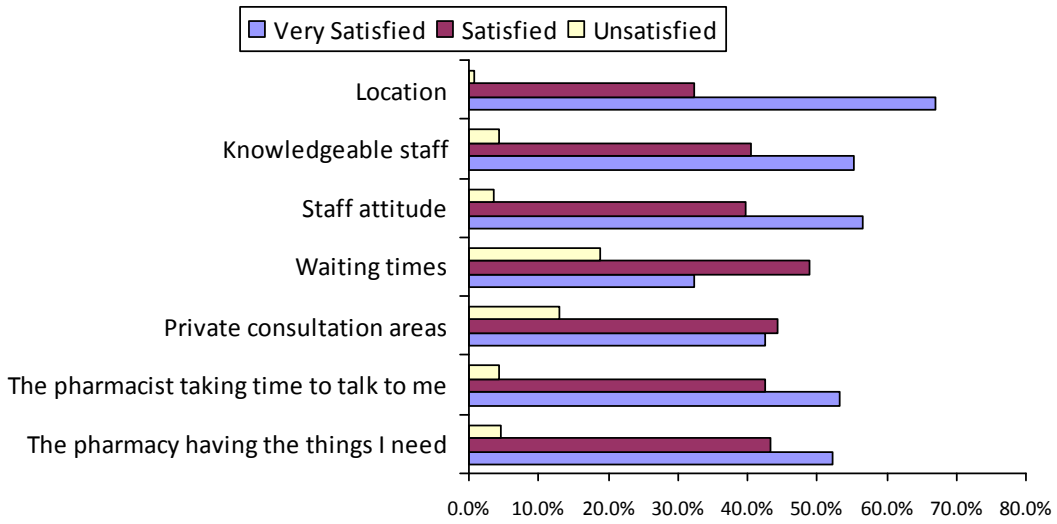
We asked respondents to rate the importance of the various services that pharmacies offer. The availability of knowledgeable staff is important closely followed by location.

Figure 28: How important are the following pharmacy services?



The final section of the survey tested the respondent's satisfaction with services. As has been seen there is a generally high level of satisfaction across most areas, the lowest level of satisfaction was with the waiting times and private consultation space – for waiting time 19% expressed dissatisfaction and consultation space 13%. These are the highest levels of dissatisfaction seen across Berkshire.

Figure 29: How satisfied were you with the following services at your regular pharmacy?



Recommendations

The regulations governing the development of pharmaceutical needs assessments requires an assessment of pharmaceutical services in terms of:

- Services currently commissioned that are necessary to meet a current need
- Services not currently commissioned that may be necessary in specified future circumstance
- Services not currently commissioned that may be relevant in the future because they would secure improvements or better access to pharmaceutical services to address needs identified in the population.

Essential services

In order to assess the provision of essential services against the needs of our population (Appendix 6) we mapped and assessed the location of pharmacies and dispensing doctors, their opening hours and the provision of other dispensing services. See Appendix 1. These are the factors that we consider to be key factors in determining the extent to which the current provision of essential services meets the needs of our current population.

Access

Current pattern of services provides good physical access to patients; however there are some gaps in this coverage. The 20 minute drive time modelling shows that approximately 3,000 residents are affected under this measure of access. In a rural areas access to services is a characteristic issue. If we look at 30 minute drive times then the numbers affected become very small.

However West Berkshire is also an older population and we therefore looked at wards where the greatest percentage rise in over 75 year's olds is predicted to occur, and this did coincide with one of the areas of poorer coverage. However in West Berkshire 86%. of pharmacy respondents offer free delivery services (not a contractual requirement) which of course minimises the access problems currently.

In future the population growth is not predicted to cause any gaps in pharmacy provision across West Berkshire.

Opening Hours

All providers are open Monday to Friday between 9 am and 5 pm depending on the day of the week. The majority open on Saturdays (only one is closed), with 6 open on a Sunday. In addition West Berkshire has two '100 hour per week' pharmacists. Currently the hours of opening in General Practice are matched by the opening hours of the local pharmacies (see appendix 3), with dispensing doctors ensuring pharmaceutical services in their surgery times.

In future with the extension of General practice working week then consideration may need to be given to extending the numbers of pharmacist open outside the normal working week to ensure access pharmacy support .

However the move to extended working for general practice could make week-end opening a key feature in future - a factor that could be explored in developing local commissioned services.

Patient views

93% of respondents used community pharmacy. The user survey shows that respondents are generally very satisfied with pharmacy services in the borough. 97% are able to access the pharmacy of their choice, with 79% being able to access services within 15 minutes. The lowest levels of satisfaction were seen with private consultation space and waiting times waiting time - 19% expressed dissatisfaction with waiting times and consultation space 13%, which are the highest levels of dissatisfaction expressed in Berkshire

Conclusion - Essential services

Overall the findings show that the pharmacy services currently provided are comprehensive and address the needs of West Berkshire residents. However the need for week end opening may need to be reviewed as General Practice extends its working week, though there are no gaps predicted during the period of this PNA.

In addition it is noted that in both the Health and Well being Strategy and the CCG commissioning plans there is a focus on self care, health promotion and early intervention services. In essence making it easier for residents to access information to understand and manage their own condition with expert professional advice and intervention as needed. Pharmacists have a key role to play in this and as this is a core essential service we would encourage all commissioners to work collaboratively with community pharmacy in this endeavour.

- Promotion of healthy lifestyles
- Prescription linked interventions
- Public health campaigns
- Signposting
- Support for self care

Advanced services

The advanced services are:

- Medicines Use Review and Prescription Intervention (MURs)
- New medicines management service (NMS)
- Appliance Use Reviews (AURs)
- Stoma Appliance Customisation Services (SACs)

These services aim to improve patients' understanding of their medicines; highlight problematic side effects & propose solutions where appropriate; improve adherence; and reduce medicines wastage, usually by encouraging the patient only to order the medicines they require and highlighting any appropriate changes to the patient's GP to change their prescription.

An important feature in the provision of advanced services is the provision of consultation areas within pharmacies; this was explored in some depth in the pharmacy contractor survey. 95% of pharmacies in West Berkshire provide access to consultation areas. In addition there is good provision of MUR services, 100% of respondents provide medicines support particularly relevant to residents with long term conditions.

Conclusion - advanced services

Again the purpose of advanced services fits well with the local population and the increasing numbers of residents with ongoing conditions and fits with the Health and Wellbeing Strategy and CCG strategic plans.

Pharmacists through their role in dispensing and MUR services can identify key residents at risk of complications and support their care. Work could continue with our pharmacy contractors to develop commissioned extensions to MUR services to widen access and target provision with high priority patient groups, for example: patients at risk of falls as an identified need. In future with the growth in long term conditions predicted a growth in the current limit on the MUR services able to be supplied by pharmacists may be required - the current limit is 400 per pharmacy.

We will also work with pharmacy contractors, the LPC and LMC to improve understanding and awareness of MUR among patients and the public.

Locally Commissioned Services

Whilst it seems that there are sufficient numbers of pharmacies within West Berkshire the JSNA has identified a number of needs that in the future pharmacists could potentially address. The table below shows identified health needs that could be addressed through commissioning of pharmaceutical services, subject to a robust business case and contractual negotiations.

Figure 30: Summary of identified health needs and potential developments in West Berkshire

Identified Health Needs	**Current service provision Community pharmacy**	**Potential community pharmacy development**
Adults Self care	Signposting is part of core contract	Strengthen use of community pharmacy as information hub for community contact - access to voluntary sector groups, exercise advice, etc. "Making every contact Count" – building on the home delivery services offered (but not a contractual element) through many pharmacies to identify frail patients at risks and support preventative integrated care
	Medicine utilisation reviews	To build on MUR and support wider information on the specific illness / motivational interviewing etc – e.g diabetes, respiratory illness
	Health promotion campaign	Develop skills to increase capacity of pharmacies teams to provide information and support healthy lifestyle choice - Making every contact count
Smoking	Solutions 4 Health sub contract	Widen participation of community pharmacy
Alcohol	Pilot programme in pharmacies raising awareness of alcohol units	Expansion of this programme into a full Alcohol Intervention and Brief Advice Service
Cancer	Health promotion campaigns - bowel screening as part of core contract.	Build on dispensing opportunities to identify worrying symptoms to sign post to care
Cardiovascular disease	NHS health checks	Expansion of provision

Identified Health Needs	Current service provision Community pharmacy	Potential community pharmacy development
		within the communities focussing on the more deprived communities
Chronic Obstructive Pulmonary Disease (COPD)	Medicine utilisation reviews	Develop capacity and techniques to support inhaler technique
Older people Older people Winter excess death Winter warmth Flu Immunisations Falls	Signpost vulnerable groups to support services Pilot of Flu immunisation to at risk groups	Widen availability of flu immunisation to all groups Screen people on high risk medication to give targeted support and signposting
Sexual Health	Emergency hormonal contraception Access to condoms - C Card scheme Chlamydia screening and treatment by PGD	
Substance misuse	Needle exchange Supervised consumption	PGD - naloxone therapy HIV Screening Hep B&C Testing and treatment

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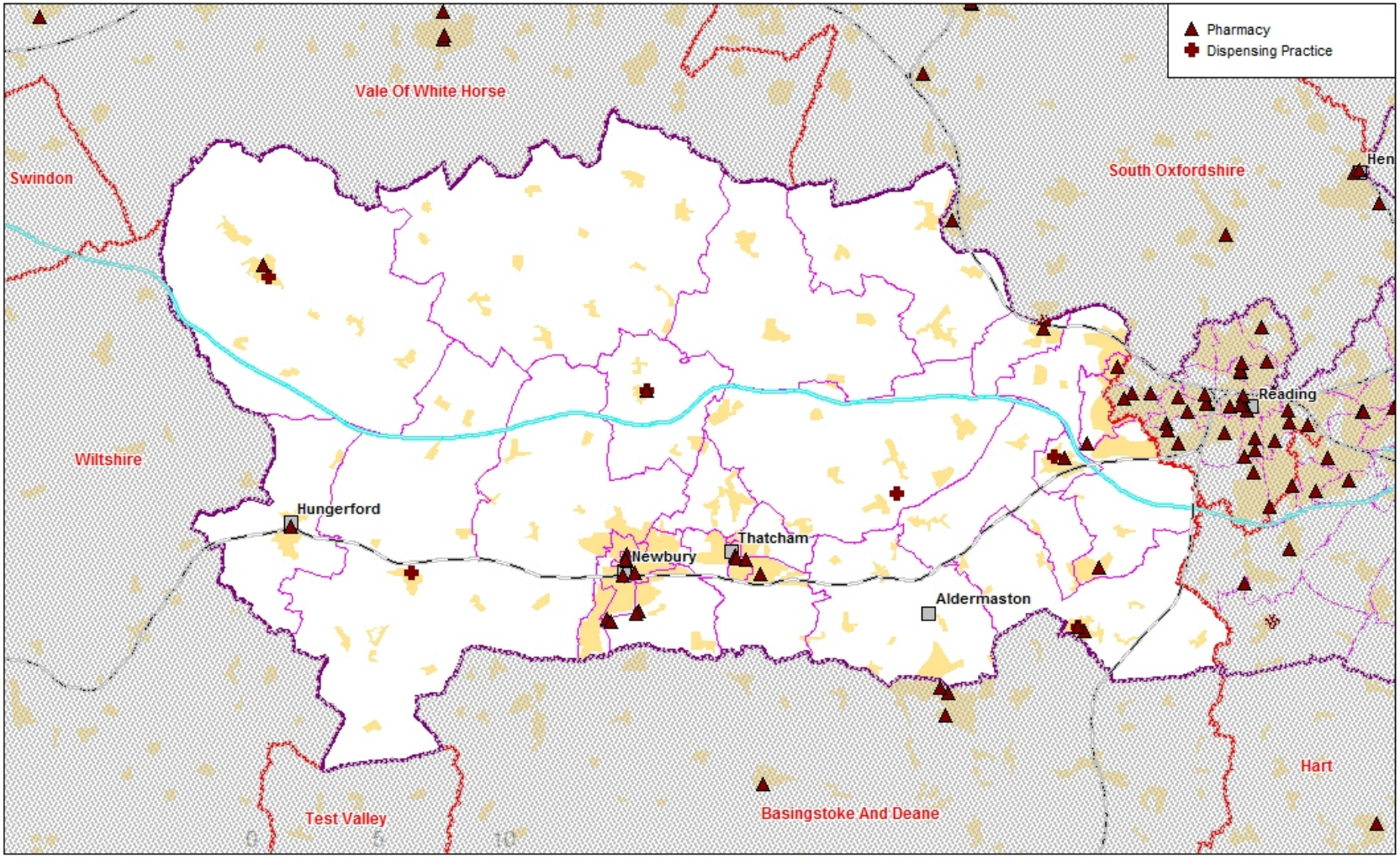
Appendix 1: Map of Pharmacy Services in West Berkshire

Figure 1: Map of Pharmacies and Dispensing Practices in West Berkshire



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ID	CODE	TRADING NAME	ADDRESS	TOWN	POSTCODE
N01	FC776	Boots the Chemists	125 High Street	Hungerford	RG17 0DL
N02	FCT83	Lloyds Pharmacy	3 The Square	Pangbourne	RG8 7AQ
N03	FDN76	Downland Pharmacy	East Lane, Chieveley	Newbury	RG20 8UY
N04	FE788	Boots the Chemists	Thatcham Medical Practice, Bath Road	Thatcham	RG18 3HD
N05	FEJ88	Sainsbury's Pharmacy	Savacentre, Bath Road, Calcot	Reading	RG31 7SA
N06	FFT63	Burghfield Pharmacy	Reading Road, Burghfield Common	Burghfield	RG7 3YJ
N07	FJV60	Boots the Chemists	4-5 Northbrook Street	Newbury	RG14 1DJ
N08	FK567	Tesco Pharmacy	Pinchington Lane	Newbury	RG14 7HB
N09	FL172	Wash Common Pharmacy	Monks Lane	Newbury	RG14 7RW
N10	FLP66	Mortimer Pharmacy	Mortimer Surgery, 72 Victoria Road	Mortimer	RG7 3SQ
N11	FM678	Overdown Pharmacy	Overdown Pharmacy 5 The Colonnade	Tilehurst	RG31 6PR
N12	FN512	Superdrug Pharmacy	81-82 Northbrook Street	Newbury	RG14 1AE
N13	FP041	Boots the Chemists	Newbury Retail Park, Pinchington Lane	Newbury	RG14 7HU
N14	FPC92	Boots the Chemists	82-83 Bartholomew Street	Newbury	RG14 5EF
N15	FQD69	Lloyds Pharmacy	Unit 2, Burdwood Centre	Thatcham	RG19 4YA
N16	FRR59	Lloyds Pharmacy	24 West End Road	Mortimer	RG7 3TF
N17	FT063	Lambourn Pharmacy	The Broadway	Lambourn	RG17 8XY
N18	FTJ67	Lloyds Pharmacy	3-5 Crown Mead, Bath Road	Thatcham	RG18 3JW
N19	FVP85	Sainsbury's Pharmacy	Hectors Way	Newbury	RG14 5AB
N20	FWP83	Lloyds Pharmacy	27 High Street	Theale	RG7 5AH
N21	FWX13	Day Lewis Rankin Pharmacy	12 The Broadway	Newbury	RG14 1BA
N22	FXR54	Lloyds Pharmacy	7 Kingsland Centre	Thatcham	RG19 3HN
Dispensing Practices					
N23	K81052	Lambourn Surgery	Brockhampton Road	Lambourn	RG17 8PS
N24	J82054	Kintbury & Woolton Hill Surgery	Newbury Street	Kintbury	RG17 9UX
N25	K81050	Downland Practice	East Lane	Chieveley	RG20 8UY
N26	K81103	Chapel Row Surgery	The Avenue	Bucklebury	RG7 6NS
N27	K81012	Pangbourne Medical Practice	Boathouse Surgery	Pangbourne	RG8 7DP
N28	K81077	Theale Medical Centre	Englefield Road	Theale	RG7 5AS
N29	K81027	The Mortimer Surgery	Victoria Road	Mortimer	RG7 3SQ

Appendix 2: Enhanced Services in West Berkshire

Figure 1: Map of Pharmacies in West Berkshire who provide GUM Services

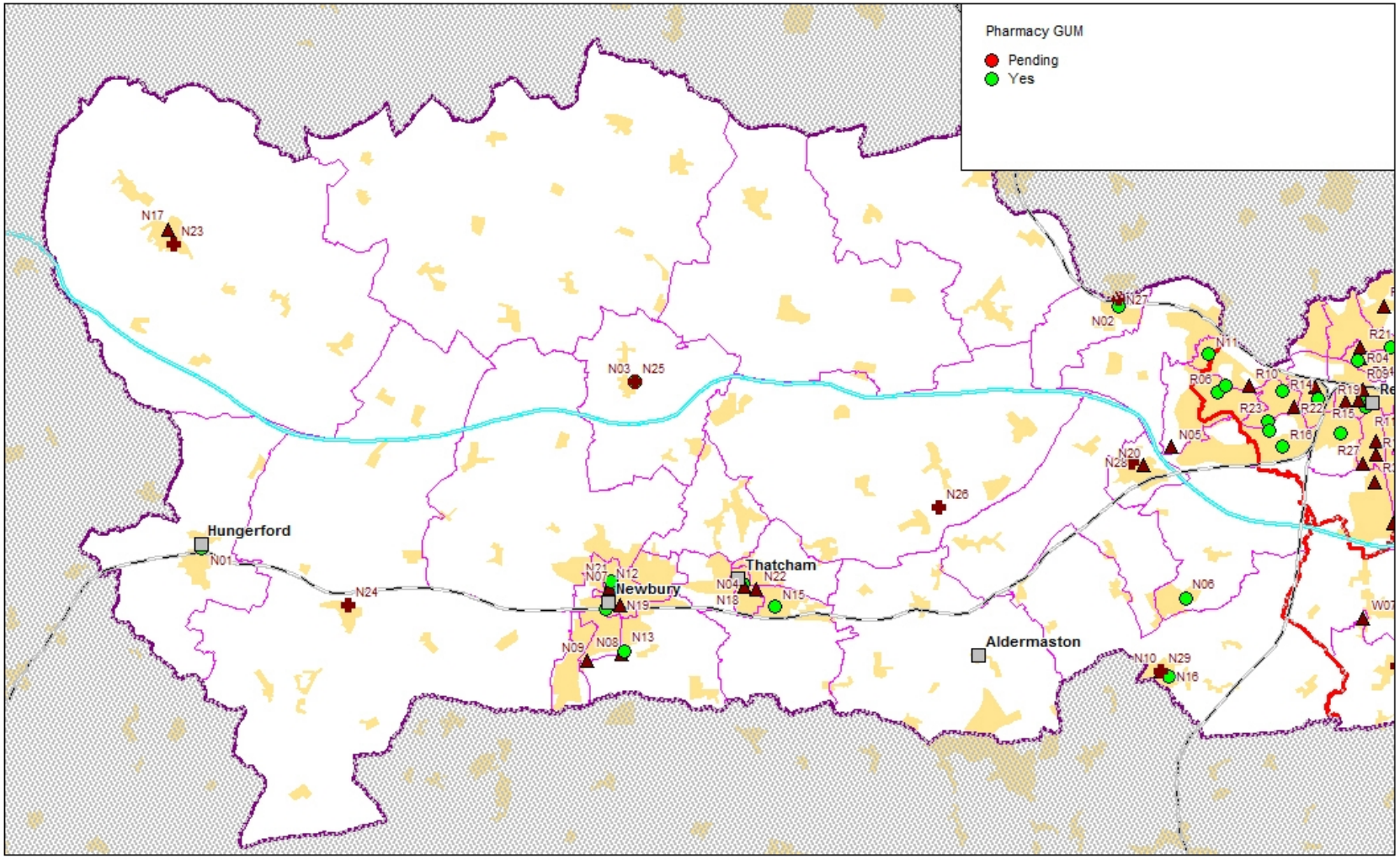

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Figure 2: Map of Pharmacies in West Berkshire who provide Needle Exchange Services

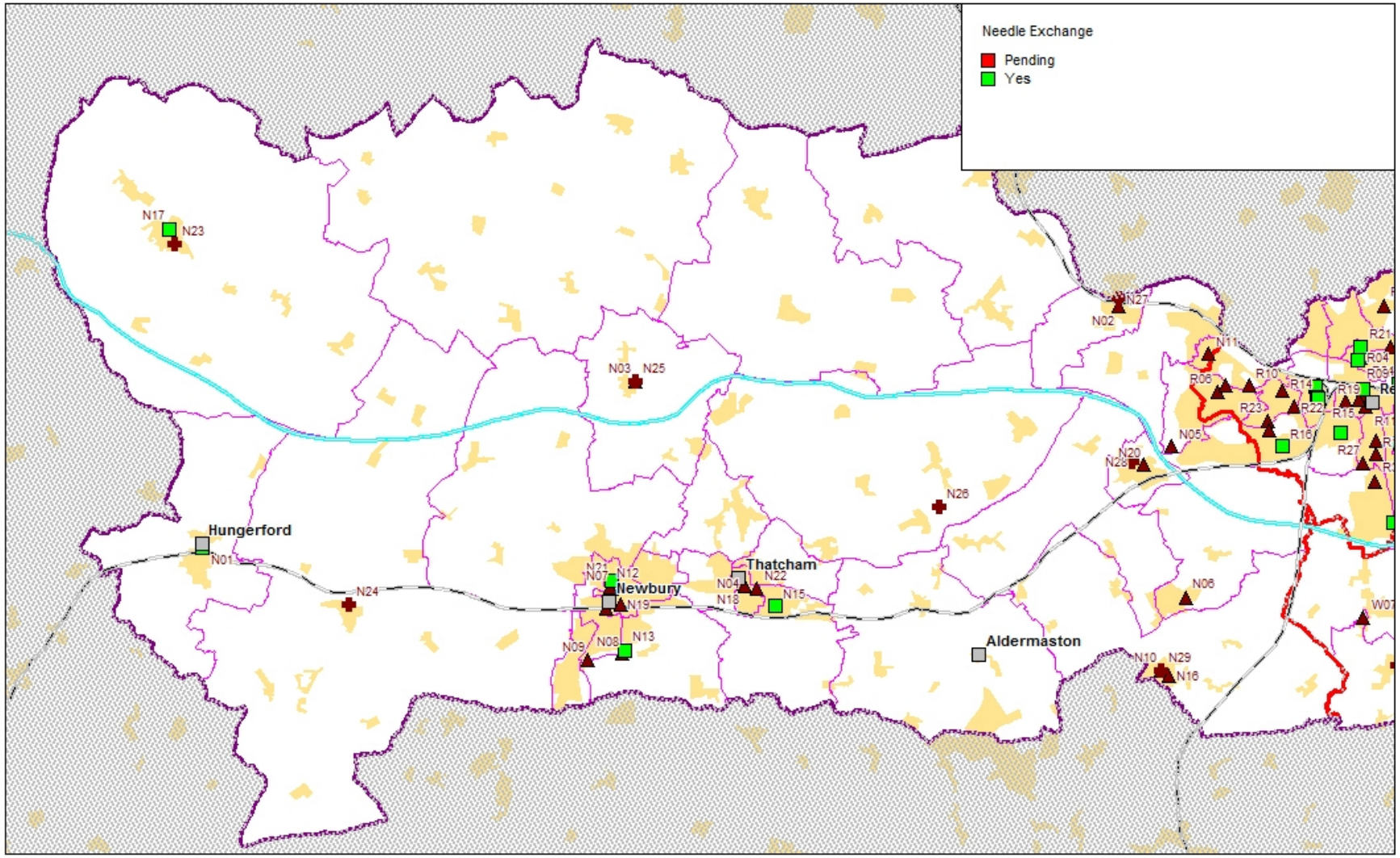

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Figure 3: Map of Pharmacies in West Berkshire who provide Supervised Consumption Services

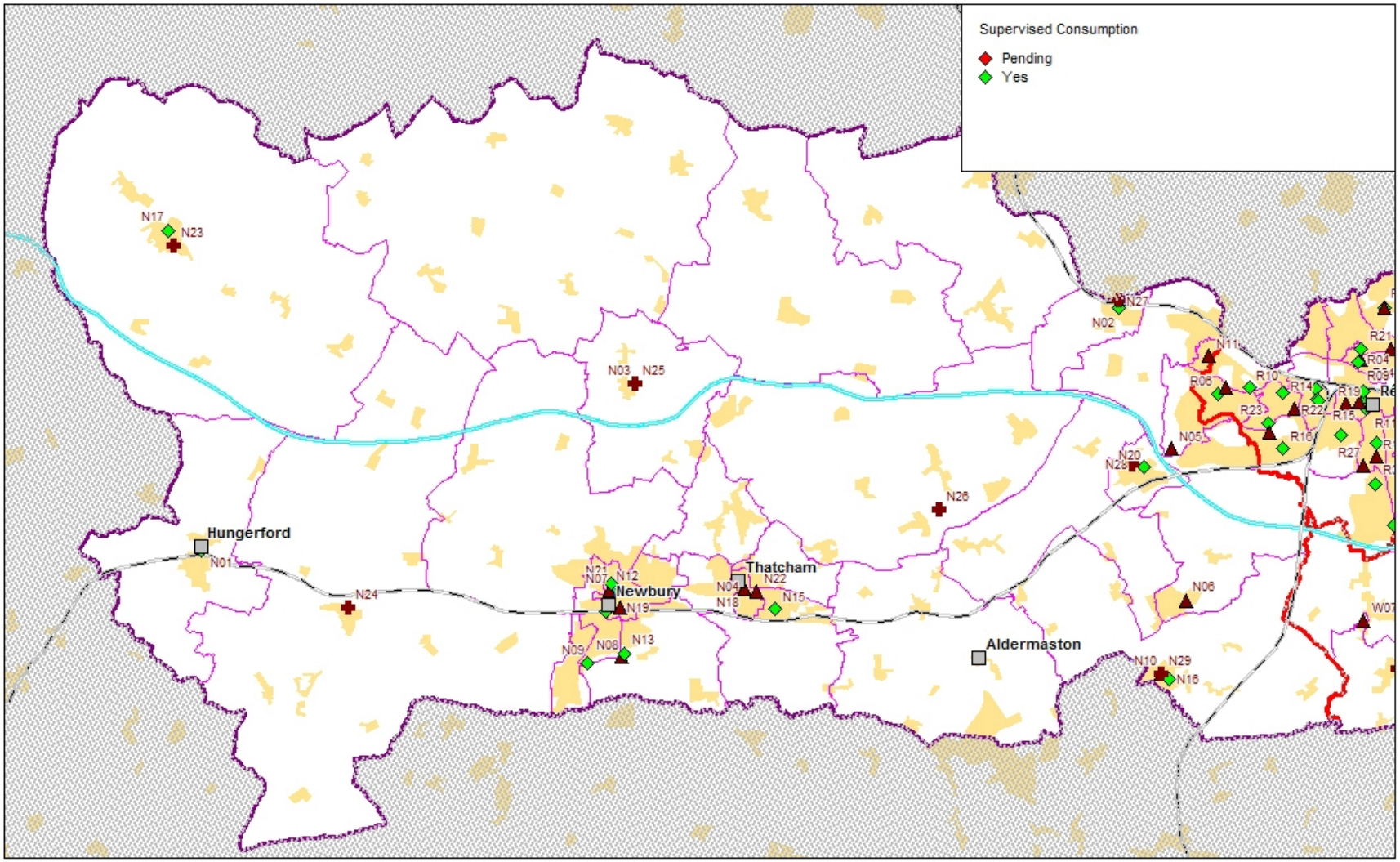

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Figure 4: Map of Pharmacies in West Berkshire who provide the NHS Health Check Programme

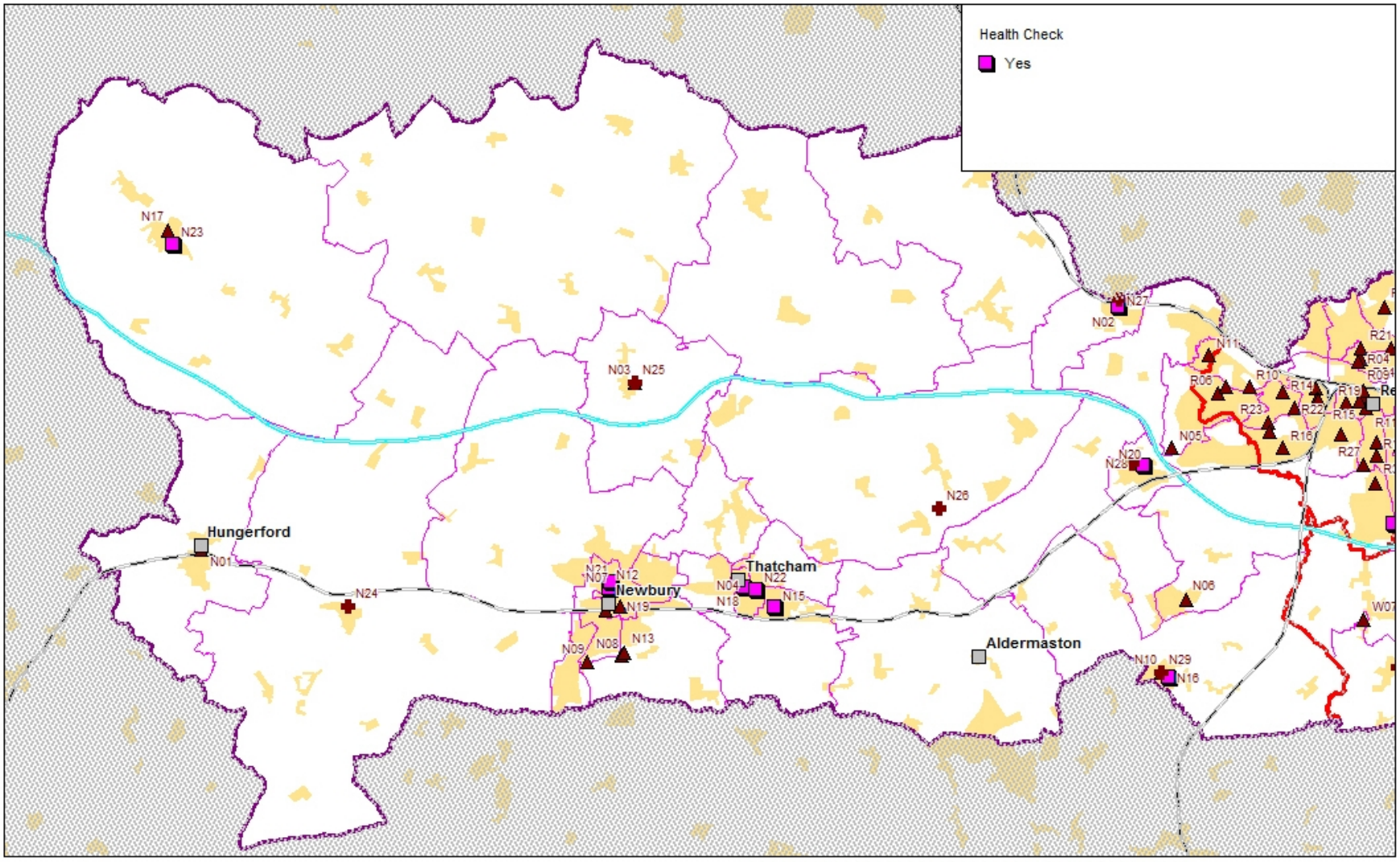

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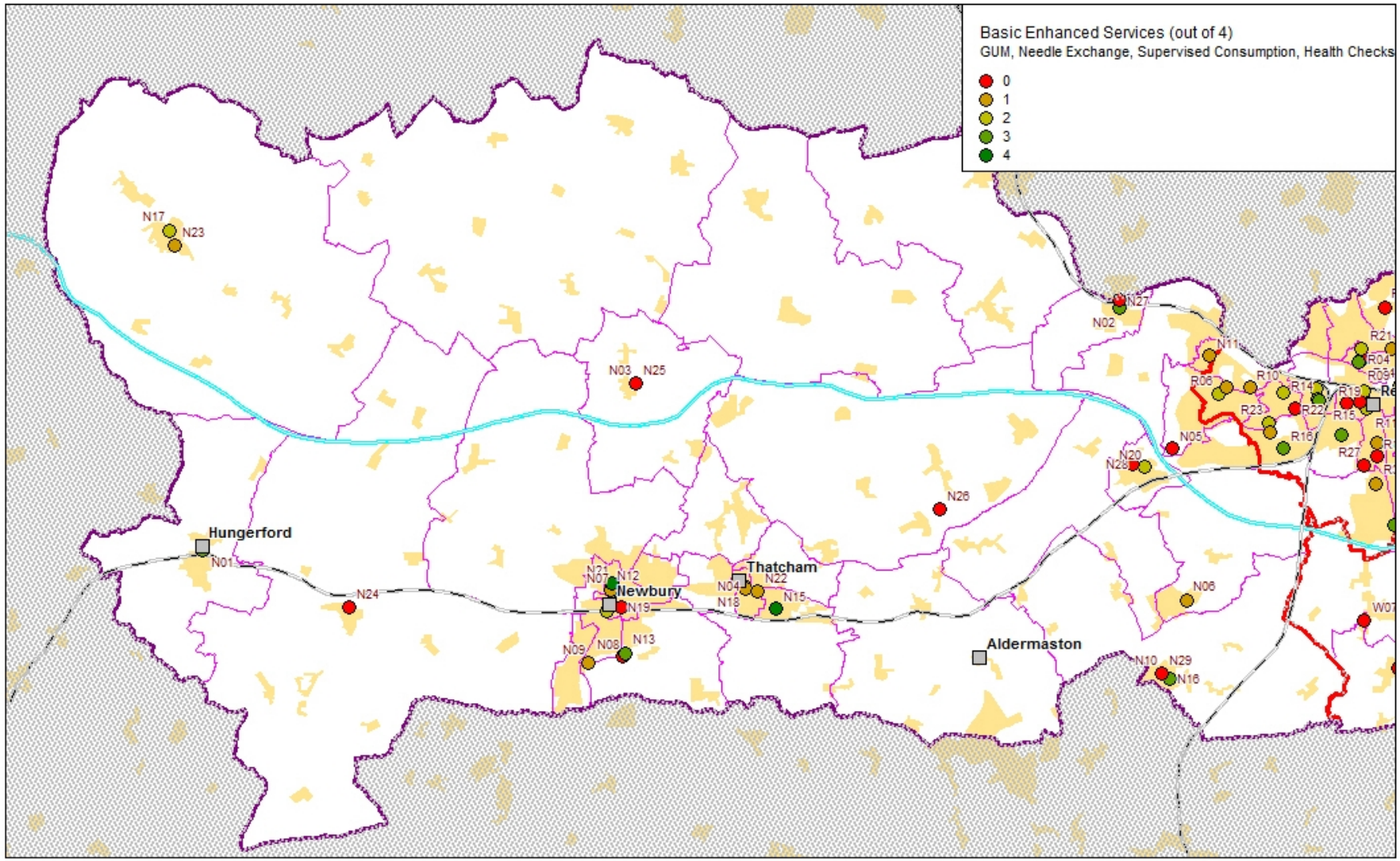
Figure 5: Map of Pharmacies in West Berkshire to show how many of the Basic Enhanced Services are provided



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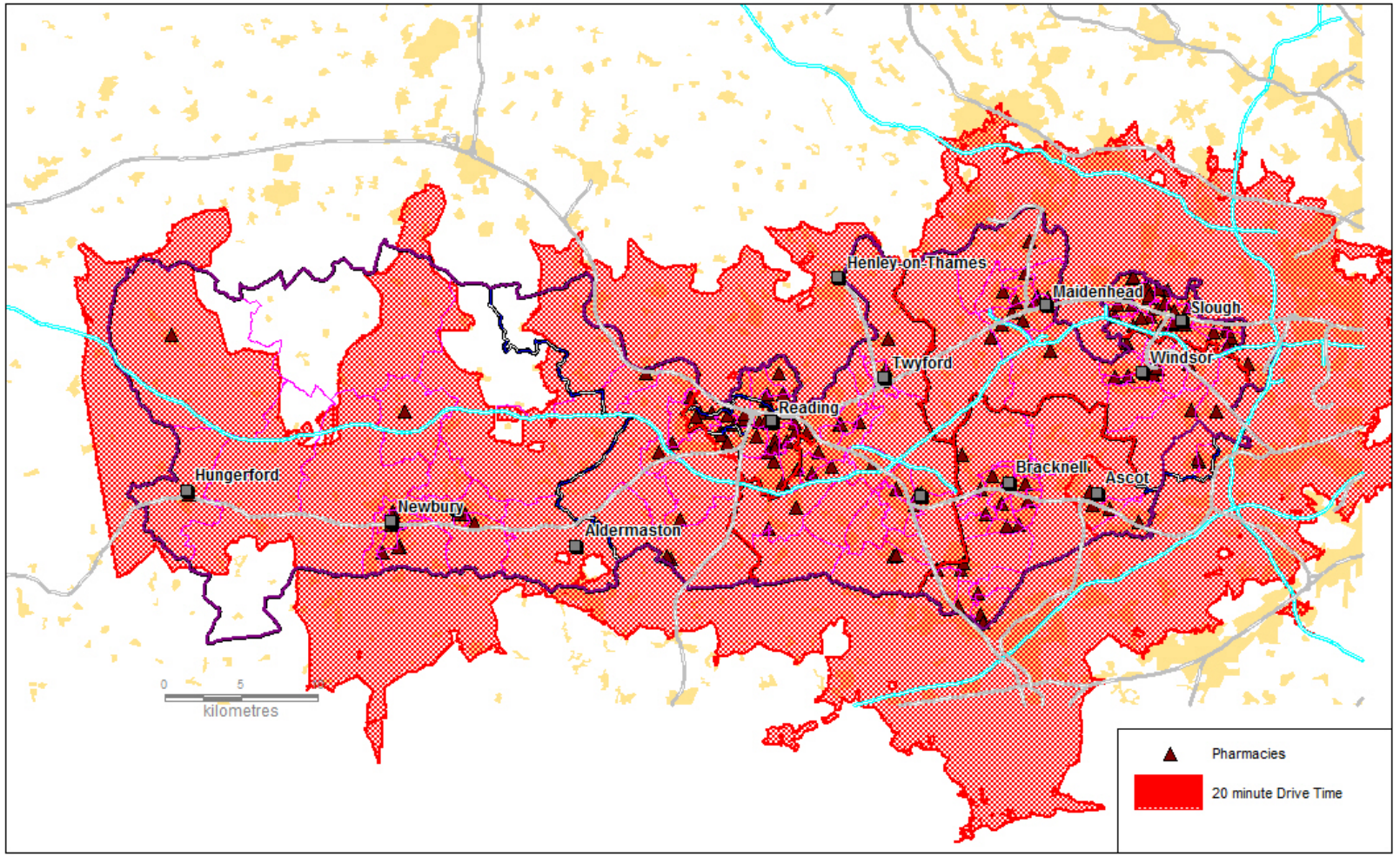
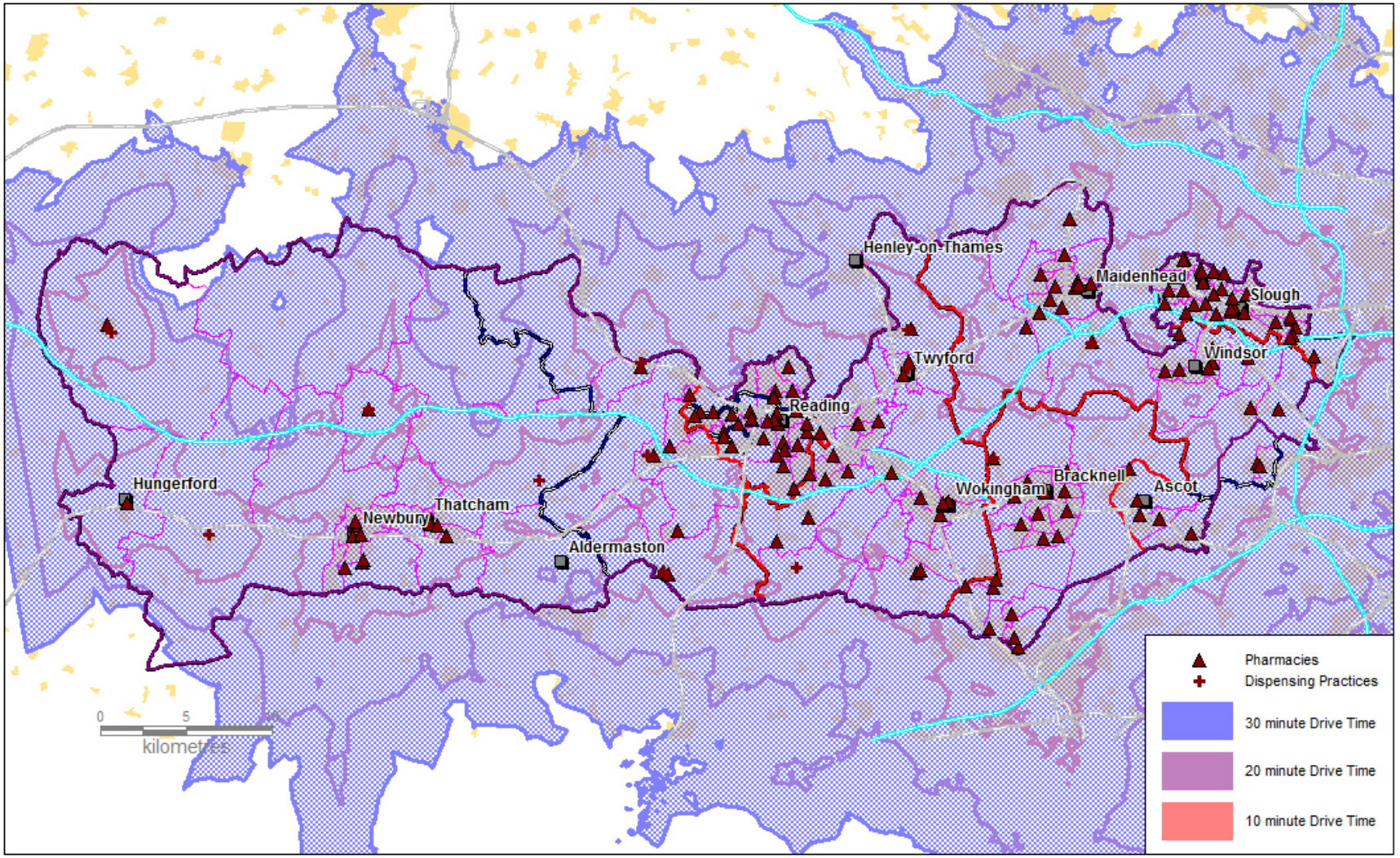
Berkshire - Pharmacy Access



Berks_PNA_Apr14_v1.wor 15/05/2014 Sid Beauchant BHFT

Berkshire - Pharmacy Access



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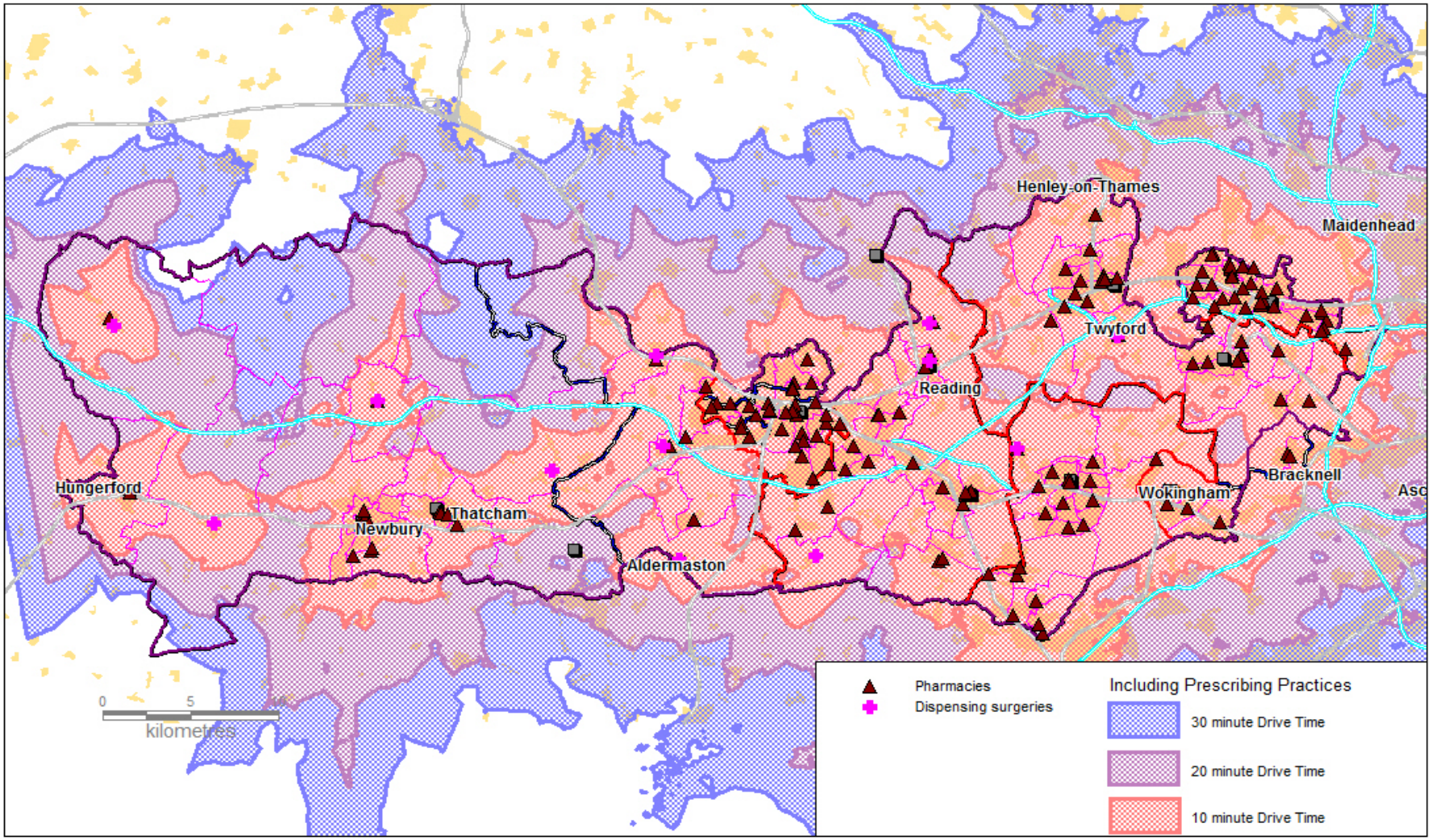
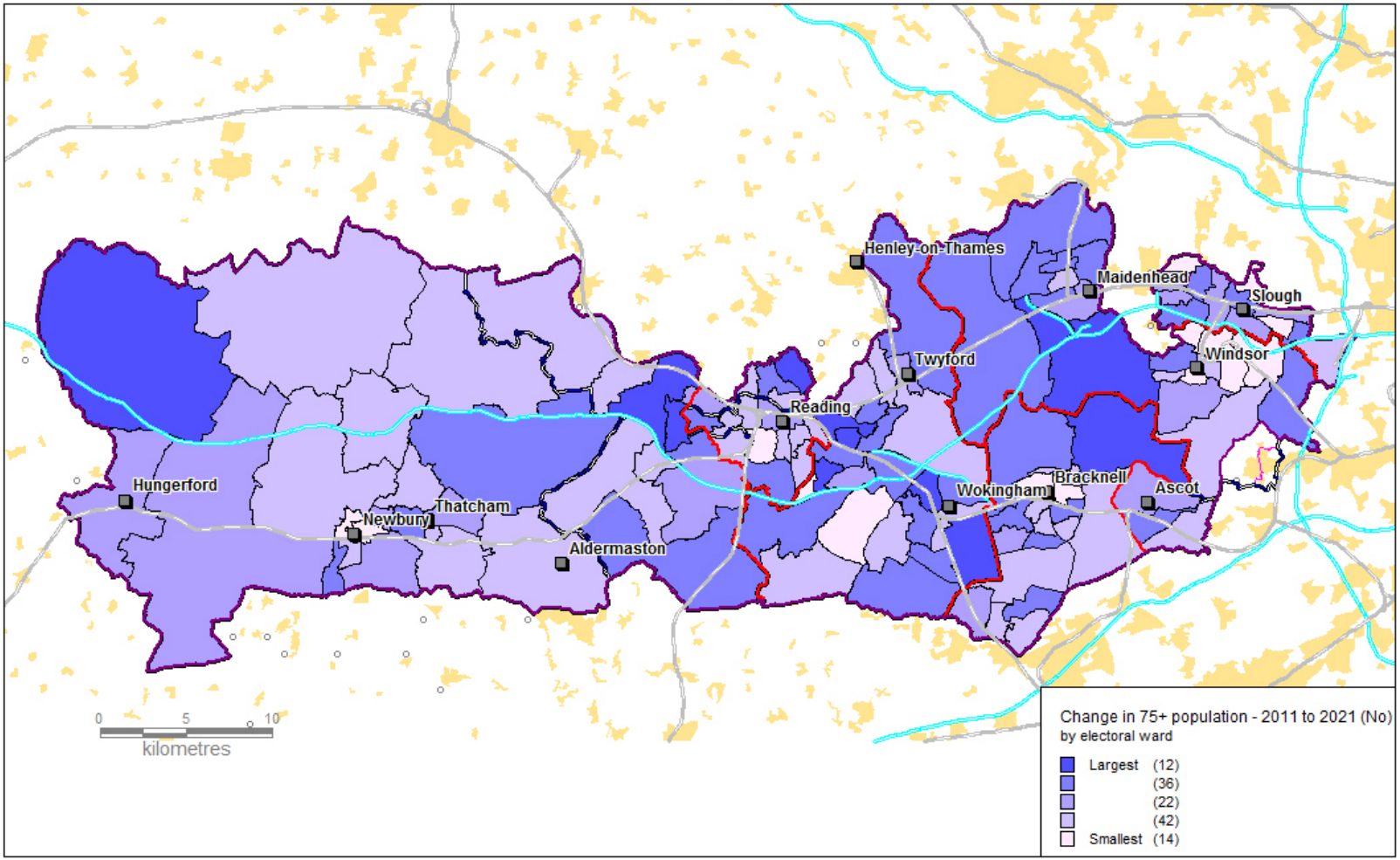


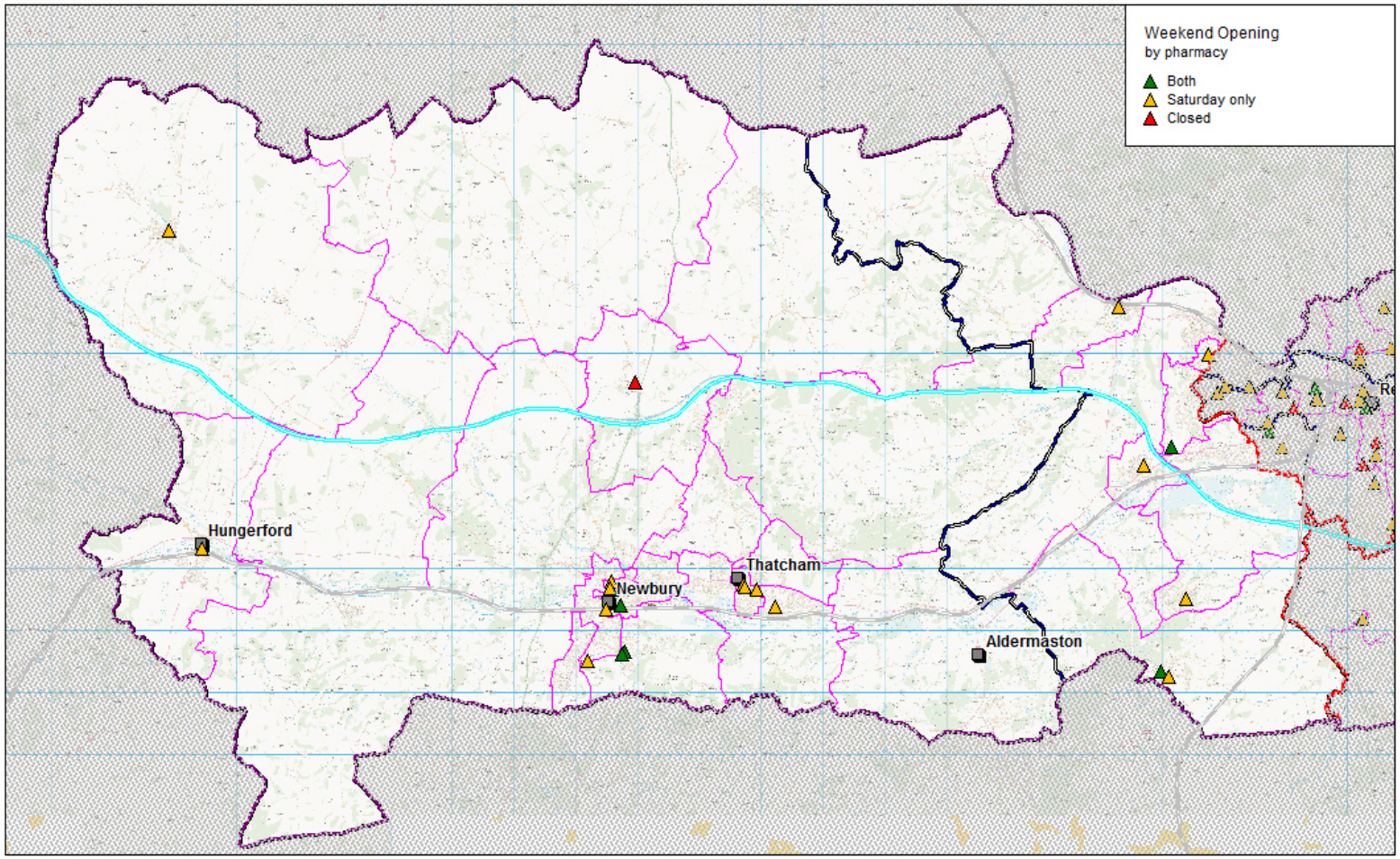
Berks_PNA_Aug14_DT_v2.wor 17/12/2014 Sid Beauchant BHFT

Local estimated Population Projections



PROJ_Local_2011_Ward_Berks.wor 19/05/2014 Sid Beauchant BHFT

West Berkshire - Pharmacy Access



Berks_PNA_Aug14_v1_WE.wor 18/11/2014 Sid Beauchant BHFT

Opening Hours

CODE	ADDRESS	POSTCODE	TOWN	TRADING NAME	OPENING HOURS - Saturday	OPENING HOURS - Sunday
FC776	125 High Street	RG17 0DL	Hungerford	Boots the Chemists	9:00-12:30; 13:00-17:00	Closed
FT063	The Broadway	RG17 8XY	Lambourn	Lambourn Pharmacy	9:00-13:00	Closed
FLP66	Mortimer Surgery	RG7 3SQ	Mortimer Common	Mortimer Pharmacy	7:30-22:05	8:00-22:00
FJV60	4-5 Northbrook Street	RG14 1DJ	Newbury	Boots the Chemists	8:30-18:00	10:00-16:00
FP041	Unit 10, Newbury Retail Park	RG14 7HU	Newbury	Boots The Chemists	8:00-24:00	10:00-16:00
FPC92	82-83 Bartholomew Street	RG14 5EF	Newbury	your local Boots pharmacy	8:30-13:00	Closed
FWX13	12 The Broadway	RG14 1BA	Newbury	Day Lewis PLC	9:00-13:00	Closed
FDN76	East Lane	RG20 8UY	Newbury	Downland Pharmacy	Closed	Closed
FL172	Monks Lane	RG14 7RW	Newbury	Wash Common Pharmacy	8:45-17:00	Closed
FVP85	Hectors Way	RG14 5AB	Newbury	Sainsburys Pharmacy	8:00-12:00; 14:00-20:00	Sun: 10:00-13:00; 15:00-16:00
FN512	81-82 Northbrook Street	RG14 1AE	Newbury	Superdrug Pharmacy	9:00-13:30; 14:00-17:30	Closed
FK567	Tesco Extra	RG14 7HB	Newbury	Tesco Pharmacy	6:30-22:00	10:00-16:00
FCT83	3 The Square	RG8 7AQ	Pangbourne	Lloydspharmacy	9:00-17:30	Closed
FEJ88	Savacentre	RG31 7SA	Reading	Sainsburys Pharmacy	8:00-20:00	10:00-16:00
FFT63	Reading Road	RG7 3YJ	Burghfield	Burghfield Pharmacy	9:00-13:00	Closed
FRR59	24 West End Road	RG7 3TF	Mortimer	Lloydspharmacy	9:00-17:30	Closed
FWP83	27 High Street	RG7 5AH	Theale	Lloydspharmacy	9:00-13:00	Closed
FM678	5 The Colonnade	RG31 6PR	Tilehurst	Overdown Pharmacy	9:00-13:00	Closed
FE788	Thatcham Medical Practice	RG18 3HD	Thatcham	Boots the Chemists	9:00-12:00	Closed
FQD69	2 The Burdwood Centre	RG19 4YA	Thatcham	Lloydspharmacy	9:00-13:00	Closed
FTJ67	3-5 Crown Mead	RG18 3JW	Thatcham	Lloydspharmacy	9:00-17:30	Closed

FXR54	7 Kingsland Centre	RG19 3HN	Thatcham	Lloydspharmacy	9:00-17:30	Closed

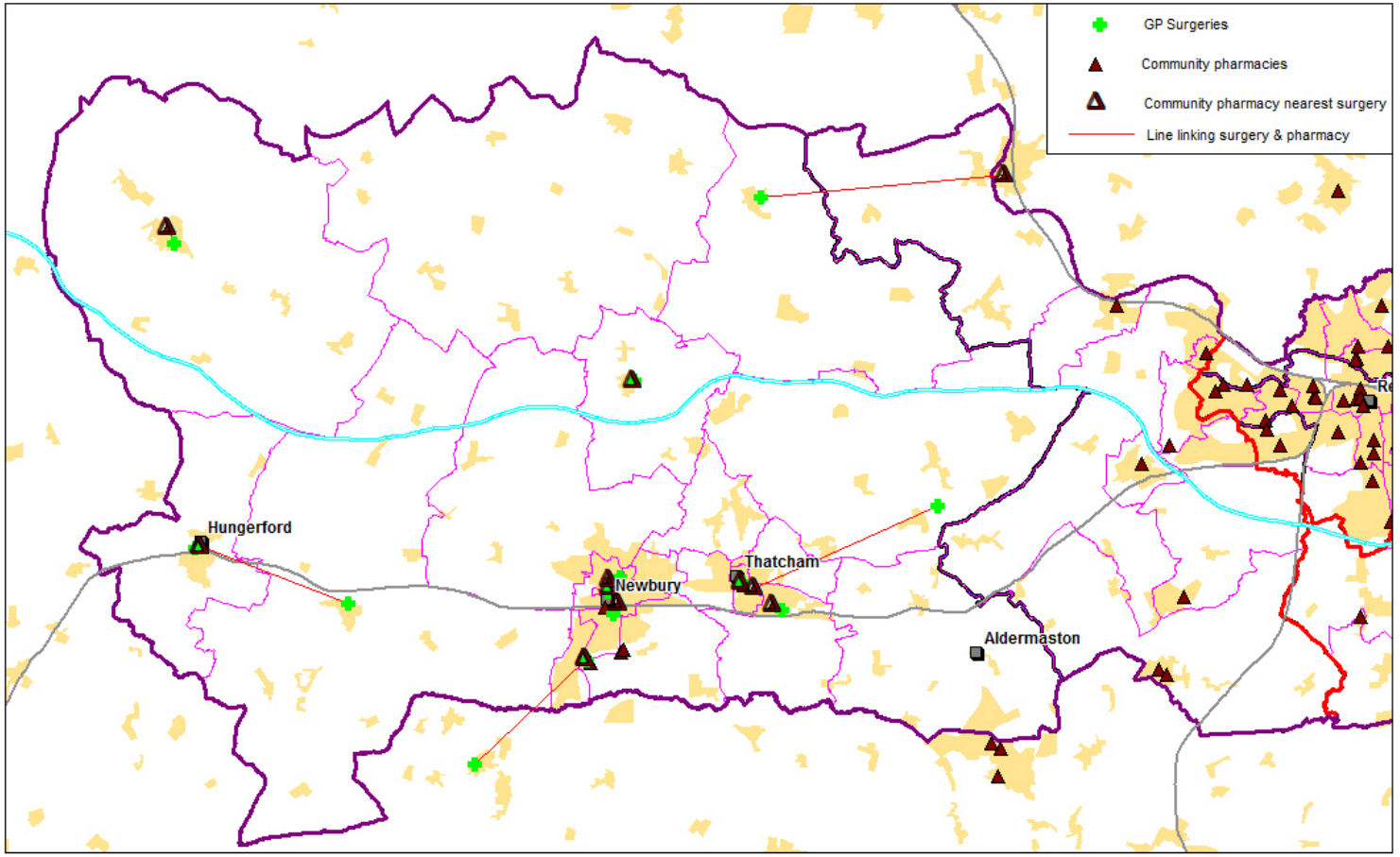
Appendix 3

Pharmacy Access in West Berkshire
Week end GP services and pharmacy access

Id	Org_Code	Surgery	Post Code	Weekend opening	Minimum distance km	CODE	Nearest pharmacy	Postcode	Weekend opening
1	J82054000	Kintbury & Woolton Hill Surgery	RG17 9UX	Closed	5.51	FC776	Boots the Chemists	RG17 0DL	Saturday only
2	J82054001	Woolton Hill Surgery	RG20 9UL	Closed	5.95	FL172	Wash Common Pharmacy	RG14 7RW	Saturday only
3	K81002000	Eastfield House Surgery	RG14 7LW	Closed	0.46	FVP85	Sainsbury's Pharmacy	RG14 5AB	Both
4	K81017000	Falkland Surgery	RG14 7DF	Closed	0.12	FL172	Wash Common Pharmacy	RG14 7RW	Saturday only
5	K81050000	Downland Practice*	RG20 8UY	Closed	0	FDN76	Downland Pharmacy	RG20 8UY	Closed
6	K81050001	Compton Surgery	RG20 6NJ	Closed	9.39	FDE03	Lloyds Pharmacy	RG8 9AT	*Saturday only†*
7	K81052000	Lambourn Surgery	RG17 8PS	2 x Saturday a month	0.75	FT063	Lambourn Pharmacy	RG17 8XY	Saturday only
8	K81057000	Hungerford Surgery	RG17 0HY	Half Saturday	0.48	FC776	Boots the Chemists	RG17 0DL	Saturday only
9	K81061000	Northcroft Surgery	RG14 1BU	Alt Saturday	0.19	FJV60	Boots the Chemists	RG14 1DJ	Both
10	K81063000	St Mary's Road Surgery	RG14 1EQ	Closed	0.46	FWX13	Day Lewis Rankin Pharmacy	RG14 1BA	Saturday only
12	K81073000	Thatcham Medical Practice	RG18 3HD	Alt Saturday	0	FE788	Boots the Chemists	RG18 3HD	Saturday only
13	K81102000	The Burdwood Surgery	RG19 4YF	1 x Saturday a month	0.35	FQD69	Lloyds Pharmacy	RG19 4YA	Saturday only
14	K81103000	Chapel Row Surgery	RG7 6NS	1 x Saturday a month	7.16	FXR54	Lloyds Pharmacy	RG19 3HN	Saturday only

† Oxfordshire pharmacy, opening times derived from website.

Berkshire - Pharmacy Access



BerksW_Pharm_Distance_0115.wor 27/01/2015 Sid Beauchant BHFT

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PharmOutcomes - Live System

Exit

PharmOutcomes® Delivering Evidence

Home Services Assessments Reports Claims Admin Gallery Help

Service Design

- Go to Service Design page
- Edit Service Accreditations

Provision Reports Preview

Basic Provision Record (Sample)

Service Support

Pharmacy Questionnaire-PNA
Please complete this questionnaire **ONCE** only to report the facilities and services offered by your pharmacy.

For technical support on the use of this data capture set please contact Pinnacle Support via the "Help" tab

PNA Questionnaire (Preview)

Date of completion 01-Sep-2014

Trading Name

Post Code

Is this a Distance Selling Pharmacy? ○ Yes ○ No
(i.e. it cannot provide Essential Services to persons present at the pharmacy)

Pharmacy email address
If no email write no email

Pharmacy telephone

Pharmacy fax

Pharmacy website address
If no website write no website

Can we store the above information and use this to contact you?

Consent to store ○ Yes ○ No

Core hours of opening

Please complete your core hours of opening.
Enter closed if closed

Monday Open		**Monday Close**	
		Monday Lunchtime (from - to)	
Tuesday Open		**Tuesday Close**	
		Tuesday Lunchtime (from - to)	
Wednesday Open		**Wednesday Close**	
		Wednesday Lunchtime (from - to)	
Thursday Open		**Thursday Close**	
		Thursday Lunchtime (from - to)	
Friday Open		**Friday Close**	
		Friday Lunchtime (from - to)	
Saturday Open		**Saturday Close**	
		Saturday Lunchtime (from - to)	

Sunday Open | Sunday Close

Sunday Lunchtime (from - to)

Total hours of opening (Core + Supplementary)

Please complete your total hours of opening

Monday Open | Monday Close

Monday Lunchtime (from - to)

Tuesday Open | Tuesday Close

Tuesday Lunchtime (from - to)

Wednesday Open | Wednesday Close

Wednesday Lunchtime (from - to)

Thursday Open | Thursday Close

Thursday Lunchtime (from - to)

Friday Open | Friday Close

Friday Lunchtime (from - to)

Saturday Open | Saturday Close

Saturday Lunchtime (from - to)

Sunday Open | Sunday Close

Sunday Lunchtime (from - to)

Consultation Facilities

Consultation areas should meet the standard set out in the contractual framework to offer advanced services

Is there a consultation area?

- ○ Available (including wheelchair access) on the premises
- ○ Available (without wheelchair access) on premises
- ○ Planned within next 12 months
- ○ No consultation room available
- ○ Other

If Other please specify

Where there is a consultation area

Is this enclosed? ○ Yes ○ No ○ N/A

N/A if no consultation room

Off-site arrangements

- ○ Off-site consultation room approved by NHS
- ○ Willing to undertake consultations in patients home/ other suitable site
- ○ None apply
- ○ Other

If Other please specify

Hand washing and toilet facilities

What facilities are available to patients during consultations?

Facilities available

- ☐ Handwashing in consultation area
- ☐ Hand washing facilities close to consultation area
- ☐ Have access to toilet facilities
- ☐ None

Tick all that apply

Information Technology

Is the pharmacy EPS* R2 enabled?

- ○ Yes, EPS R2 enabled
- ○ Planning to become EPS R2 enabled in the next 12 months
- ○ No current plans to provide EPS R2

EPS R2: Electronic Prescription Service Release 2

Information is often distributed to pharmacies as email attachments or via websites. Please indicate whether you are able to use the following common file formats in your pharmacy:

File format types

- ☐ Microsoft word
- ☐ Microsoft Excel
- ☐ Microsoft Access
- ☐ PDF
- ☐ Unable to open or view any file formats

Please tick all that apply

Essential Services (appliances)

In this section, please give details of the essential services your pharmacy provides.

Does the pharmacy dispense appliances?

- ○ Yes - All types, or
- ○ Yes, excluding stoma appliances, or
- ○ Yes, excluding incontinence appliances, or
- ○ Yes, excluding stoma and incontinence appliances, or
- ○ Yes, just dressings, or
- ○ None
- ○ Other

If Other please specify

Advanced Services

Please give details of the Advanced Services provided by your pharmacy.
Please tick the box that applies for each service.

Yes - Currently providing
Soon - Intending to begin within the next 12 months
No - Not intending to provide

Medicines Use Review service	☐ Yes	☐ Soon	☐ No
New Medicine Service	☐ Yes	☐ Soon	☐ No
Appliance Use Review service	☐ Yes	☐ Soon	☐ No
Stoma Appliance Customisation service	☐ Yes	☐ Soon	☐ No

Commissioned Services

Use this section to record which Local services you currently deliver or would like to deliver at your pharmacy. These can be Enhanced Services, commissioned by the NHS England Area Team, Public Health Services commissioned by a Local Authority or CCG services.
Please tick the box that applies for each service.

CP - Currently Providing NHS funded service
WA - Willing and able to provide if commissioned
WT - Willing to provide if commissioned but would need training
WF - Willing to provide if commissioned but require facilities adjustment
PP - Currently providing private service
If you are not willing or able to provide please leave blank.

Anticoagulant Monitoring Service	☐ CP	☐ WA	☐ WT	☐ WF	☐ PP
Anti-viral Distribution Service	☐ CP	☐ WA	☐ WT	☐ WF	☐ PP
Care Home Service	☐ CP	☐ WA	☐ WT	☐ WF	☐ PP
Chlamydia Treatment Service	☐ CP	☐ WA	☐ WT	☐ WF	☐ PP
Contraception Service	☐ CP	☐ WA	☐ WT	☐ WF	☐ PP (not an EHC service)

Local Authority Commissioned Services
List services already commissioned in your locality here

Disease Specific Medicines Management Service:

Allergies	☐ CP	☐ WA	☐ WT	☐ WF	☐ PP
Alzheimer's/dementia	☐ CP	☐ WA	☐ WT	☐ WF	☐ PP
Asthma	☐ CP	☐ WA	☐ WT	☐ WF	☐ PP
CHD	☐ CP	☐ WA	☐ WT	☐ WF	☐ PP
Depression	☐ CP	☐ WA	☐ WT	☐ WF	☐ PP
Diabetes type I	☐ CP	☐ WA	☐ WT	☐ WF	☐ PP

Diabetes type II ☐ CP ☐ WA ☐ WT ☐ WF ☐ PP

Epilepsy ☐ CP ☐ WA ☐ WT ☐ WF ☐ PP

Heart Failure ☐ CP ☐ WA ☐ WT ☐ WF ☐ PP

Hypertension ☐ CP ☐ WA ☐ WT ☐ WF ☐ PP

Parkinson's disease ☐ CP ☐ WA ☐ WT ☐ WF ☐ PP

Other (please state - including funding source)

Area Team Services
List your Area Team commissioned services here

End of Disease specific Medicines Management Service options.

Emergency Hormonal Contraception Service ☐ CP ☐ WA ☐ WT ☐ WF ☐ PP

Gluten Free Food Supply Service ☐ CP ☐ WA ☐ WT ☐ WF ☐ PP
(i.e. not supply on FP10)

Home Delivery Service ☐ CP ☐ WA ☐ WT ☐ WF ☐ PP
(not appliances)

Independent Prescribing Service ☐ CP ☐ WA ☐ WT ☐ WF ☐ PP

Therapeutic areas covered (if providing)

Language Access Service ☐ CP ☐ WA ☐ WT ☐ WF ☐ PP

Note: This is not the NMS or MUR service.

Medication Review Service ☐ CP ☐ WA ☐ WT ☐ WF ☐ PP

Medicines Assessment and Compliance Support Service:

Medicines Management Support Service: ☐ CP ☐ WA ☐ WT ☐ WF ☐ PP
i.e. the EL23 service (previously the Vulnerable Elderly / Adults Service)

DomMAR Carer's Charts ☐ CP ☐ WA ☐ WT ☐ WF ☐ PP

End of Medicines Assessment and Compliance Support options.

Minor Ailments Scheme ☐ CP ☐ WA ☐ WT ☐ WF ☐ PP

MUR Plus/Medicines Optimisation Service ☐ CP ☐ WA ☐ WT ☐ WF ☐ PP

Therapeutic areas covered (if providing)

Needle and Syringe Exchange Service ☐ CP ☐ WA ☐ WT ☐ WF ☐ PP

Obesity management (adults and children) ☐ CP ☐ WA ☐ WT ☐ WF ☐ PP

On Demand Availability of Specialist Drugs Service:

Directly Observed Therapy ☐ CP ☐ WA ☐ WT ☐ WF ☐ PP

If yes state which medicines

Out of hours services ☐ CP ☐ WA ☐ WT ☐ WF ☐ PP

Palliative Care scheme ☐ CP ☐ WA ☐ WT ☐ WF ☐ PP

End of On Demand Availability of Specialist Drugs Service options

Patient group directions

Many Local Services involve the supply of a POM using a PGD. please list those provided by the pharmacy in the text box below but indicate who commissions the service by ticking the boxes below and annotating each service name with the key:

AT=Area Team
LA=Local Authority
CCG=Clinical Commissioning Group
Pr=Offers a Private Service

Patient Group Direction Service ☐ AT ☐ LA ☐ CCG ☐ Pr
Not including EHC (see separate question)

Please list the names of the medicines available if providing PGD services

Medicines available

Phlebotomy Service ☐ CP ☐ WA ☐ WT ☐ WF ☐ PP

Prescriber Support Service ☐ CP ☐ WA ☐ WT ☐ WF ☐ PP

Schools Service ☐ CP ☐ WA ☐ WT ☐ WF ☐ PP

Screening Service:

Alcohol ☐ CP ☐ WA ☐ WT ☐ WF ☐ PP

Chlamydia ☐ CP ☐ WA ☐ WT ☐ WF ☐ PP

Cholesterol ☐ CP ☐ WA ☐ WT ☐ WF ☐ PP

Diabetes ☐ CP ☐ WA ☐ WT ☐ WF ☐ PP

Gonorrhoea ☐ CP ☐ WA ☐ WT ☐ WF ☐ PP

H. pylori ☐ CP ☐ WA ☐ WT ☐ WF ☐ PP

HbA1C ☐ CP ☐ WA ☐ WT ☐ WF ☐ PP

Hepatitis ☐ CP ☐ WA ☐ WT ☐ WF ☐ PP

HIV ☐ CP ☐ WA ☐ WT ☐ WF ☐ PP

Other Screening (please state - including funding source)

End of screening service options

Seasonal Influenza Vaccination Service ☐ CP ☐ WA ☐ WT ☐ WF ☐ PP

Other vaccinations

Childhood vaccinations ☐ CP ☐ WA ☐ WT ☐ WF ☐ PP

HPV ☐ CP ☐ WA ☐ WT ☐ WF ☐ PP

Hepatitis B ☐ CP ☐ WA ☐ WT ☐ WF ☐ PP
(at risk workers or patients)

Travel vaccines ☐ CP ☐ WA ☐ WT ☐ WF ☐ PP

Other (please state - including funding source)

End of Other vaccinations options

Sharps Disposal Service ☐ CP ☐ WA ☐ WT ☐ WF ☐ PP

Stop Smoking Service:

NRT Voucher Service ☐ CP ☐ WA ☐ WT ☐ WF ☐ PP

Smoking Cessation Counselling Service ☐ CP ☐ WA ☐ WT ☐ WF ☐ PP

End of Stop Smoking Service options

Supervised Administration ☐ CP ☐ WA ☐ WT ☐ WF ☐ PP
Of methadone,buprenorphine etc.

End of Supervised Administration Service options

Supplementary prescribing ☐ CP ☐ WA ☐ WT ☐ WF ☐ PP

Which therapy area

Vascular Risk Assessment Service ☐ CP ☐ WA ☐ WT ☐ WF ☐ PP
NHS Healthchecks

Healthy Living Pharmacy

Is this a Healthy Living Pharmacy

- ○ Yes
- ○ Currently working towards HLP status
- ○ No

If Yes, how many Healthy Living Champions do you currently have? ____ Full Time Equivalents

Collection and Delivery services

Does the pharmacy provide any of the following?

Collection of prescriptions from surgeries ○ Yes ○ No

Delivery of dispensed medicines - Free of charge on request ○ Yes ○ No

Delivery of dispensed medicines - Selected patient groups

List criteria

Delivery of dispensed medicines - Selected areas

List areas

Delivery of dispensed medicines - chargeable ○ Yes ○ No

Languages

One potential barrier to accessing services at a pharmacy can be language. To help the local authority better understand any access issues caused by language please answer the following two questions:

What languages other than English are spoken in the pharmacy

What languages other than English are spoken by the community your pharmacy serves

Almost done

If you have anything else you would like to tell us that you think would be useful in the formulation of the PNA, please include it here:

Other

Please tell us who has completed this form in case we need to contact you.

Contact name

Contact telephone

For person completing the form, if different to pharmacy number given above

Thank you for completing this PNA questionnaire.

Test Values

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Pharmacy Users Survey

Public Health Berkshire

The local Pharmaceutical needs assessment is a survey that Public Health within local government is undertaking to make sure that pharmacies across Berkshire are providing the right services, in the right locations, to support residents.

As part of this confidential survey we want to get your views on services, so your answers are important to us. The survey is confidential and will be used to plan our services.

Please complete this survey and place it into the collection box

1 Do you use?

- Community pharmacy ☐
- A dispensing appliance supplier? (someone who supplies appliances such as incontinence and stoma products) ☐
- An internet pharmacy? (a service where medicines are ordered on-line and delivered by post) ☐

2 How often do you use a pharmacy?

- More than once a month ☐
- Once a mont ☐
- 3–11 times a yea ☐
- Less than 3 times a year ☐

3 Which of the following services do you currently use at a pharmacy?

- Sunday opening ☐
- Late night opening (after 7pm) ☐
- Early morning opening (before 9am) ☐
- Prescription dispensing ☐
- Buying over the counter medicines ☐
- Buying travel medicines (e.g. anti-malarials) ☐
- Medicines advice and reviews ☐
- Delivery of medicines to my home ☐
- Collection of prescription from my surgery ☐
- Long-term condition advice (e.g. help with your diabetes/asthma) ☐
- Respiratory Services ☐
- Emergency hormonal contraception (morning-after pill) ☐
- Cancer treatment support services ☐
- Substance misuse Service ☐
- Alcohol support services ☐
- Stop smoking service ☐
- Health tests, e.g. cholesterol, blood pressure ☐
- Healthy weight advice ☐
- 'Flu vaccination ☐
- Diabetes screening - Private ☐ NHS ☐
- Blood pressure check - Private ☐ NHS ☐

4 Which of the following services would you use at a pharmacy, if available?

- Sunday opening ☐
- Late night opening (after 7pm) ☐
- Early morning opening (before 9am) ☐
- Prescription dispensing ☐
- Buying over the counter medicines ☐
- Buying travel medicines (e.g. anti-malarials) ☐
- Minor Ailment Scheme (access to certain subsidised over the counter medicines to avoid a GP visit) ☐
- Electronic prescription service ☐
- Medicines advice and reviews ☐
- Delivery of medicines to my home ☐
- Collection of prescription from my surgery ☐
- Long-term condition advice (e.g. help with your diabetes/asthma) ☐
- Respiratory services ☐
- Emergency hormonal contraception (morning-after pill) ☐
- Cancer treatment support services ☐
- Substance misuse service ☐
- Alcohol support services ☐
- Stop smoking service ☐
- Health tests, e.g. cholesterol, blood pressure ☐
- Healthy weight advice ☐
- 'Flu vaccination ☐
- Diabetes screening ☐
- Blood pressure check ☐
- Other (please specify) .....

continued...

5 Are you able to get to a pharmacy of your choice?

Yes ☐ No ☐

6 Do you use one pharmacy regularly?

Yes ☐ No ☐

7 Reason for using your regular pharmacy

Location

- In the supermarket ☐
- In town/shopping area ☐
- Near to my doctors ☐
- Near to home ☐
- Near to work ☐
- Other ☐

Services

- They offer a delivery service ☐
- They offer a collection service ☐
- The staff speak my first language ☐
- The staff are knowledgeable ☐
- The staff are friendly ☐
- Other ☐

8 How do you usually travel to your usual pharmacy?

- Walk ☐
- Car (passenger) ☐
- Car (driver) ☐
- Taxi ☐
- Bus ☐
- Bicycle ☐

9 How long does it take you to travel to your pharmacy?

- Less than 15 mins ☐
- 15 – 30 mins ☐
- 30-60 mins ☐
- Over an hour ☐

10 How important are the following pharmacy services?

	Very Important	Important	Unimportant
Home delivery of your medication	☐	☐	☐
Prescription collection from your surgery	☐	☐	☐
The pharmacy having a wide range of things I need	☐	☐	☐
The pharmacist taking time to listen/provide advice	☐	☐	☐
Private areas to speak to the pharmacist	☐	☐	☐
Shorter waiting times	☐	☐	☐
Knowledgeable staff	☐	☐	☐
Location	☐	☐	☐
Late opening times (after 7pm)	☐	☐	☐

11 How satisfied were you with the following services at your regular pharmacy?

	Very Satisfied	Satisfied	Unsatisfied
The pharmacy having the things I need	☐	☐	☐
The pharmacist taking time to talk to me	☐	☐	☐
Private consultation areas	☐	☐	☐
Waiting times	☐	☐	☐
Staff attitude	☐	☐	☐
Knowledgeable staff	☐	☐	☐
Location	☐	☐	☐

continued...

12 About You

My age is:

- Prefer not to say ☐
- 65-74 ☐
- 55-64 ☐
- 45-54 ☐
- 70+ ☐
- 35-44 ☐
- 25-34 ☐
- 18-24 ☐

I would describe my sexuality as:

- Prefer not to say ☐
- Heterosexual (Straight) ☐
- Lesbian ☐
- Gay ☐
- Bisexual ☐
- Other ☐

Please tell us your faith or religion:

- Prefer not to say ☐
- Christian ☐
- Muslim ☐
- Hindu ☐
- No faith or religion ☐
- Other ☐

I would describe my ethnic origin as:

- British White ☐
- White Other ☐
- Irish ☐
- Pakistani ☐
- Asian ☐
- Indian ☐
- Bangladeshi ☐
- Black Caribbean ☐
- Black African ☐
- Gypsy/Irish Traveller ☐
- Other ☐

Do you consider yourself to be disabled?

Yes ☐ No ☐

What is your marital status?

- Single ☐
- Married ☐
- Life-partner ☐
- Civil Partnership ☐
- Other ☐
- Prefer not to say ☐

Which of the following best describes your working situation?

- I work as volunteer ☐
- I am working part-time ☐
- I am working full-time ☐
- I am retired ☐
- I am not working ☐
- Prefer not to say ☐

Thank you!

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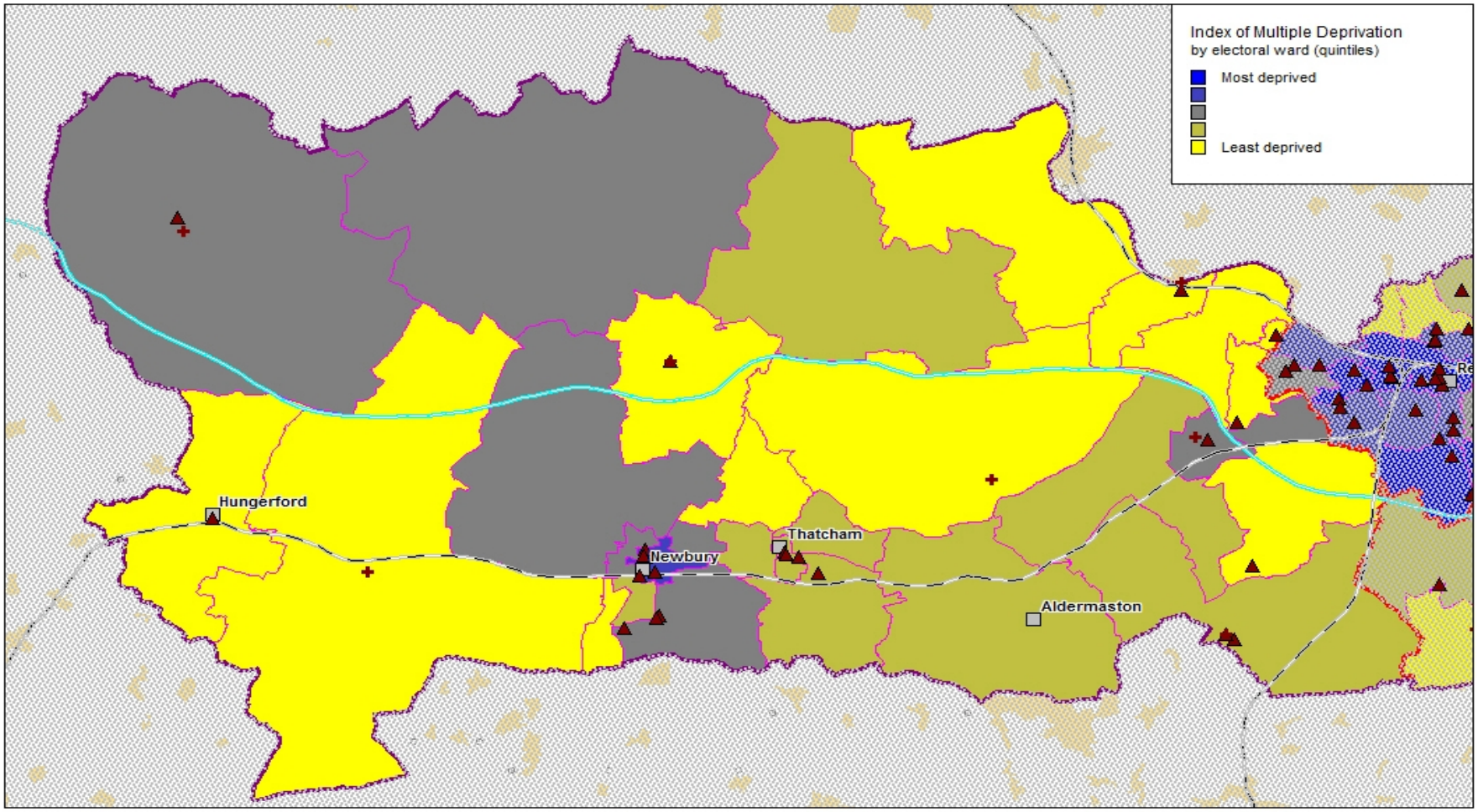
Appendix 6: Deprivation Map of West Berkshire

Figure 1: Map of West Berkshire to show the levels of deprivation by ward



Source: Index of Multiple Deprivation, Department of Communities and Local Government (2010)

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