Public Document Pack

Notice of Meeting

Health and Wellbeing Board

Thursday, 26th November 2015 at 9.00am

at Shaw House Church Road Newbury

Date of despatch of Agenda: Wednesday, 18 November 2015

For further information about this Agenda, or to inspect any background documents referred to in Part I reports, please contact Jessica Bailiss / Moira Fraser / Jo Reeves on (01635) 503124 / 519045 / 5194
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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), Dr Barbara Barrie (North and West Reading CCG), Leila Ferguson (Empowering West Berkshire), Dr Lise Llewellyn (Public Health), Rachael Wardell (WBC - Community Services), Cathy Winfield (Berkshire West CCGs), Councillor Hilary Cole (Executive Portfolio: Adult Social Care, Housing), Councillor Lynne Doherty (Executive Portfolio: Children's Services), Councillor Graham Jones (Executive Portfolio: Health and Wellbeing), Councillor Mollie Lock (Shadow Executive Portfolio: Education and Young People, Adult Social Care) and Andrew Sharp (Healthwatch) and Councillor Roger Croft (Leader of Council)

Also to: Jessica Bailiss (WBC - Executive 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	**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.	
9.02 am	3	**Minutes** To approve as a correct record the Minutes of the meeting of the Board held on 24th September 2015.	7 - 18
	4	**Health and Wellbeing Board Forward Plan** For information.	19 - 20
9.10 am	5	**Actions arising from previous meeting(s)** For information.	21 - 22
	6	**Public Questions** Members of the Health and Wellbeing Board to answer questions submitted by members of the public in accordance with the Executive Procedure Rules contained in the Council's Constitution. *(Note: There were no questions submitted relating to items not included on this Agenda.)*	

7 **Petitions**
Councillors or Members of the public may present any petition which they have received. These will normally be referred to the appropriate Committee without discussion.

Items for discussion

Systems Resilience

9.10 am	8	**Health and Social Care Dashboard (Shairoz Claridge/Tandra Forster/Rachael Wardell)** Purpose: To present the Dashboard and highlight any emerging issues.	23 - 26

Integration Programme

9.20 am	9	**An update report on the Better Care Fund and wider integration programme (Tandra Forster/Shairoz Claridge)** Purpose: To keep the Board up to date on progression with the BCF and wider integration programme *(Please note that Appendix A to this report is included within the separate information only pack, circulated with this agenda)*	27 - 40

Health and Wellbeing Strategy/Joint Strategic Needs Assessment

9.30 am	10	**Feedback on the Health and Wellbeing Strategy Hot Focus: Looked After Children (Mac Heath)** Purpose: To feedback on activity that has taken place over the last three months.	41 - 52
9.45 am	11	**Joint Strategic Needs Assessment and the District Needs Assessment (Lesley Wyman)** Purpose: To present a snapshot of the JSNA, which includes any changes the Board needs to be aware of.	53 - 78

Public Engagement

10.00 am	12	**Draft Strategy for Community Engagement (Dr Bal Bahia)** Purpose: To present the draft strategy to the Board for comment.	79 - 94

10.10 am	13	**Update from Healthwatch West Berkshire (Jo Karasinski)** Purpose: To inform the Board on Healthwatch West Berkshire's plans for the coming year.	95 - 100

Governance and Performance

10.20 am	14	**Delivery Plan Performance Report (Lesley Wyman)** Purpose: To provide exception reports from each of the delivery groups.	101 - 104

Other issues for discussion

10.35 am	15	**Emotional Health Tier 2 design proposals (Andrea King/Sally Murray)** Purpose: To present the Tier 2 design proposals to the Board.	105 - 172
10.50 am	16	**Members' Question(s)** Members of the Health and Wellbeing Board to answer questions submitted by Councillors in accordance with the Executive Procedure Rules contained in the Council's Constitution.	
	17	**Question submitted by Councillor Adrian Edwards** *"Will this Health and Wellbeing Board consider appointing a senior executive from the Berkshire Healthcare NHS Foundation Trust to the Board?* *Bracknell Forest District Council in Berkshire have benefitted from appointing a senior BHFT executive to their H & W Board as it has significantly strengthened their capacity to address their health aspects of their brief, as it has done in other areas outside Berkshire. If this Board was to invite BHFT to provide a representative, the Trust would nominate one of its Board level Executive Directors to take on this responsibility."*	

Other information not for discussion

	18	**Seasonal Influenza Campaign 2015-16** Purpose: To update the Health and Wellbeing Board on local implementation of national Flu plan for 2015-16.	173 - 180

19 **Future meeting dates**

28 January 2016
24 March 2016
26 May 2016
7th July 2016 (provisional)
29th September 2016 (provisional)
24th November 2016 (provisional)
27th January 2017 (provisional)
30th March 2017 (provisional)
25th May 2017 (provisional)

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, 24 SEPTEMBER 2015

Present: Dr Bal Bahia (Newbury and District CCG), Adrian Barker (Healthwatch), Rachael Wardell (WBC - Community Services), Cathy Winfield (Berkshire West CCGs), Councillor Hilary Cole (Executive Portfolio: Adult Social Care, Housing), Councillor Lynne Doherty (Executive Portfolio: Children's Services), Councillor Graham Jones (Executive Portfolio: Health and Wellbeing), Councillor Mollie Lock (Shadow Executive Portfolio: Education and Young People, Adult Social Care) and Councillor Roger Croft (Executive Portfolio - Deputy Leader, Finance, Insurance, Health & Safety, Human Resources, Pensions, ICT & Corporate Support) and Lesley Wyman (WBC – Public Health).

Also Present: Jessica Bailiss (WBC - Executive Support), Nick Carter (WBC - Chief Executive), Tandra Forster (WBC - Adult Social Care) and Shairoz Claridge (Newbury and District CCG)

Apologies for inability to attend the meeting: Dr Barbara Barrie, Leila Ferguson, Dr Lise Llewellyn and Councillor Gordon Lundie

PART I

32 Declarations of Interest

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

Adrian Barker declared an interest in all matters pertaining of Time to Talk West Berkshire, by virtue of the fact that he was a trustee and Chairman of the youth counselling charity. He 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.

33 Minutes

The Minutes of the meeting held on 30th July were approved as a true and correct record and signed by the Chairman.

Adrian Barker reported that the item he raised at the last meeting regarding health impacts from major developments would be discussed at the Health and Wellbeing Management Group on 1st October 2015.

34 Health and Wellbeing Board Forward Plan

The Health and Wellbeing Board noted the forward plan.

35 Actions arising from previous meeting(s)

Adrian Barker referred to the action from the previous meeting regarding the Children and Young People's Survey, as the full report had now been circulated. He felt that the following points needed to be picked up, which had not been highlighted at the meeting:

- 8% of children and young people surveyed in West Berkshire had said they were unhappy, which was above the national average.
- At one of the schools which took part, 68% said they had been bullied in the last year.

Lesley Wyman confirmed that these points would be picked up by both the Mental Health and Wellbeing Delivery Group and Children and Young People Delivery Group. Rachael Wardell reported that there was already work around bullying taking place and it would be interesting to see if the data within the Children and Young People's Society's report matched that locally.

Adrian Barker stated that the Board had not been informed of these points when they had been presented the data from the West Berkshire survey at the previous meeting and it was not an omission within the minutes.

Cathy Winfield reported that there was a specific piece of work taking place around children and young people's mental health. A lot of time had been spent developing tier three Child and Adolescent Mental Health Services (CAMHs) and CAMHs was also being extended to offer more tier four services. More focus was required regarding prevention and early intervention. Money was currently being directed into more costly parts of the pathway.

Rachael Wardell reported that a huge piece of work had also taken place over the summer on children's mental health and wellbeing and included exciting proposals such as an Emotional Health and Wellbeing Academy to help develop skills to help young people at a tier 2 level.

Adrian Barker reported that there were many new innovative ways of working being implemented for example around CAMHs and Adult Social Care. He suggested it would be worth revisiting the Health and Wellbeing Strategy to ensure these areas were incorporated. There was currently no process in place that he was aware of for refreshing the Health and Wellbeing Strategy (H&WBS). Lesley Wyman stated that all the new ways of working would be considered by the Delivery Groups. All of the groups were multi-agency and would be responsible for a number of actions. Lesley Wyman requested clarification on what needed to change within the H&WBS and Adrian Barker stated that he believed it was about joining up the new strands of work.

Cathy Winfield felt that it would helpful to have a planning event prior to the refresh of partner plans and the H&WBS. This would support the joining up of work strands, the allocation of resources and ensure issues were jointly addressed. Rachael Wardell supported this as a way forward and felt that it would be helpful to know what impact new pieces of work were having. The priorities within the H&WBS were clear, although how areas were changing as a result was not yet apparent. Dr Bal Bahia stated that it was important to consider how the information would be communicated into the Health and Wellbeing Board and delivery groups on a regular basis.

RESOLVED that a planning event should be scheduled for 2016 prior to the refresh of partner plans and the Health and Wellbeing Strategy.

Councillor Hilary Cole felt that it was important to maintain the H&WBS. Adult Social Care was rapidly evolving in an ever changing environment and therefore it was important to ensure the H&WBS was fit for purpose and remained flexible.

36 Public Questions

There were no public questions received.

37 Petitions

There were no petitions presented to the Board.

38 Health and Social Care Dashboard (Shairoz Claridge/Tandra Forster/Rachael Wardell)

Tandra Forster introduced the item to Members of the Health and Wellbeing Board with the purpose of highlighting any emerging issues.

Tandra Forster referred to ASC1 regarding the proportion of people still at home 91 days after discharge for hospital to reablement/rehabilitation services. This particular measure would be impacted upon by the change in the eligibility criteria. As a result of work taking place, including the Joint Care Provider Project, it was hoped that this indicator would remain green.

Rachael Wardell introduced the Children's Social Care section of the Dashboard to the Board. Positively the number of Looked after Children (LAC) has decreased and it was highlighted that the numbers had been managed down safely.

CSC2 regarding the number of Child Protection Plans was red. It was expected that this number would come down as the service was stabilised. Positively the number of agency staff had decreased.

Rachael Wardell highlighted that CSC3 was measured differently to how it had been in the past. The latest figure was red compared to what was considered the normal range. The remaining three indicators for Children's Social Care were green.

Councillor Mollie Lock queried how many children in West Berkshire were currently looked after. Rachael Wardell could not give the exact figure but reported that it was around 160.

Cathy Winfield referred to the target for Child Protection Plans and felt that it seemed unfair to set a target against such measure. Rachael Wardell confirmed that the service did not consider this a target. In relation to the Dashboard a red or green rating simply indicated pressure upon the service. It was agreed that the measure was more appropriate as a bench mark rather than a target.

Shairoz Claridge introduced the Acute Sector of the Dashboard to Members of the Board. Regarding AS1: four hour Accident and Emergency target, it was reported that the Royal Berkshire Hospital had achieved the target throughout quarter one. Great Western Hospital and Hampshire Hospitals were not commissioned by Newbury and District CCG and had their own processes in place. Great Western Hospital had met the target however, Hampshire Hospitals had not.

Shairoz Claridge referred to AS2 regarding the number of Delayed Transfers of Care per 100 000 population. Although the latest data was still on target there had been a slight rise since the previous set of latest data was reported.

Tandra Forster drew attention to AS3 regarding the average number of Delayed Transfers of Care, which were attributable to social care per 100 000. There had been a spike in average bed days and the red target was driven by other hospital pathways. Although Newbury and District Clinical Commissioning Group (CCG) was not the commissioner for Hampshire Hospitals, the area was still a contributing factor to their performance. It was hoped that the Better Care Fund Joint Care Provider Project would

support the Royal Berkshire Hospital to improve its figures. There were a variety of factors in place that would hopefully bring the figure down.

Cathy Winfield felt that good progress had been made and stated that she kept oversight of the 'fit to go' list. There was rising concern about the approaching winter with regards to workforce. Recruitment drives for nursing staff had taken place in both the Philippines and Ireland. The Urgent Care Board was due to meet imminently and would be focusing on the resilience of care homes. Tandra Forster agreed that workforce was consistently an issue. There were soon to be new NICE Guidelines and this coupled with the Home Care Living Wage, made the area particularly difficult tot tackle.

Councillor Lock asked if links were made with the John Radcliff Hospital, as she was aware of a case where a patient had been sent home from hospital with no home care provision in place for four to five days. Tandra Forster reported that there should be a joined up discharge process. It was not a hospital's responsibility to ensure the care was in place however, it was its responsibility to have the right conversations.

With winter approaching Cathy Winfield felt that it was important to understand contracts with nursing homes. Tandra Forster confirmed that most of the Council's money was with Birchwood Nursing Home. Following the Health and Wellbeing Board meeting Tandra Forster reported that she was due to attend a meeting on seven day working. It was reported that there was a very enthusiastic social worker in post at the Royal Berkshire Hospital and it was hoped that they would gather support.

Shairoz Claridge reported that AS5 regarding Ambulance response times was red against the target. This indicator needed to be achieved on a Thames Valley basis. Work was going on with the South and Central Ambulance Team (SCAS), who had faced particular challenges around recruitment. Councillor Graham Jones queried if the possibility of achieving the target was diminishing with winter on the horizon. Cathy Winfield reported that a lot of focus had been given to workforce issue, which was hoped would overcome the further winter pressures. SCAS had also been asked for a recovery plan. Adrian Barker queried if the latest data (74%) was a Thames Valley figure and Shairoz Claridge confirmed that the figure was for West Berkshire.

Shairoz Claridge reported that AS6, AS7 and AS8 were all measures of volume. Moving onto the Community Services section of the Dashboard, it was highlighted that performance for CSC1 regarding Mental Health – Crises Response/percentage of responses within four hours, was very positive at 100%. Quarter one data had showed a consistently high achievement for this indicator.

Rachael Wardell stressed that the recruitment was a major issue and the recruitment and the retention of staff were the main areas for concern that needed to be tackled with a whole system approach.

Cathy Winfield reported That CCG Chief Officers had met and as a result of concerns raised about workforce a review of governance arrangements had been initiated.

RESOLVED that The Health and Wellbeing Board be informed about recruitment and workforce issues being faced by Health and Social Care and have the opportunity to discuss.

39 An update report on the Better Care Fund and wider integration programme (Shairoz Claridge/Tandra Forster)

Tandra Forster introduced her report that sought to update Members of the Health and Wellbeing Board about progress on the Better Care Fund schemes. It was reported that

the two locality projects were currently rated as amber however, remedial actions had been agreed to ensure projects were on track.

The Joint Care Provider Project was progressing well. The project would help to reduce duplication within the system and focused on the development of seven day working.

The Personal Recovery Guide Project was proving to be challenging and needed further work.

Tandra Forster explained that regarding the Integrated Health and Social Care Hub, she would be giving a presentation to the Board on Adult Social Care's new way of working late on the agenda. There were elements of the Integrated Health and Social Care Hub project that would be incorporated into this new work in the future.

Regarding the Hospital at Home Project Cathy Winfield reported that it had been a particularly challenging project. It had been extremely difficult during the test launch stages to identify people who met the criteria of the project and suited the scheme. In conclusion, if something was not working then it was important to re-assess the situation. There were other services running in parallel to the project such as respiratory failure and rapid response and it had been the view of the clinicians that these services were working well however, there needed to be further focus on increasing provision. The decision had been taken not to invest in the project any further and a new proposal would be drawn up as a result of this decision .

A large focus moving forward would be around Nursing and Care Homes and attention needed to be given to identifying what was already being done for example by General Practitioners, local authorities and hospitals.

The Health and Wellbeing Board would need to give a view in the future of how under spends should be used.

RESOLVED that the Health and Wellbeing Board to be consulted on how under spends from the BCF should be used going forward.

Shairoz Claridge reported that the Frail Elderly scheme was now in the delivery phase and wider transition work would need to take place across Berkshire West. Tandra Forster expressed her support for the area of work however emphasised challenges being faced. The Department of Health required a performance base however, there was only a very small performance team in place making this demand extremely challenging.

40 The New Way of Working (Tandra Forster)

Tandra Forster gave a presentation to the Board, which aimed to advise them about the Adult Social Care Change Programme. The 'New Way of Working for Adult Social Care' project had been approved by the programme Board in December 2014.

There were huge challenges being faced by the system including growth in the number people aged 85 and over along with increases in the number of people living longer but not necessarily healthier lives.

A one model approach was being adopted and involved increased intensive support across tier one and two services with the aim of reducing the number of people reaching tier three services, which involved ongoing long term support. The new approach was fully compliant with the Care Act and followed a number of golden rules including offering tier one and two services before tier three services; no waiting lists; helping people to live as independently as possible; consideration to what would help carers continue caring and people and families planning their own support.

Regarding the next steps, planning implementation workshops had been scheduled, one of which had already taken place. The aim of these workshops was to consider how to go about shifting the whole of Adult Social Care into the new way of working. Evaluation of the second phase would take place and would involve comparing findings to initial evaluations that had taken place.

Lesley Wyman felt that prevention was missing from the new model including helping everyone to stay healthy. This was really about linking the work of Public Health to Adult Social Care. Tandra Forster indicated that prevention fell within the model as tier one and two services.

Councillor Hilary Cole commented that it was not possible to help people until they entered the system. Councillor Cole commended Tandra Forster and her team for amount of effort that had been put into the area of work. She felt it was an excellent project that would reduce cost and improve the lives of residents living in the district. Dr Bal Bahia added that there was a great deal of effort taking place across the board in this area by Primary Care and Hospitals, particularly with regards to prevention.

Cathy Winfield referred to 'Sam and his Journey', of which the first step was 'Ageing Well'. Rachael Wardell reported that this referred to the 'how' thinking across the Communities Directorate and that this same approach was being applied to metal health and wellbeing. It was very important to work closely with partners including the voluntary sector and the police as well as health partners.

Tandra Forster concluded that all staff within the service were undertaking training to help people help themselves.

41 A Review of Governance arrangements in respect of Health and Social Care Integration within Berkshire West (Nick Carter)

Nick Carter introduced his report to Members of the Health and Wellbeing Board, which aimed to inform the Board of the review of governance arrangements in place to support system integration across Berkshire West.

Nick Carter reported that he had been asked to carry out the piece of work following a residential conference that had taken place, which had included all partners involved in the area of Adult Social Care. The governance was proving to be a hindrance and therefore a review was requested. It was highlighted that the report and recommendations included had already been agreed and it would be going to the Berkshire West Integration Board in October 2015. It had been acknowledged that the process of integration took time and required good understanding between partners and good relationships.

It had been noted that the Chairman of the Integration Board had minimal accountability or responsibility around the integration agenda and therefore significant focus had been placed on the role of the Chairman as part of the review. A Management Group involving the Chairman had been proposed to take a view of what was working well and what was not.

There were two key groups; the Integration Board and the Delivery Group and the roles of the two groups had become undefined.

The three areas identified as benefitting most from integration work included elderly frail, children and mental health. These themes had not yet been bought together. The Integration and Delivery Group needed to focus on bringing these three areas together in a more coherent way.

To bring senior people together was often difficult and therefore every Wednesday going forward would become 'Integration Day', where integration had to be given priority over all other business.

It had been acknowledged within the report that elected Members needed to be included to a greater level within integration work. It had therefore been decided that the Chairman of the Health and Wellbeing Board would be invited to join the Integration Board once established. A lot of work had taken place at a Berkshire West level and it was felt that the Health and Wellbeing Boards within each of the localities needed greater insight into this work. Councillor Graham Jones agreed that the accountability was disjointed however, this was picked up by the report.

Adrian Barker reiterated his point regarding involvement of the public. He hoped in time the public would be regarded as an equal partner. Nick Carter felt that the Board meetings were where most interaction should take place with the public. The report addressed internal facing governance, which was in need of review. Cathy Winfield added that specific strands of work had included their own public engagement processes for example the work around 'Sam' had included a huge amount of work with the public. Adrian Barker concluded that in the future it would be nice to see the public involved in strategic discussions.

42 Feedback on the Health and Wellbeing Strategy Hot Focus: Mental Health and Wellbeing in Adults (Rachel Johnson/Lesley Wyman)

Rachel Johnson drew attention to her report which gave feedback on activity that had taken place over the last three months since the Hot Focus Session on Mental Health and Wellbeing in Adults.

Rachel Johnson reported that the Hot Focus Session had been well attended and had received very positive feedback from those who had attended. Group work had taken place on what the gaps and needs there were across services.

A Mental Health Forum had been set up since the Hot Focus Session to look at establishing a strategic way forward for mental health.. The group had met several times, commencing with two workshops to set out the key issues and a vision. A workshop had also taken place to develop an action plan for the area and had received input from a range of stakeholder organisations and service users. The action plan included issues raised at the Hot Focus Session and was about to go out to wider consultation. Further work was required around prevention, recovery and education including removing stigma that surrounds mental health issues. The action plan covered a 12 month period and then looked to three and five years.

Lesley Wyman asked if suicide prevention work was included under the action plan and it was confirmed that it was currently separate. It was suggested that these two areas should be brought together.

Councillor Lynne Doherty queried if the action plan mentioned included children's mental health. Rachel Johnson reported that it did as it belonged to the Adult Mental Health Group. Councillor Doherty stressed the need for both areas to be brought together.

Cathy Winfield explained that there was a group already in place looking at children's mental health issues. The work in this area was very specific and therefore it would be better not to disrupt what was taking place. It was however, important that there was good communication links between the two groups.

Councillor Cole felt that as services were dealing with individuals there should be a holistic approach. There was a cut off point when a child became an adult and with this

came a new set of services, which could be daunting and confusing. Councillor Mollie Lock supported Councillor Cole's views regarding moving towards a holistic approach.

Rachael Wardell explained that the law set out the distinctions between adults and children and the eligibility for children was different, there were also stricter safeguarding measures in place. Adults had more freedom to choose unlike children and this was why the services needed to be different. The period of transition was challenging regardless of if an individual had a disability. Work taking place was person centred and focused on understanding families in context of their communities and it was hoped that this would help smooth out the transition period. Dr Bal Bahia felt that it was important that discrete services were mindful of this challenging period and ensuring it was as smooth as possible.

Lesley Wyman reported that the Delivery Plans belonging to the Delivery Groups would need to cover all aspects of mental health including the transition from childhood.

Adrian Barker commended the work taking place however felt that an Adult Mental Health Strategy be developed rather than a stand alone action plan.

43 Better Care Fund - Under spends and Use of Contingency Fund (Tandra Forster/Shairoz Claridge)

Tandra Forster drew attention to the Better Care Fund Report, which informed the Board about under spends and use of contingency fund. Approval was being sought from the Board for the adjustment of the financial plan and proposed alternative investments.

Tandra Forster moved on to talk about schemes that were likely to under spend. Firstly because Hospital at Home had not fulfilled its purpose it was proposed that the money from the project be moved into the contingency fund. Regarding the Health and Social Care Hub, Adult Social Care was currently implementing its change programme. As the Council had paused its involvement with this project, money that had not been used would go into the Better Care Fund.

Regarding alternative use of the funds, as part of the BCF approval process a detailed expenditure plan had needed to be submitted to the Department of Health and NHS England for approval. Where it was identified that full funding was not required for its original purpose for that year, the recommended action was for the money to be transferred into the BCF contingency fund. Any proposals for how the money should be spent would then require approval from the Health and Wellbeing Board before funds were allocated to either partner.

The first proposal was for the sum of £58k to be allocated to Frail Elderly Pathway to deliver a financial model that would underpin the work. Rachael Wardell expressed her full support for the proposal.

Councillor Graham Jones proposed that the Health and Wellbeing Board approved the proposal that money be allocated to the Frail Elderly Pathway and this was seconded by Councillor Hilary Cole. The notion was carried when put to the vote.

RESOLVED that £58k be allocated to the creation of a financial model to underpin the Frail Elderly Pathway.

Cathy Winfield confirmed that the BCF would continue and it was possible that the NHS might get a multi year planning application. This was deemed to be positive however, it was highlighted that if this was the case then there might be delays in when the money was received. There would be the requirement for BCF plans to be on a Clinical Commissioning Group (CCG) foot print rather than the Local Authority. Therefore the Health and Wellbeing Board would be responsible for all of Newbury and District CCGs

plans and 50 percent of North and West Reading. There would be a formal review of how BCF money had been used in 2016.

In 2015 money placed into the BCF by the CCG had been labelled as new money. Due to anticipated pressures this money would most likely be dedicated in the future and therefore the amount of money for new schemes would be lower. The amount of money labelled as new money had been very ambitious

Tandra Forster stated that regarding impact, changes in projects could have significant consequences.

44 Berkshire West Health and Wellbeing Peer Challenge (Nick Carter)

Nick Carter introduced the report to Members of the Health and Wellbeing Board. A development session supported by the Local Government Association had already been provided for the Board and the Peer Challenge was a continuation of this work. Peer Challenges were subsidised by the Department of Health and were free to local authorities.

Nick Carter highlighted that it was a Peer Challenge of the Health and Wellbeing Board and it would take place on a Berkshire West basis with Reading and Wokingham local authorities. Lesley Wyman and Councillor Graham Jones had recently attended a scoping meeting to discuss the format. It would be a single review of all three Boards and it was likely to take place in March 2016.

Councillor Graham Jones reported that ideally he would like to see the Peer Challenge take place earlier however, March fell after the budget cycle. He stated that at the scoping meeting they had not finalised discussions about format and structure and more time was needed on this. Lesley Wyman highlighted that all three areas would have their review within the given timescale once agreed. It would be an opportunity to hold the mirror up and assess how the Board was progressing. All three areas were very different and to ensure each Health and Wellbeing Board was reviewed, more people would be required to conduct the review over a slightly longer period. The LGA had been confident that this was possible.

Councillor Graham Jones had noted that no one from the Clinical Commissioning Group (CCG) had been present at the initial scoping meeting and therefore the next meeting would be inclusive of CCG colleges.

45 Female Genital Mutilation (Fran Gosling Thomas)

Fran Gosling-Thomas introduced the report to the Health and Wellbeing Board. She apologised that the report had been brought back to the Board so soon after initially being brought to their attention in March 2015 however, greater focus needed to be given to Female Genital Mutilation (FGM).

A task and finish group had been set up around the issue of FGM however this had now completed its initial tasks. There was work taking place on the issue across partner agencies however, there was no agreed over-arching strategy or action plan in place. Many groups were interested in helping to support address the issue however, nobody had picked it up and taken responsibility for Governance.

The Local Safeguarding Children's Board (LSCB) were keen to contribute to areas of work however, because of a significant implementation plan as a result of a recent Ofsted inspection, it did not have the capacity to provide a leading roll on FGM.

Reading did a lot of cross boundary work and had a higher prevalence of FGM. Therefore it had been asked to be the lead authority on the issue for the West of

Berkshire. Fran Gosling-Thomas stressed that areas needed to pull together with strong support from their LSCBs. Fran Gosling-Thomas asked the Board if it would be willing to take the strategic lead for West Berkshire or jointly take on this role with the LSCB.

Cathy Winfield felt that the task and finish group needed to carry on its work and the Health and Wellbeing Board should oversee this. Fran Gosling-Thomas confirmed that this group had diminished around April 2015 however, the group lead would be happy to re-convene. There was a need however, for clarity around governance.

Rachael Wardell reported that the issue had been raised at the Safeguarding Adult's Board.

Fran Gosling-Thomas reported that she had written a letter to the Chairman of the Reading Health and Wellbeing Board and was awaiting a response. Meanwhile it was felt that West Berkshire needed to build its own framework for the issue, to highlight its intentions and governance including a small number of action.

Rachael Wardell noted that the appendices to the report highlighted the need for information sharing and communication on the issue. It was felt that these areas had not yet been achieved. Fran Gosling-Thomas added that public awareness in health settings needed improving.

Cathy Winfield stressed that somebody needed to pull the task and finish group back together, which would then report to all three Health and Wellbeing Boards. There had been an issue in the Chairman of the group had possessed no authority to ensure authority to ensure agencies were doing their part to tackle the problem. Reporting up to the Health and Wellbeing Board could help this issue.

Fran Gosling-Thomas stated that the task and finish group had been a small group and the membership would need revisiting if it was to reconvene. Clarity was needed from Reading on if it was happy to lead on the issue. The bottom line was that areas could not tackle the issue in isolation.

Councillor Graham Jones queried whether the issue could be picked up at the next Board meeting by which time Reading might have responded. Rachael Wardell highlighted that even if Reading led the area of work, local work still need to be underway. Fran Gosling-Thomas stated that West Berkshire required a basic strategy on the issue.

Rachael Wardell stated that the issue of FGM should also be being picked up by the Personal Social Health and Economic curriculum. Schools where this was required would need to be identified.

Dr Bal Bahia stated that as a GP he thought hid role was to inform the police if a case of FGM was suspected. Rachael Wardell explained that the issue caused a number of dilemmas. Cases were most likely to be identified within delivery suites at the Royal Berkshire Hospital. If the person in question was to have a daughter then there would be a safeguarding response would be prompted however, there might be no risk to the child depending on how the mothers circumstances might of changed.

Councillor Graham Jones proposed that the Board approved the recommendation within the appendix to the report and this was seconded by Councillor Hilary Cole. This notion was carried at the vote.

RESOLVED that the recommended action outlined in the appendix one for a quarterly FGM delivery and safeguarding partnership meeting to be initiated that include developing policy and practice, awareness raising, intelligence gathering and sharing and data monitoring, was approved by the Board.

46 Members' Question(s)

There were no Members' questions received.

47 Health and Wellbeing Conference (Jessica Bailiss/Jo Naylor)

The Health and Wellbeing Board noted the report.

48 Future meeting dates

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

(The meeting commenced at 9.00 am and closed at 10.57 am)

CHAIRMAN …….

Date of Signature …….

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Health and Wellbeing Board Forward Plan 2015/16

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?
26th November 2015 (pm) Health and Wellbeing Board Development Session						
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/Rachael Wardell	Health and Wellbeing Management Group	Part I
Primary Care Strategy Update	To update the Board on progress with the Primary Care Strategy from North and West Reading CCG and Newbury and District CCG .	For information and discussion	17th December	Bal Bahia/Sarah Wise	Health and Wellbeing Management Group	Part I
111 procurement	To update the Board on procurement for the 111 service.	For information and discussion	17th December	Shairoz Claridge	Health and Wellbeing Management Group	Part I
Integration Programme						
Better Care Fund Guidance for 2016 and the process for 2016/17	To inform the Board of the new Guidance for 2016.	For information and discussion	17th December	Cathy Winfield /Shairoz Claridge	Health and Wellbeing Management Group	Part I
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
Commissioning Plans						
Alignment of Commissioning Plans	To timetable/forward plan the alignment of commissioning plans	For Information and discussion	17th December	Tandra Forster/Shairoz Claridge/Lesley Wyman	Health and Wellbeing Management Group	Part I
Governance and Performance						
Delivery Plan Performance Report	To provide exception reports from each of the delivery groups.	For information and discussion	17th December	Lesley Wyman	Health and Wellbeing Management Group	Part I
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	17th December	Andy Day/Nick Carter	Health and Wellbeing Management Group	Part I
Development Plan						
Development Plan and Governance for the Health and Wellbeing Board	To keep an overview of the Board's progression	For Information and discussion	17th December	Nick Carter/Graham Jones	Health and Wellbeing Management Group	Part I
Other Issues for discussion						
Learning Disabilities	To update the Board on work taking place in this area.	For information and discussion	17th December	Patrick Leavey	Health and Wellbeing Management Group	Part I
Recruitment and workforce issues	To inform the Board about recruitment/workforce issues being faced by Health and Social Care.	For information and discussion	17th December	Tandra Forster	Health and Wellbeing Management Group	Part I
Local Account	To ensure the Health and Wellbeing Board is sighted on activity taking place across Adult Social Care and what the plans are for the coming year.	For Information and discussion	17th December	Tandra Forster	Health and Wellbeing Management Group	Part I
11th February - half day hot focus session - CAMHs						
Health and Wellbeing Hot Topic: Children and Adolescent Mental Health Service.	**To introduce the hot topic to the Board followed by a briefing on activity planned for the next three months.**			**Mac Heath/Sally Murray/Andrea King**		
February/March 2016 (date tbc) - PARTNERSHIP CONFERENCE (this is a follow up event to that which took place on 5th November 2015)						
24th March 2016						
Items for Discussion						
System Resilience						
Health and Social Care Dashboard	To present the Dashboard and highlight any emerging issues	For information and discussion	25th February	Tandra Forster/Shairoz Claridge/Rachael Wardell	Health and Wellbeing Management Group	Part I
Street Triage	To provide an update for the Board.	For information and discussion	25th February	Shairoz Claridge/Jason Jongali	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	25th February	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: Falls Prevention	To feedback on activity that has taken place over the last three months.	For information and discussion	25th February	Lesley Wyman/TBC	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	25th February	Tandra Forster/Shairoz Claridge/Lesley Wyman	Health and Wellbeing Management Group	Part I
Governance and Performance						
Delivery Plan Performance Report	To provide exception reports from each of the delivery groups.	For information and discussion	25th February	Lesley Wyman	Health and Wellbeing Management Group	Part I
28th April 2016 - half day hot focus session, topic tbc						
26th May 2016						
Items for Discussion						
System Resilience						
Health and Social Care Dashboard	To present the Dashboard and highlight any emerging issues	For information and discussion	28th April	Tandra Forster/Shairoz Claridge/Rachael Wardell	Health and Wellbeing Management Group	Part I

Health and Wellbeing Board Forward Plan 2015/16

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?
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	28th April	Tandra Forster/Shairoz Claridge	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	28th April	Tandra Forster/Shairoz Claridge/Lesley Wyman	Health and Wellbeing Management Group	Part I
Governance and Performance						
Delivery Plan Performance Report	To provide exception reports from each of the delivery groups.	For information and discussion	28th April	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 Board's progression	For Information and discussion	28th April	Nick Carter/Graham Jones	Health and Wellbeing Management Group	Part I
23rd June 2016 - half day hot focus session, topic tbc						
7th July 2016						
Items for Discussion						
System Resilience						
Health and Social Care Dashboard	To present the Dashboard and highlight any emerging issues	For information and discussion	9th June	Tandra Forster/Shairoz Claridge/Rachael Wardell	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	9th June	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: Children and Adolescent Mental Health Service.	To feedback on activity that has taken place over the last three months.	For information and discussion	9th June	Mac Heath/Sally Murray/Andrea King	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	9th June	Tandra Forster/Shairoz Claridge/Lesley Wyman	Health and Wellbeing Management Group	Part I
Governance and Performance						
Delivery Plan Performance Report	To provide exception reports from each of the delivery groups.	For information and discussion	9th June	Lesley Wyman	Health and Wellbeing Management Group	Part I
29th September 2016						
Items for Discussion						
System Resilience						
Health and Social Care Dashboard	To present the Dashboard and highlight any emerging issues	For information and discussion	1st September	Tandra Forster/Shairoz Claridge/Rachael Wardell	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	1st September	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 : TBC	To feedback on activity that has taken place over the last three months.	For information and discussion	1st September	TBC	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	1st September	Tandra Forster/Shairoz Claridge/Lesley Wyman	Health and Wellbeing Management Group	Part I
Governance and Performance						
Delivery Plan Performance Report	To provide exception reports from each of the delivery groups.	For information and discussion	1st September	Lesley Wyman	Health and Wellbeing Management Group	Part I

RefNo	Meeting	Action	Action Lead	Agency	Agenda item	Comment
64	24-Sep-15	Adrian Barker referred to the action from the previous meeting regarding the Children and Young People's Survey, as the full report had now been circulated. He felt that the following points needed to be picked up: 1. 8% of children and young people surveyed in West Berkshire had said they were unhappy, which was above the national average. 2. At one of the schools which took part, 68% said they had been bullied in the last year.	Children and Young People Delivery Group Mental Health and Wellbeing Delivery Group	Multi-agency	Actions from previous meeting	This will feed onto the work of the delivery groups.
65		It was suggested that a planning event should be scheduled for 2016 prior to the refresh of partner plans and the Health and Wellbeing Strategy. This would support the joining up of work strands, the allocation of resources and ensure issues were jointly addressed.	Jessica Bailiss/All	HWBB	Actions from previous meeting	Planning Event scheduled for the 26th November 2015.
66		LAC Healthchecks to be added as a measure to the H&SC Dashboard.	Jessica Bailiss	WBC	Health and Social Care Dashboard	This has been incorporated.
67		The Health and Wellbeing Board to be informed about/given the opportunity to dicuss recruitment and workforce issues being faced by Health and Social Care.	Tandra Forster/Health and Wellbeing Board	HWBB	Health and Social Care Dashboard	This has been placed on the forward plan for the Board meeting in January 2016.
68		The Health and Wellbeing Board to be consulted on how under spends from the BCF should be used going forward.	Cathy Winfield/Tandra Forster/Shairoz Claridge	HWBB	An update on the BCF and wider integration programme	Items will come to the Health and Wellbeing Board for discussion when necesary.
69		Quarterly FGM delivery and safeguarding partnership meetings to be initiated that include developing policy and practice, awareness raising, intelligence gathering and sharing and data monitoring.	Jenny Selim	NHS	Female Genital Mutilation	Jenny Selim will be leading on FGM for East and West Berkshire and has formed the development group, which will lead on a FGM Strategy/Action Plan for the area. The first meeting of this group will take place on 18th November 2015.

Actions carried over from previous meeting(s)

RefNo	Meeting	Action	Action Lead	Agency	Agenda item	Comment
53	26-Mar-15	Comparator Data to be provided regarding the Joint Self Assessment for Learning Disabilities	Tandra Forster	WBC	Joint Self Assessment for Learning Disabilities	There is now a service manager in place for Learning Disabilities. An update will be brought to the Board in January.
54		Learning Disability Action Plan to be circulated to Board Members along with a more comprehensive version of the Self Assessment document.	Tandra Forster	WBC	Joint Self Assessment for Learning Disabilities	There is now a service manager in place for Learning Disabilities. An update will be brought to the Board in January.

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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	2015/16 Target	Positive or negative trend	Latest data	Narrative
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		92%	↓	**90% Q2**	Relates to a low cohort and affected by low numbers and therefore fluctutates from month to month. The Joint Care Provider project means that our volumes are increasing and will make this indicator less volatile. We feel confident that we will still meet planned target.
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	↓	**383 Q2**	We are currently monitoring the volume of activity - both assessments against the national eligibility criteria and work that is now completed prior to this such as enablement and provision of prevntative services such as equipment.
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	↑	**64% Q2**	The change in eligibility framework resulting from the Care Act has created a new imperative for this work; all long term clients will have to have had a review under the new framework by 31 March 2016. Additional capacity has been brought in to focus on this area of work, it has taken time to bed in so there was a slow start to work in quarter 1. Additional capacity has resulted in increased pace; there is a lag in updating the case management system so progress is not accurately reflected.

Children's Social Care

Ref.	Indicator	Basis	Frequency	Normal Range	2015/16 Target	Positive or negative trend	Latest data	Narrative
CSC1	The number of looked after children per 10,000 population	West Berkshire Children's Services	Quarterly	Between 38 and 46 per 10,000		↓	**48 Q2**	The number of Looked After Children has remainned relatively constant over the last six months between 49 (April 15) and 48 (end Sept 15) LAC, but our rate per 10,000 remains above the average range. All LAC arrangements are currently subject to legal review to ensure appropriate arrangements.
CSC2	The number of child protection plans per 10,000 population	West Berkshire Children's Services	Quarterly	Between 28 and 34 per 10,000		↓	**37 Q2**	The number of Children subject to Child Protection Plans remains almost identical to the end of Q1. Our rate per 10,000 is very similar to that of our Comparator Group of authorities for 2014/15, but continues just above the normal range. All Child Protection Plans in place over 12 months are subject to audit to ensure appropriateness.
CSC3	The number of Section 47 enquiries per 10,000 population	West Berkshire Children's Services	Quarterly	Between 80 and 100 per 10,000		↓	**169 Q2**	A high volume of S47 Enquiries in September has increased our rate per 10,000 but a review of S47 thresholds has given assurance that appropriate S47 threshold is applied.
CSC4	To maintain a high percentage of (single) assessments being completed within 45 working days	West Berkshire Children's Services	Quarterly		70%	↑	**80% Q2**	Performance against this indicator has improved significnatly since the end of Q1 . A much higher percentage of single assessments are now being completed on time and this is gradually impacting on our YTD figures.
CSC5	Looked after children cases which were reviewed within required timescales	West Berkshire Children's Services	Quarterly		99%	↓	**99% Q2**	Performance agianst this indicator continues to be strong.
CSC6	Child Protection cases which were reviewed within required timescales	West Berkshire Children's Services	Quarterly		99%	↓	**98% Q2**	Performance agianst this indicator continues to be strong.
CSC7	Percentage of LAC with Health Assessments completed on time.	West Berkshire Children's Services	Quarterly		90%	↑	**73% Q2**	Although well below our target of 90%, performance against this indicator has greatly improved since the end of Q1 and continuing improvement is being progressed.

Acute Sector

Ref.	Indicator	Basis	Frequency	Baseline data	2015/16 Target	Positive or negative trend	Latest data	Narrative
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%	↑	**96.1% August**	Since April 95.8% of patients spent 4 hours or less in Accident and Emergency at RBFT and the target for this indicator is 95%. The Urgent Care Programme Board continues with a robust approach to ensure performance is as high as possible and all partners are working together to ensure the target is maintained through quarter 3.
		Hampshire Hospitals NHS Foundation Trust				↓	**90.1% August**	The lead commissioners for these contracts have been approached to provide comment on what arrangements are in place to ensure that this target is met going forward
		Great Western Hospitals NHS Foundation Trust				↓	**93.2% August**	The lead commissioners for these contracts have been approached to provide comment on what arrangements are in place to ensure that this target is met going forward
AS2	Average number of Delayed Transfers of Care (all delays) per 100,000 population (18+)	Berkshire Healthcare NHS Foundation Trust	Monthly			↑	**0.7 August**	The last quarter saw an increased number of attendances in A&E resulting in a higher number of admissions. This increase in activity combined with challenges in sourcing external homecare has hindered our ability to support timely discharge from hospital. Working jointly with health partners through the Joint Care Provider project we are engaging earlier with patients to help plan discharge, this work has been focused on the RBH but has now been expanded to Great Western and North Hant Hospitals. We are also piloting 7 day working across all hospital pathways to ensure a consistent response across the week. In addition we anticipate increased capacity in external homecare following a recent contract award.
		Great Western Hospitals NHS Foundation Trust				↑	**3.2 August**	
		Hampshire Hospitals NHS Foundation Trust				↓	**2.8 August**	
		Oxford University Hospitals NHS Trust				↓	**0.3 August**	
		Royal Berks NHS Foundation Trust				↑	**2.2 August**	
		Total West Berkshire		14.7 (2012/2013 data)		↑	**9.2 August**	
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			↑	**0.7 August**	
		Great Western Hospitals NHS Foundation Trust				↑	**1.0 August**	
		Hampshire Hospitals NHS Foundation Trust				↓	**2.2 August**	
		Oxford University Hospitals NHS Trust				↔	**0.0 August**	
		Royal Berks NHS Foundation Trust				↑	**0.8 August**	
		Total West Berkshire			4	↑	**4.7 August**	

Acute Sector (continued)								
Ref.	**Indicator**	**Basis**	**Frequency**	**Baseline data**	**2015/16 Target**	**Positive or negative trend**	**Latest data**	**Narrative**
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 August**	A new process has been recently established to monitor and reduce DToCs in community beds. BHFT produce a weekly list of all the delays in Community beds and this is then discussed with Council representatives on the System Resilience conference calls so that actions can be agreed and progressed to expedite discharge and minimise delays. This has been done in recognition of the significant impact of delays in community beds on capacity and flow through the whole system
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%	↓	**72.5% August**	During August the Thames Valley wide 75% standards were not achieved for Red 1 or Red 2 calls responded to within 8 minutes. Performance deteriorated in July across the whole SCAS geography due to an upgrade to their IT system that is used for dispatching vehicles. The CAD IT system upgrade in July has continued to have an effect on performance in August. SCAS are completing a data exercise to try and understand the differential impact of resources versus the CAD upgrade. Resources in Thames Valley continue to be under plan despite investment from the CCGs due to difficulties with recruitment and high numbers of staff leaving. There has been a decrease in conveyance though and an increase in hear and treat and see and treat. The Thames Valley CCGs have taken the following action to support an improvement in performance; Contract Performance Notice served for TV performance Financial withholding for July and August TV performance A letter requesting further actions/assurance around winter performance and resilience funds for TV In addition to actions associated with the above CCG action, we are in the process of arrangement an CFO/AO level engagement event with SCAS and TV commissioners to give SCAS the opportunity to provider further assurance to the CCGs.
AS6	A&E Attendances	Royal Berkshire Foundation Trust for Berkshire West	Monthly	1256 average monthly figure from 13/14		↑	**1,168 August**	Q1 A&E attendances were in line with expected activity. The system focused on planning for the Easter period and ensuring alternatives to Emergency Department were available so that patients did not default to A&E. Resilience initiatives were funded for an additional month during April.
		Hampshire Hospital Foundation Trust for Berkshire West	Monthly	300 average monthly figure from 13/14		↑	**404 August**	
		Great Western Hospital for Berkshire West	Monthly	168 average monthly figure from 13/14		↓	**212 August**	
AS7	Number of non elective admissions	Royal Berkshire Foundation Trust for West Berkshire	Monthly	547 average monthly figure from 13/14		↑	**517 August**	Q1 non elective admissions were also in line with expected levels. Resilience initiatives were funded through April rather than being ceased on 31st March to ensure that any peaks in activity linked to the Easter period could be managed.
		Hampshire Hospital Foundation Trust for West Berkshire		157 average monthly figure from 13/14		↓	**179 August**	
		Great Western Hospital for West Berkshire		84 average monthly figure from 13/14		↔	**103 August**	
AS8	Total number of 111 calls (Answered in 60 seconds)	Berkshire wide	Monthly		No Target	↓	**14,354 Q2**	South Central Ambulance Service are consistently meeting the target to answer 95% of calls to NHS 111 within 60 seconds

Primary Care								
Ref.	**Indicator**	**Basis**	**Frequency**	**2014/15 Benchmark**	**2015/16 Target**	**Positive or negative trend (see key)**	**Latest data**	**Comments**
PC1(a)	GP referrals to secondary Care	Newbury & District CCG	Quarterly		N/A			
PC1(b)	GP referrals to secondary Care	North & West Reading CCG	Quarterly		N/A			
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**	**2015/16 Target**	**Positive or negative trend (see key)**	**Latest data**	**Comments**
CS1	Mental Health - Crisis response % of responses with 4 hours	Berkshire West	Quarterly		90%			

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 figure 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	Definition: Those clients that have had long term support for more than 12 months that have been reviewed in the last 12 months. 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.	Looked after child: These are children who are looked after by the authority
CSC2		Child Protection Plan: A detailed inter-agency plan setting out what must be done to protect a child from further harm, to promote the child's health and development and if it is in the best interests of the child, to support the family to promote the child's welfare.
CSC3		Section 47 Enquiry: Where there is reasonable cause to suspect that a child is suffering, or likely to suffer, significant harm, the local authority is required under s47 of the Children Act 1989 to make enquiries, to enable it to decide whether it should take any action to safeguard and promote the welfare of the child.
CSC4	Target Numbers for CSC 4, 5 and 6 come from those set in Children's Services' Service Plan. Trend data is based on the last quarter.	Single Assessments: The single assessment is a new assessment document. It is gradually replacing the initial and core assessments by combining both within one document.
CSC5		
CSC6		
CSC7		

(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. (Data has been backdated to ensure reporting methodoligy matches that used for AS3)	(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. The calculation for each trust/hospital is: (YTD Average of Delays per month/ population)*100000. So for April, the figure for the YTD Average part will include April only, but for May it would include the average of April and May and so on for each month until the end of the financial year. The result of the above calculation for each hospital is then totalled up to give the West Berks Part 2 figure	(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 in another healthcare provider.
AS8	Data is based on Berkshire as a whole	NHS 111 is a new service that was introduced to make 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. (data provided will sometimes be an estimate and will be marked with an (e) accordingly if so)	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. (data provided will sometimes be an estimate and will be marked with an (e) accordingly if so)	
PC2		
PC3		

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

Title of Report:	**Better Care Fund – Progress Report**
Report to be considered by:	The Health and Wellbeing Board
Date of Meeting:	26th November 2015

Purpose of Report: **To update the Health and Wellbeing Board about progress on the Better Care Fund schemes and to seek approval of the quartely data return.**

Recommended Action: **For information and approval.**

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. Programme Status

1.1 Work is underway on all of the schemes in the West Berkshire BCF programme. The two locality projects are currently rated as amber, remedial actions have been agreed to ensure projects are on track.

2. BCF Quarterly Data Collection

2.1 The Department of Health (DoH) has introduced a quarterly template to enable the Health and Wellbeing Boards to track performance on the delivery of the Better Care Fund Programme of work. The second quarter report has been submitted and the third quarter is being prepared for submission. Delegated authority to the Corporate Director, Communities Directorate to be confirmed by the Board.

2.2 As part of the assurance process the return requires Health and Wellbeing Board approval. This would normally be completed prior to submission to the DoH however timeframes this time did not allow this.

3. 'Showcasing' West Berkshire.

3.1 The national Better Care Support Team has requested an opportunity to carry out an Insight Visit to understand how the BCF has been applied in West Berkshire as a positive model of the scheme. This will take place in February 2016.

4. Better Care Fund from 1st April 2016

4.1 Currently BCF funding ceases on 31st March 2016, however the Department of Health has confirmed that the will be a BCF for 16/17. At this stage NHS England has not confirmed it's position and no operational guidance has yet been issued.

5. BCF Projects progress

(1) **Hospital At Home**

The project is currently on hold; as some health staff had been appointed to this project they are being used in 2 short term projects a) to explore the potential of a Care Home crisis response team to try to reduce the numbers of unnecessary admissions to hospitals from care homes, and b) to provide enhanced medical support in Prospect Park Hospital for Older inpatients; currently these projects are planned up to 31/3/16.

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

The Health Hub is already successfully operating as a conduit for referrals from Health to Local authorities. The scope of the project has been to develop a single triage point for all referrals to Health and the Local Authorities. This development would contradict the new approach to Adult Social Care that the Council is adopting where the emphasis is on a detailed engagement with clients at the first point of contact in order to link individuals with universal services, and where necessary funded services as quickly as possible to minimise dependency on Council funded services. The position that the Council is taking is that the current function of the Hub is helpful, however, the Council would not transfer it's resources to the proposed Health and Social Care Hub to support a Triage function being carried out on behalf of West

Berkshire Council. The project is expected to proceed on the basis that it will provide the Triage function as planned for Wokingham Council. As the project develops it is expected to consider the range of emergency and out of hours responses that are needed by all providers and west Berkshire Council will be interested in the potential benefits of the Hub in delivery of those services.

(3) **Care Home Project** Scheme is focussed on preventing admissions to hospital. It is investing in a Pharmacist and Speech and Language Therapist to support the delivery of care in care homes. It is encouraging care homes to access health services within the homes. It is also running a leadership programme for a number of care home managers.

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

The project will simplify access to and reduce duplication in the delivery of care by BHFT Intermediate Care, and the Council's Maximising Independence and Reablement care Services.The Innovation phase of the project, testing the new 'Pathway' for all individuals being discharged from the Royal Berkshire Hospital commenced on June 1st. This will be followed by a Consolidation Phase responding to discharges from Swindon, Basingstoke and West Berkshire Community Hospitals from 1st November 2015. Under the project some initial testing of the value of providing a limited Care Management service in the 3 acute hospitals on Saturdays and Sundays is proving successful and plans are being developed to make this a regular service. Funding is in place to 31st March 2016 under the BCF and the extension of this service will be dependent upon BCF funding agreements beyond that date. This project will shortly be closed as the service becomes 'business as usual'.

(5) **Personal Recovery Guide**

The scheme will provide a Guide to vulnerable residents who are using the complex network of health and social care services. Contracts have been signed with British Red Cross, AgeUK and the Volunteer Centre West Berkshire (VCWB) to provide this joint service in a pilot phase which commenced on 1st July 2015; all three providers have staff and volunteers in place to deliver this service and have engaged in a publicity campaign to attract users of the service. Proving the value of this service is planned to lead to an ongoing contract through competitive tender from April 2016.

(6) **Workforce Project**

The project is developing the role of Generic Support Worker as a model to explore combining health and social care tasks to rationalise the number of staff who may be visiting individuals in their own homes. The Council's Reablement Service is taking part in the planning and implementation of this pilot.

6. Equalities

6.1 Projects contained within the Better Care Fund programme are focused service improvement and should result in a better service for all.

7. Recommendations

7.1 That the quarterly data collection return be approved, as set out in paragraph 2.2 of this report.

Appendices

Appendix A – Highlight Report (In separate information only pack)
Appendix B – Integration Portfolio Status Report and Risk Register
Appendix C - BCF Quarterly Data Collection 14/15 (Will follow within a supplement pack)

Consultees

Officers Consulted:	Toby Ellis, Paul Coe, Steve Duffin, Shairoz Claridge, Patrick Leavey
Other:	Not applicable

BW10 Integration Programme Report

Reporting Period – September 2015

Programme RAG Status and Headlines

A

- **Revised Berkshire West 10 (BW10)** Integration governance and board structure operational from September.
- **Delivery Group** Terms of Reference reviewed and updated.
- **Programme Management Office (PMO)** – Head of PMO post now vacant. Only part time cover in place for PMO functions, current officer leaves end of October.
- **Hospital at Home** – The project has formally been paused due to a lack of activity going onto the agreed pathway.
- **Integrated Carers Commissioning** - Status change from Green to Amber - The fragmentation of commissioning arrangements for carers information advice and support provision is likely to detract from the stated aspiration to move towards single pot funding for all carer support across the West of Berkshire.

Key progress for last period

- **Reading BC** – Part year review of Better Care Fund (BCF)/Reading Integration completed - Identified the need to review milestones. Partners for Change work commenced in Adult Social Care with innovation sites expected to be in place by November.
- **West Berks BC** – **Joint Care Provider** - An element of the project (condition 1 – Discharge) has been adopted as business as usual, preparation underway to extend to other acute NHS sites. **7 Day Services** - Pilot of weekend Social Worker presence at RBH has proved successful and beneficial. **Personal recover guide** - scheme is operational, initial referrals made within the RBH with positive feedback.
- **Wokingham – H&S Hub -** Project Board established. Revised project plan and schedule drawn up and in place, implementation time-scale revised from October 2015 to April 2016. **Step up/step down (SUSD) -** occupancy increased and referral options expanded to include GP. Re-designing pathway to make Hub first point of contact Project impact recording being undertaken, estimated savings included on HR.

Berkshire wide Programme and Enablers

- **Connected Care** – Project Board has agreed to move into the procurement process (Phase 2). Procurement documentation being prepared, looking to issue materials to the market week commencing 19 October.
- **Enhanced Support to Care Homes** - 14 care homes from Berkshire West attending leadership programme. Pharmacy/medicine management programme delivered £26k savings .
- **Frail Elderly Pathway** – Update provided via standalone report
- **Hospital at Home -** Phase 2 go-live for September paused. Options appraisal for project re-configuration under review.
- **Integrated Carers Commissioning** - Berks West CCGs, Reading and West Berkshire have continued to develop service descriptions in preparation for re-commissioning carer Information Advice & Support service.
- **Market Management** – Business case for purchasing data pooling via Data Hub complete.
- **Workforce -** Project manager recruited and in post from September. New Project Initiation Document drafted and to go to Delivery Group for review/comment.

Planned activities for next period

- **Reading BC** - BCF/Integration workshop action log to be reviewed at Reading Integration Board BW10 Delivery Group. Finalise Discharge to Assess (DTA) GP cover and continue work with Royal Berkshire Hospital to streamline discharges. Agree format of DTA project evaluation. Detail of extended hours and Saturday opening for GPs being formulated.
- **West Berks BC** – *BCF04 Joint Care Provider* - New Pathway to be route for service for all patients from community or full range of hospitals from 2nd November 15. *BCF03 Personal Recovery Guide* – extend referrals to GP, develop outcomes monitoring and specification for tender
- **Wokingham BC** - Continue consultation to look at impact of SUSD and its expansion to 3 units. Complete negotiations with Optalis regarding expanding Domiciliary Care service to 24/7. New Head of Service for Integrated short term health & social care team recruited
- **Connected Care** - Phase 2 Procurement documentation is being prepared, looking to issue materials to the market week commencing 19 October.
- **Enhanced Support to Care Homes** - Care Home best practice group to finalise guidance by November 2015.
- **Frail Elderly Pathway** – Update provided by standalone report
- **Hospital at Home -** Proposals for the remainder of 15/16 being worked up with the local teams and will be shared with the Health and Well-Being boards for agreement. – see Highlight report for proposed options .
- **Integrated Carers Commissioning -** Berks West Carers Commissioning Strategy outline and Project Plan prepared for the Berks West Carers Forum.
- **Market Management** - Data Hub/Service Directory business case complete and decision on commissioning to be confirmed at October project group.
- **Workforce** – Local Authorities to evaluate Generic Support Worker (GSW) Job Description. Trial Introduction of GSWs across Berkshire

Key Risks	Mitigating Actions
Finance (Risk 19): BCF schemes started 2015/16 are not funded in subsequent years threatening continuation of integration programme.	Identify possible additional sources of funding for continuation of schemes. FSG undertaking preparatory work pending NHSE guidance on BCF for 16/17.
Connected Care (risk 28): Risk that the project funding proposals are not sufficiently secure	Project leads working with Finance Sub Group to identify funding options and strengthen proposal, where required
Hospital at Home (risk 22)Insufficient referrals to service undermines business case assumptions on number of patients admitted and Length of Stay on inpatient wards - Impacts as per Risks 1, 2 & 3	Project proposals for the remainder of 15/16 being worked up with the local teams and will need to be shared with the Health and Well-Being boards for agreement.

BW10 Integration Programme Report

Reporting Period – September 2015

RAG Assessment	Progress vs. previous	↑ ↔ ↓	Update on Progress – Programme Management
	↔		***Delivery Group, Finance Sub Group, Programme Management Office (PMO)***

Delivery Group

- New DG regime met for first time in September. Group Terms of Reference reviewed and updated. The primary programme need was agreed as a need to refresh and refocus on the intended outcomes and required benefits for the programme of activities.
- Other governance reviewed/agreed including - refreshing role definition in projects to clarify responsibility to drive change in 'business as usual', agreeing 'what good looks like' and maintaining a library of best practice examples of Business Cases and Highlight reports, review of group membership and subgroups.
- Areas of future focus to include - Co-production and user involvement, PMO and Learning Disabilities/Mental Health work stream resources.

Finance Sub Group

- Undertaking full year to date spend and full year forecast for all Integration/BCF projects to agree robust financial position – feedback/report available post October meeting.
- October meeting to begin undertaking initial BCF forward planning to prepare for 16/17finanical years, and beyond.

Programme Management Office

- Head of PMO post now vacant.
- Only part time cover in place for PMO functions, current part time PM leaves end of October.

RAG Assessment	Progress vs. previous	↑ ↔ ↓	Update on Progress – Frail Elderly Pathway
	↔		***Frail Elderly Pathway***

Update provided by standalone report

BW10 Integration Programme Report

Reporting Period – September 2015

RAG Assessment	Progress vs. previous	↑ ↔ ↓	Update on Progress - Locality Programmes
A	↔		***Reading***

Current Status

- Part year review of BCF/Reading Integration completed - Identified the need to review milestones for all projects.
- Discharge to Assess up and running (105 referrals to the Willows and 432 through CRT) and GP cover proposal now drafted and awaiting funding agreement.
- 2 pilots for neighbourhood clusters up and running. Health model reviewed with possibility of restart with social care to restart September 15.
- Partners for Change work commenced in Adult Social Care with innovation sites expected to be in place by November. This work will refine the approach to neighbourhood clusters.
- Social Care and community nursing and therapy services operating 7 day cover.
- Acute and GP surgeries yet to implement whole systems 7 day cover. Ongoing work between CCG's and GP surgeries with detail of extended hours and Saturday surgery opening for GPs now being formulated.
- Section 75 pooled budget agreement (s75) with RBC Legal for review and due to be signed off imminently.

Next steps/Planned Activity

- **Discharge to Assess (DTA**) – Discussions on-going with regards to funding GP cover for 14 beds before going out to tender for the service. Work has started to scope the use of two or three beds for planned respite admissions to accommodate people with mental health needs.
- **Whole System Whole Week: 1) Neighbourhood Clusters** - Review of pilot projects in Reading and how they fit with BCF to be undertaken.
- **Whole System Whole Week: 2) 7 day access** - Further work with RBH to address issues regarding discharge. Emergency Duty Service contract is up for renewal and initial discussion about our requirements going forward have started.
- **Whole System Whole Week 3) GP Access 7/7** - Detail of extended hours and Saturday surgery opening for GPs now being formulated.

Key issues raised

- Identified the need to review milestones for all projects. This is ongoing work which will be finalised once the detail of projects has been signed off by the Partnership Board.

BW10 Integration Programme Report

Reporting Period – September 2015

RAG Assessment	Progress vs. previous	↑ ↔ ↓	Update on Progress - Locality Programmes
A	↔		***West Berkshire***

Current Status

- **Joint Care Provider (inc 7 day services and direct commissioning)**
  - An element of the Joint Care Provider project (condition 1 – Discharge) has been adopted as business as usual and preparation is underway to extend this part of the service to other acute NHS sites. Scoping and delivery timescales for the initial elements of the remaining three conditions are in preparation. Future activity to be undertaken as business as usual. Project closedown undertaken – closure report and post-project actions document prepared.
  - Milestone Status – A new project plan concerning the extension of the Discharge condition and the initial stages of the remaining three conditions is in preparation.
- **Personal recover guide/Key worker project**
  - The scheme is operational in pilot phase and some initial referrals have been made within the RBH. Initial feedback from RBH staff very positive. Project closedown undertaken – closure report and post-project actions document prepared.
  - VCWB has recruited a Team Manager and are appointing volunteers . British Red Cross has appointed a manager, two Care Navigators and 1 Personal Recovery Guide. Age UK have also appointed a PRG Team Manager.
  - By 30 September 18 referrals to the service had been made leading to 16 patients being supported by the scheme.
  - The providers remain on target to offer incremental building service through all 3 charities by 1st October 15

Next steps/Planned Activity

- **Joint Care Provider**
  - Pathway Redesign (Discharge) - Full implementation of new pathway from 2nd November 15.
- **7 day services**
  - Care Management Staff to be operational at Weekends to continue discharge and community care planning processes across 7 days from 2nd November 15.
  - Operational Management weekend cover to be established to support enhanced service.
- **Direct Commissioning (Trusted Assessors)**
  - Community Nursing Staff will now have a role in urgent care and undertake rapid response assessments and in that role they will procure care.
  - Council staff under the New Way Of Working within Adult Social Care are able to initiate care where it is appropriate to avoid having to go through a second access route to care provision.
- **Personal Recover Guide**
  - Extend referrals to GPs – publicity is now available for distribution.
  - Outcomes monitoring in development
  - Develop contract specification as preparation for upcoming tender exercise.

BW10 Integration Programme Report

Reporting Period – September 2015

RAG Assessment	Progress vs. previous	↑ ↔ ↓	Update on Progress - Locality Programmes

Subject to WISP confirmation	↔		***Wokingham***
			Project Status
			• BCF programme in Wokingham is progressing with Step Up Step Down being utilised more effectively, the Health and Social Care Hub progressing regarding operational, technical and HR issues, the appointment of a new Head of Service for the WISH team, the new Community Navigator Co-ordinator starting and the Local section 75- signed by both parties who each have a copy. The CCG have signed Berks West S75 with Council's for signing.
			• A Project Support Officer is to start 19/10/15 and additional Finance support will start 9/11/15, the HWBB were briefed regarding 2015 Quarter 1 Department of Health return.
			Next Steps Planned activity
			• Integrated short term health & social care team
			  • New Head of Service to start 9/11/15
			• Step Up Step down
			  • Further resident meeting and consultation to look at impact of SUSD and its expansion.
			  • Expand the service to 3 units
			• Domiciliary Care Plus
			  • Complete negotiations with Optalis LTS regarding expanding Domiciliary Care service to 24/7.
			  • Options appraisal to be returned to WISP for night domiciliary care elements with additional financial information.
			  • Complete service specification and pathway for night domiciliary care service.
			• Neighbourhood Cluster Teams
			  • Neighbourhood Cluster Steering group to agree which services can be clustered, clear plans for implementation including timescales, KPIs / metrics will be developed and agreed, and the PID and project plan will be updated.
			  • Public "Have your Say" event is taking place on 20th October
			  • GPs to consider whether Vitality – type partnership arrangement is a suitable model for Wokingham; if not, then alternative ways of working can be explored. Aim to reach a decision by end of October.
			  • Overview & Scrutiny Review expected to start late Oct/Nov.
			• Primary Prevention
			  • Meeting to discuss Ageing Well and subsequent work to develop locality-wide Prevention strategies scheduled for 15 October.
			• Access to general practice
			  • Consider access for patients with practices not covered by CES scheme.
			
			- Hub progress reported on page 6 -

BW10 Integration Programme Report

Reporting Period – September 2015

RAG Assessment	Progress vs. previous ↑ ↔ ↓	Update on Progress - Berkshire West Projects & Enablers

A	↔	***Connected Care***
		Current Status
		• Phase 1 – complete
		• Phase 2
		  • Connected Care Board has agreed to move into the procurement process.
		  • Procurement documentation is being prepared, looking to issue materials to the market week starting 19 October.
		  • Funding sources have been identified (CCG's priming the project via existing funding streams) – subject to confirmation.
		  • Pilot project user acceptance testing has identified significant issues.
		Next steps/planned activity
		• Start the development of the Full Business Case and associated (CCG) partnering agreement.
		• Start the development of the participating organisation partnering agreement.
		• Issue the Invitation To Tender (ITT) week starting 19 October.
		• Develop the ITT briefing pack for those directly involved in the marking process.
		• Orion pilot: Deploy to the identified teams.
		New Risks Identified
		• FY15-16 Primary Care Infrastructure Fund has not been confirmed and may not be confirmed until late Q4. Future multi-year funding for phase 3 (full deployment of selected solution) has not been confirmed.
		  • IMPACT: Move into the procurement in the knowledge that it may need to be cancelled if no Primary Care Infrastructure funding is available (project becomes unaffordable).
		  • IMPACT: Build the multi-year cost model on sensible assumptions. Ensure protection for Wokingham CCG via the Partnering Agreement.

A	↔	***Market Management*** **Current Status** Project group re-convened early September following 2 month absence due to vacant Project Manager (PM) post (PM role now delivered via BW10 PMO). Group reviewed position of current initiatives and the required next steps to complete. Group also considered position of the project in relation to the wider Joint Commissioning aspirations and general consensus was that projects should merge. This will be further explored upon completion of current initiatives and at October project group. **Planned next steps:** • Market Management Information System - Compile Data Hub/Directory business Case and circulate to group for comments and clarification prior to next project group - Yes/No decision on progress at October meeting • Fair Pricing – Review of existing locality Older People residential costing models (i.e. locally tailored LaingBusisson tool kits) • Provider failure protocols - Review local protocols and align processes, where appropriate, and identify areas where partner collaboration can strengthen management/failure policy

BW10 Integration Programme Report

Reporting Period – September 2015

RAG Assessment	Progress vs. previous ↑ ↔ ↓	Update on Progress - Berkshire West Projects & Enablers
A	↔	***Workforce*** **Current status:** • New Project Manager appointed 7th September 2105 to implement the Workforce Action Plan signed off by the Partnership Board. • The Senior Responsible Officer (SRO) and two NHS members of the group have left the service. A new SRO is required as are two new NHS representatives. September meeting very poorly attended. • Funding for the project continues to be drawn from the from Health Education Thames Valley award. **Key Achievements:** • Updated Project Initiation Document (PID) drafted and will go to Delivery Group and Finance Sub Group for comment/approval • Report received from Skills for Health following three successful workshops. The report outlines the project methodology, outcomes and Next Steps/Recommendations. The workshop successfully defined the role of the Generic Support Worker and is represented in a Job Description Template. The Report has been circulated to the Steering Group for comment. **Next steps:** • LA to evaluate Generic Support Worker (GSW)Job Description • Trial Introduction of GSWs across Berkshire **Key issues raised:** • Currently no project SRO • If the valuation of the GSW Job Description is higher than current rates for Health Care Assistants and Support Workers the project may not be fully supported.
G	↔	***Health and Social Care Hub – Wokingham Locality Progress*** **Key Achievements** • Project Board established, meeting monthly • Revised project plan and schedule drawn up and in place. Implementation time-scale revised from October 2015 to April 2016 • Operational implementation group (OIG) established • Cross organisation HR links made and linked to OIG • WBC customer service ASC activity modelling underway as part of the cost for change work. • Integrated hub presentation completed for WBC ASC staff away day **Planned Next steps** • Staff engagement workshops to begin • Integrated hub staffing and cost for change option paper to drawn up and presented to the November project board meeting. • WBC ASC lean pathway transfer to be complete by 02/11/2015. • Staff engagement schedule due to be agreed week ending 09/10/2015.

BW10 Integration Programme Report

Reporting Period – September 2015

RAG Assessment	Progress vs. previous	↑ ↔ ↓	Update on Progress - Berkshire West Projects & Enablers
R	↓		***Hospital at Home***
			Project Status • The project has formally been paused: due to a lack of activity going onto the agreed pathway. During the soft launch period only 1 patient was successfully accepted out of the 36 patients identified as potentially suitable. • Berkshire Healthcare Foundation Trust have been asked to suspend further recruitment at this time to allow for consideration of next steps. • Staff including advanced nurse practitioners and a Community Geriatrician have already been appointed to and are in post. • A multi-agency task and finish group has been tasked with developing a proposal for the immediate redeployment of the staff already in post to support current system pressures and winter resilience. • The group has also been tasked to explore potential options for the future to be considered jointly between the Local Authorities and CCGs in the context of the wider integration programme and the 16/17 planning round. These proposals will be required to go through the local integration groups, CCG QIPP and Finance Committee for onward to the HWBs for approval. • Interim staff work plan proposals were shared with the 3 Local Authorities and Senior leads and presented to the Urgent Care Programme Board on 24th September, in order to gain support on the immediate redeployment of staff to support system resilience. **Next Steps** • Proposals for the remainder of 15/16 being worked up with the local teams and will need to be shared with the Health and Well-Being boards for agreement. – see Highlight report for detail of proposed options.
A	↓		***Integrated Carers Commissioning***
			Key Achievements: • **Carer Information Advice & Support Contract (IAS):** Berks West CCGs, Reading and West Berkshire have continued to develop service descriptions in preparation for re-commissioning carer IAS. Wokingham Borough Council is not a party to these arrangements. • **Carers breaks provision and support:** Ongoing consultation in Reading on a Wellbeing Bidding Framework which includes funding opportunities for carer support – now extended to include cares of disabled children as well as carers of adults. Similarly, West Berkshire is engaging with VCS providers to develop their second VS Prospectus. Wokingham is reviewing currently commissioned carer services through one to one engagement with providers. **Next Steps/Planned Activities** • **Carer Information Advice & Support contract:** Host a provider event to help finalise details of the bidding framework approach and then formally invite bids. • **Carers breaks provision and support:** Finalise Bidding Framework for Reading and Prospectus for West Berkshire. Concluded review in Wokingham. • **BW Carers Commissioning Strategy:** Outline and Project Plan to be prepared for the BW Carers Forum. **New Risks Identified** • The fragmentation of commissioning arrangements for carers information advice and support provision is likely to detract from the stated aspiration to move towards single pot funding for all carer support across the West of Berkshire.

BW10 Integration Programme Report

Reporting Period – September 2015

RAG Assessment	Progress vs. previous	↑ ↔ ↓	Update on Progress - Berkshire West Projects & Enablers
A	↔		***Enhanced Support To Care Homes***

Current status

- Project: Green due to all recruitment needs met.
- Financial: Amber - The intended reduction in non-elective admissions has not been met for month 4
- Activity: Green - reduction in activity has been met for the first time with the revised Healthcare Resource Group (HRG) codes.
- Milestones: Amber - One milestone outstanding; monitoring of accurate data on admissions.

Key Achievements

- Care home leadership programme - 14 care homes from Berkshire West attending course
- Pharmacy/medicine management - Report received demonstrating a £26k monthly savings
- Care home data - Comprehensive database in development

Next steps/planned activity

- Hospital at Home programme to consider opportunities for identifying care home resident at risk of NELs
- Review market management scheme and links to Care Home Scheme
- Care Home best practice group to finalise guidance by November 2015

New Risks Identified

- Ensure Local Authority (LA) engagement is maintained in Care Home working group .
    - IMPACT: LA Contracting knowledge on scheme initiatives will be compromised
- Ongoing risk of the accuracy of monitoring of non-elective admissions continue; validation by analytics completed and to be discussed at coding meeting with RBFT
    - IMPACT – Non Elective (NEL) activity monitoring could be incorrect

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Title of Report:	**Health and Wellbeing of Looked After Children Update**
Report to be considered by:	The Health and Wellbeing Board
Date of Meeting:	26th November 2015

Purpose of Report: **The purpose of this report is to provide the Health and Wellbeing Board with an update on the progress of Health Assessments for Looked After Children, subsequent to the Health & Wellbeing 'Hot Focus Session' that took place on 11th June 2015.**

Recommended Action: **To note the limited success at progressing this matter and to consider approaches being undertaken to ensure priority is given to the Health of our LAC in West Berkshire.**

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:		
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Outcome Where one or more 'Yes' boxes are ticked, the item is relevant to equality. In this instance please give details of how the item impacts upon the equality streams under the executive report section as outlined.

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Executive Report

1. Introduction

1.1 The Children Act 1989 clearly sets out the need for children who enter into the care of the local authority, to have an initial health assessment at the point of coming into formal care, and then dependent on their age, a follow up review health assessment at either six or 12 monthly intervals. The guidance is clear that this assessment then informs the child's statutory care plan. It informs and advises of the child's state of health and the health care needs that the local authority will need to attend to whilst the child is in the care of the local authority.

1.2 It was acknowledged that there were significant challenges in this expectation being met within West Berkshire and a 'Hot Focus' session was undertaken on 11th June 2015 to highlight this challenge and seek partnership commitment to evidence improvement.

1.3 This report sets out to update the Health and Wellbeing Board on the progress made and to highlight the need for this matter to remain a priority for the Board.

2. Context

2.1 At the point of the Hot Focus session in June 2015, it was confirmed that Health Assessments are commissioned by Berkshire West CCGs and the BHFT West Looked After Children Team are responsible for ensuring that:

- Looked After Children experience high quality care in line with the NICE Quality Standard for the health and wellbeing of Looked After Children and young people
- Looked After Children access timely initial and review health assessments resulting in timely and appropriate access to health services
- To ensure all Looked After Children and eligible care leavers have a health care plan that is designed to meet their individual health needs

Specifically the service is contracted to provide:

- 100% of Initial Assessments and the resulting care plan of children placed by the six local authorities up to 20 miles of the Berkshire boundary are completed within 20 working days of a child becoming looked after. This assumes and is dependent upon the timeliness of the notification from children's social care, and the timely completion of medicals by primary care and community paediatricians in Berkshire West.
- 100% of Review Health Assessments of children placed by the six local authorities within the Berkshire boundaries and for children placed up to 20 miles outside the CCG boundaries, are completed by the appropriately trained practitioner within the required timescales (child five years of age six monthly, child > five years of age annually). All assessments completed have a clear and outcomes led healthcare plan identifying any health needs for each individual child.

- The healthcare plan is completed and shared with children's social care once completed.

- Evidence of improved health outcomes through ensuring that health care plans are updated and any gaps in the child's health records are closed.

2.2 At the point of the June Hot Focus Session, it was identified that of our total LAC population in West Berks of 164, only 51% had completed health assessments on time.

2.3 This figure was identified against a National Average of 88% but a commitment given that all the LAC in West Berks should be offered a timely Health Assessment and a success of over 90% was achievable by Christmas 2015.

3. Hot Focus Session on LAC Health

3.1 The session was convened on 11th June 2015 and well attended by a range of agencies and partners.

3.2 The session consisted of a presentation by Mac Heath, Head of Service for Children and Families from the Local Authority with Ginny Garnett, Locality Lead Children's Services (West) Berkshire Healthcare NHS Foundation Trust, giving a brief overview of the LAC system from the BHFT perspective. The session was then divided into two groups to map concerns and barriers and highlight comments or key issues. Notes of the session and issues raised are included in Appendix A.

4. Actions undertaken subsequent to the Hot Focus Session

4.1 Significant commitment, activity and focus has continued on Health Assessments for LAC in West Berkshire since June 2015 by both the Local Authority and Health Services. This has been evidenced through:

- Regular meetings between BHFT and the LA to monitor progress.

- Correspondence between Chief Exec of West Berkshire Council and BHFT to identify three specific priorities for improvement.

- Renewed process, flowchart, system and escalation policy on notifying, identifying and completing health assessments (see Appendix B).

- Corporate Parenting Panel presentation in September 2015.

- Regular contact between to the Locality Manager for Health Visiting and School Nursing, Locality Director (BHFT), Service Manager (LAC) within West Berkshire and West Berkshire Head of Children and Families Service.

- New systems monitored by identified points of access within Health and Children's Social Care.

5. Progress Report June - October 2015

5.1 Through renewed commitment to this priority, gradual but consistent improvement has been achieved on both Initial and Review LAC Health Assessments.

5.2 In June 2015, 51% of 164 LAC had Health Assessments completed on time. In September 2015, 73% of 172 LAC were achieved within timescales. The invalidated figure for October 2015 shows 81% having been achieved.

5.3 This data would suggest that partners have 'turned the curve' on this issue but progress has not been without determined focus and scrutiny. It will need to continue if we are to achieve the commitment we set out in June, as we still fall below the national average of 88% and outside of our set target of over 90%.

5.4 If the current trajectory continues this should be achieved by December 2015.

5.5 It is clear from analysis of the data, there is a good success rate on those LAC placed within our West Berkshire borders and within the Berkshire Authorities. However, when a child is placed over 20 miles from our home authority this continues to be the most challenging, and continues to offer concern as those children placed at a distance are frequently the most vulnerable.

6. Conclusion

6.1 This report contextualises the approach undertaken since June 2015 and confirms:

- The renewed systems and approaches put in place to address the issue of LAC health assessments are working.
- The level of Health Assessments within timescales is an improving picture
- Focus will need to continue on this matter to achieve complete success

6.2 It is accepted that the responsibility and success of this matter can only be addressed through close partnership working and the continued focus this is given by Health Services and the Local Authority.

Appendices

Appendix A – Notes of Hot Focus Session held on 11th June 2015
Appendix B – Procedures of Initial & Review Health Assessments for Looked After Children

Consultees

Local Stakeholders: Ginny Garnett

Officers Consulted: Sandi Dopson

Health and Wellbeing Hot Focus Session – Looked After Children

The Hot Focus Session for Looked After Children took place on 11th June 2015. The Session consisted of a presentation from Catherine Parry and Mac Heath (WBC - Children's Services) followed by group discussions on challenges facing LAC services and opportunities for partnership collaboration.

Group 1: decided to map the LAC System and highlight key issues (Ginny Garnett gave a brief overview of the LAC system from a BHFT perspective)

Mapping	Comments /Key Issues
Each Child (LAC) must receive a Health Assessment within 28 days. This service is provided by a paediatrician from the Royal Berkshire Hospital. Under 5's • Provided with service from a Health Visitor and other universal services. • Each child must receive a review every 6 months – this is a statutory requirement. This review is carried out by a Health Visitor. Over 5's • A paediatrician carries out the Health Check (within 28 days). • This Healthcheck takes about one hour. • The paediatrician provides one day per week for this service for LAC across Berkshire West. • The service is provided from the RBH. 5 – 16 (with no additional needs) • Health Review is carried out annually by a school nurse.	Why can't this service be provided from West Berkshire Community Hospital? *This would be difficult because the service is provided for Berkshire West as a whole.* Does it need to be a paediatrician who carries out the Healthcheck or could it be a GP? *When GPs have been responsible for this in the past, timescales were not met.* *GPs sometimes carry up the follow up review however, never the initial assessments.* **Key Issue; location of services requires focus gong forward with regards to making them as convenient as possible.** **Key Issue: beyond the 20 mile radius covered by the LAC nurses, health documentation often requires chasing and this can be particularly challenging.** **Key Issue: There is an issue with the process regarding consent (Parents are not permitted to refuse access to a child's information if aged under 16). Enduring consent - can cause delays.**

• School Nurses are responsible for safeguarding, public health promotion and the school immunisation programme. • There are 3.8 School Nurses in West Berkshire. • Enduring Consent is required from the parent • There are issues with the annual review process – this needs unpicking and reviewing. • Schools Nurses/Health Visitors send assessment notes to the LAC nurse who then creates a Health Care Plan. • There are 2.6 LAC Nurses across Berkshire West. One full time for West Berkshire; one full time for Reading and then the remaining 0.6 for Wokingham. • LAC nurses are also responsible for those aged 16+ within a 20 mile radius. Those with additional needs • These children are now given priority to ensure they are placed at the top of a waiting list or at least maintain their position on a list if they move area. • The aim is to return these children to universal services. Those with Complex Health Needs • Under 5's – are seen by Community Children Nurses from the RBH and they are responsible for carrying out Health Assessment. • Over 5's are usually sent to one of the specialist schools in the area. There are usually paediatric nurses onsite at these schools and they are responsible for the Health Assessments.	**Key Issue: Information is not shared between GPs and Community Nurses. This is a national problem due to negative publicity around sharing health records. There are plans to review this over the next five years.** **Key Issue: artificial boundaries within the NHS.**

Group 2

Challenges/Needs	Comments/Opportunities
Could we do a Health Assessment before a child goes into care?	Parental information and Red Books
Paediatrician – one day a week. Can do six appointments/week.	Online booking System
These appointments are not being filled.	
Appointments take place in Reading.	
The child might still go into care without receiving a Health Assessment.	
There is an action plan in place with BHFT to make sure Health Assessments take place.	
Communication difficulties between health and social care around information sharing.	
Better contract management is required.	
Connected care – linking health and social care IT systems.	Communication issues need resolving.
	Further use of technology is required and similar conversations would be taking place in Wokingham and Reading.
Is the pathway absolutely clear and is there capacity to deliver it?	There is not a capacity issue in relation to paediatricians. Capacity issues are in relation to having enough LAC nurses to make the paediatrician appointments.
If something goes wrong is it escalated?	
Consent for Health Assessment to take place – it might not be given. This can be taken forward if in the child's best interest.	Improve partner and children and young peoples understanding of medicals.
	Forster parents might be the most appropriate people to take child to appointments.
Health Care plans are reviewed twice per year for under	

5's and once per year for over 5's.		
Independent Reviewing Officers have to be robust in addressing issues at review.		
Serious case reviews – need to make sure enough information is shared to be useful.		
Health Visitors and Schools Nurses are present at reviews. GPs are invited but do not always attend.		
When a child comes into care many things need to be done. Health Assessments should be a main priority.	Priority Status	
Is there a place for a VSP for Children's Services? What services are available?	Mapping exercise	
Are the Health and Wellbeing Board sited and do they understand the issues regarding LAC?		
Skill up family support workers in Children's Centres.		
Challenge of Joint Commissioning – pooling budgets across schools, Local authority and health sector.		
Those going out of area – is the NHS and LA in the area informed. Holding each other to account. e.g. virtual Head Teacher who will challenge where the child is place.	Designated Nurse for LAC	
Can there be an interested professional who can address this and can there be a similar role in health e.g. Lead Nurse for LAC.		
There is a designated nurse who covers West Berkshire, Reading and Wokingham.	Health Passports (LCT)	
Are Health Assessments being carried out for LAC coming to West Berkshire from other areas.	Outcomes and quality	
Detail needs to be broken down.		
Better planning for assessments		

Care Plan Pathway – sometimes about health issues but often not. Health professional attends Care Plan meeting. Social Workers – Should there be one for children and families (exceptions). Child and family focus maintained. Family resource service – holistic. Prevent children coming into care. Health Assessments – holistic. National template. Includes triangulation of data including physical and mental health (healthy lifestyle). Health Assessment Review is multi disciplinary. School involvement – V.H.T to make sure they are in right place. Care Plans – are they fully enacted and children referred to appropriate services?	

General discussion

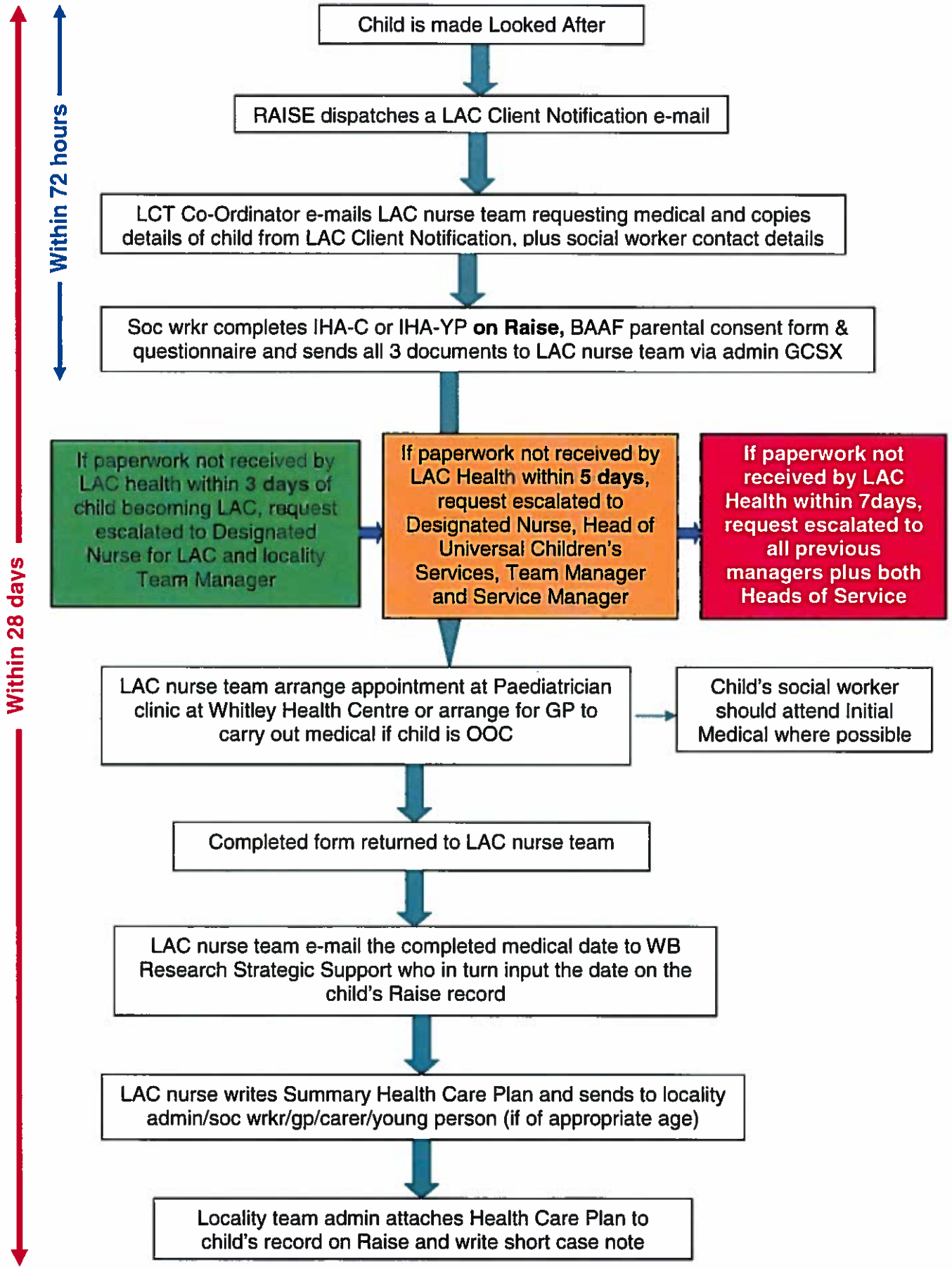
- If the process is causing a problem, explore different ways of doing things.
- The business process needs streamlining.
- There are Health Passports available for LAC however, although the system has been implemented, at the time of the Ofsted Inspection only one LAC had a passport.
- Parents of LAC have been challenged by the courts. Theoretically this could happen to any parent who is not providing a high enough quality of care for their child.
- The LAC process needs rearticulating.
- Services need to be clear about what they are trying to achieve.
- The LA is a statutory authority – what are LAC being subjected to ensure the LA can demonstrate requirements are being met.
- GOLDEN NUGGET = Streamline Service

- The number of LAC is likely to rise and therefore there will be more initial assessments.
- The back log may require temporary additional resources.
- Realistic timeframes would have to be set.
- Trajectory plan for back log.
- Early help – FRS.
- Communicating impact
- Need to look at underlying reasons for children coming into care.
- What could the community do through community hubs, Children's Centres, engaging Health Visitors and GPs?
- Forum suggestions are welcome for where cohesion challenges can be taken for discussion.

Summary Issues

- **Planning needs of Council going forward**
- **Continuity and sustainability**
- **Accommodation needs**
- **Myths, legends and perceptions**
- **Are they our children?**
- **Values, culture and society**
- **VOICE OF THE CHILD**

PROCEDURE FOR INITIAL HEALTH ASSESMENT FOR A NEW LOOKED AFTER CHILD



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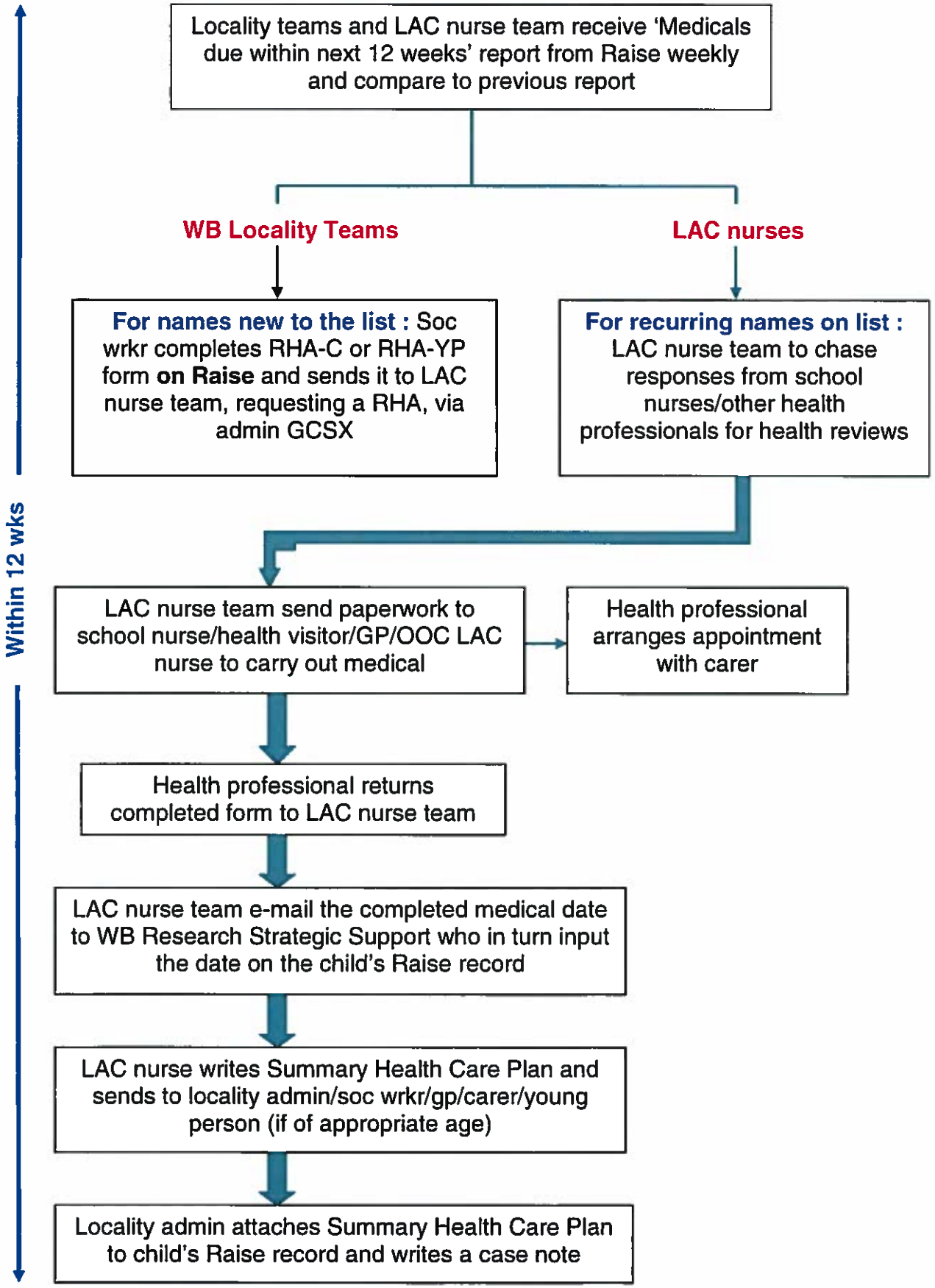
PROCEDURE FOR REVIEW HEALTH ASSESSMENTS FOR LOOKED AFTER CHILDREN



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Title of Report:	**Update on Joint Strategic Needs Assessment and District Needs Analysis**
Report to be considered by:	The Health and Wellbeing Board
Date of Meeting:	26th November 2015

Purpose of Report: **To update the Board on the process of merging the JSNA and the District Profile and to share some of the latest data on JSNA chapters.**

Recommended Action: **To approve the process of merging the JSNA and the District Profile and note new data and how it relates to the Health and Wellbeing Strategy**

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

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

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

Health and Wellbeing Board Chairman details	
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Executive Report

1. Introduction

Statutory Guidance on the development of Joint Strategic Needs Assessments was published by the Department of Health in March 2013, at the time of the reorganisation of the NHS and the movement of Public Health from the NHS into Local Authorities.

The JSNA uses data and evidence about the current health and wellbeing of residents in West Berkshire and highlights the health needs of the whole district. It demonstrates how needs might vary for different age groups and identifies health inequalities for disadvantaged or vulnerable groups.

The JSNA also takes into consideration a wide range of factors that help shape the health and wellbeing of individuals, families and local communities.

Councils and clinical commissioning groups (CCGs) have an equal and joint duty to prepare JSNAs as part of the NHS reforms outlined in the Health and Social Care Act 2012. This process is overseen by the Health and Wellbeing Board.

The JSNA is the key source of information which is used by the Health and Wellbeing Board to agree the priorities within the Health and Wellbeing Strategy. In addition to allowing local councils to provide information and data on the current picture of health and wellbeing in West Berkshire, the JSNA also provides an evidence base to help decision makers, commissioners and other interested groups to decide what services people need and to develop commissioning plans so these needs are met.

The JSNA is available on the West Berkshire Council website and data is refreshed as it becomes available. Much health related data is pulled together by the Public Health Shared Team who then disseminate data sets out to the local Berkshire Public Health teams.

The structure of the JSNA takes a life course approach and focuses on the demographics of the West Berkshire population and information about different groups of people throughout their life. The main sections including demography are **starting well**, which is about giving children a healthy start in life and laying the groundwork for good health and wellbeing throughout life; **developing well**, which focuses on children and young people aged between 5 and 19 years, detailing what affects their health; **living well**, which looks at general health and wellbeing of adults, including lifestyles and health protection; **ageing well**, providing information about the health of people aged 65 and over and finally a section on the **wider determinants of health and vulnerable groups.**

Information and data about many of the wider determinants of health are available for West Berkshire in the form of a **District Profile**. This has been produced locally for a number of years and has provided a wealth of facts and figures that can also be used to guide commissioning of services within the district. There are considerable overlaps

between the JSNA and the District Profile resulting in the decision to bring together these two key documents and a proposal was taken to West Berkshire's Corporate Board on September 15th that proposed a formal approach for the development and updating of a comprehensive District Needs Analysis (DNA) building on the methodology developed to date for the production of the District Profile and the JSNA. It is believed that formalising the approach will clarify expectations, help to allocate resources available and coordinate the approach to needs assessments locally to avoid duplication.

Corporate Board was asked to approve the methodology proposed for the production and updating of the DNA as the key document that will inform strategies and plans for meeting the needs of the people living, working or visiting West Berkshire. The DNA would fulfill the mandatory requirements to produce the JSNA in addition to creating the evidence base for all strategies and plans developed by the council, partner organisations and the wider community.

The DNA will highlight needs and unmet needs. It will not include a comprehensive picture of what is being or what should be done in response to the identified needs, as this will be covered in the strategies and plans developed based on the DNA.

The production and subsequent updating of the DNA, will be based on a two level editorial group to generate the details and interpretation of linked datasets.

The aims of the DNA are to:

Create a repository of data and statistical information with regards to the demographic, social and economic characteristic of West Berkshire District to inform strategic and operational planning

Identify the needs of the population in West Berkshire and wherever possible highlight unmet need.

Respond to statutory requirements to have formal needs assessments (e.g. Joint Strategic Needs Assessment etc.)

Identify opportunities for joint working (services within the council or between the council and other organisations and groups) and more effective use of the limited resources.

In order to reduce duplication and ensure consistency of analysis and identification of needs and gaps in addressing the needs, the intention is that the DNA should incorporate the items usually included in a JSNA (Joint Strategic Needs Assessment). Following the same principle, any other needs assessments, statutory or non statutory should be covered by the District Needs Analysis as the main body of evidence to inform strategic and operational planning.

The process of updating individual JSNA chapters, updating the District Profile and merging these two into one District Needs analysis has now begun in earnest. A joint workshop was run in September 2015, bringing together individual officers responsible for

gathering, processing and reporting data and information within the council, including the Public Health and Wellbeing team. This is the First Editorial Group who were required to consider updated datasets and identify key needs and especially unmet needs of local communities. This step includes an iterative process of identifying additional lines of enquiry, sourcing additional data (complementary data and/or in depth disaggregation) to add to the dataset and include in further analysis. Key findings or issue areas are distilled in preparation for the next step of the process.

The second editorial group, made up of senior representatives from the council's services will be presented with the key findings and co-produce the 'What does it mean?' type statements that will inform strategic and operational plans. This can also be an iterative process to allow for additional intelligence to be sourced and included.

The Identification of key messages will form the high level overview regarding needs and unmet needs in West Berkshire. These would be the sources of intelligence for info-graphics as a potential solution to increase the accessibility of a wide range of audience to what is a rather technical, statistics heavy document.

A strict version control process will be employed whereby each section of the DNA will be allocated to a designated data provider who will be responsible for.the updating of information/data when it becomes available. The Research, Consultation and Performance team within West Berkshire Council will oversee this process, with updates being released on a quarterly basis and version control documentation logging the changes made and the version reference number. This will ensure an audit trail from any strategies or plans developed to the DNA version that has informed them. The DNA will reflect annual values of different indicators included which are usually published at different points during the year. On an annual basis all contributors to the DNA will meet to decide if any substantial amendments are required.

In the attempt to respond to a number of needs assessment requirements, solutions are being explored to use web pages' functionality to update and publish on the Internet separately the sections of the DNA.

Different contents pages will combine only the relevant sections of the DNA in order to cater to the users' needs e.g. someone interested in the JSNA will be directed to the relevant sections.

Each section of the DNA will be structured based on a template agreed by the data providers (initial template being currently used for JSNA is attached as Appendix A).

Solution will be explored for presenting the key findings as part of a high level summary (e.g. info graphics) accessible for a wider audience to be able to get an effective overview of the District, the needs and the unmet needs of the local communities.

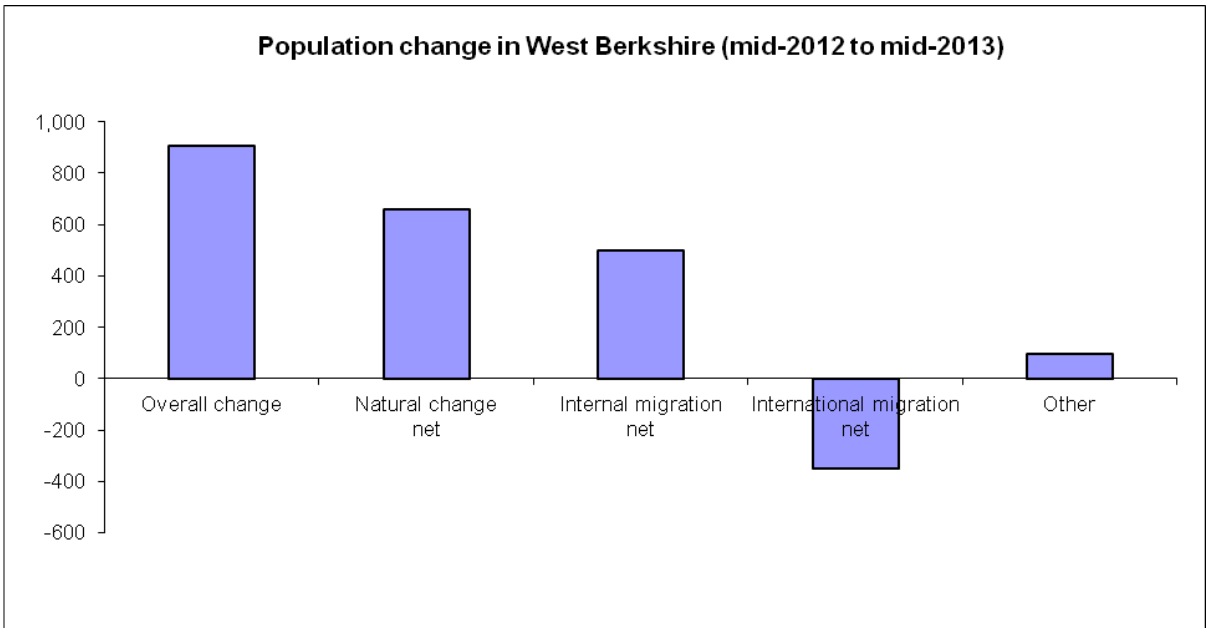
Current updates for the Health and Wellbeing Board from the JSNA

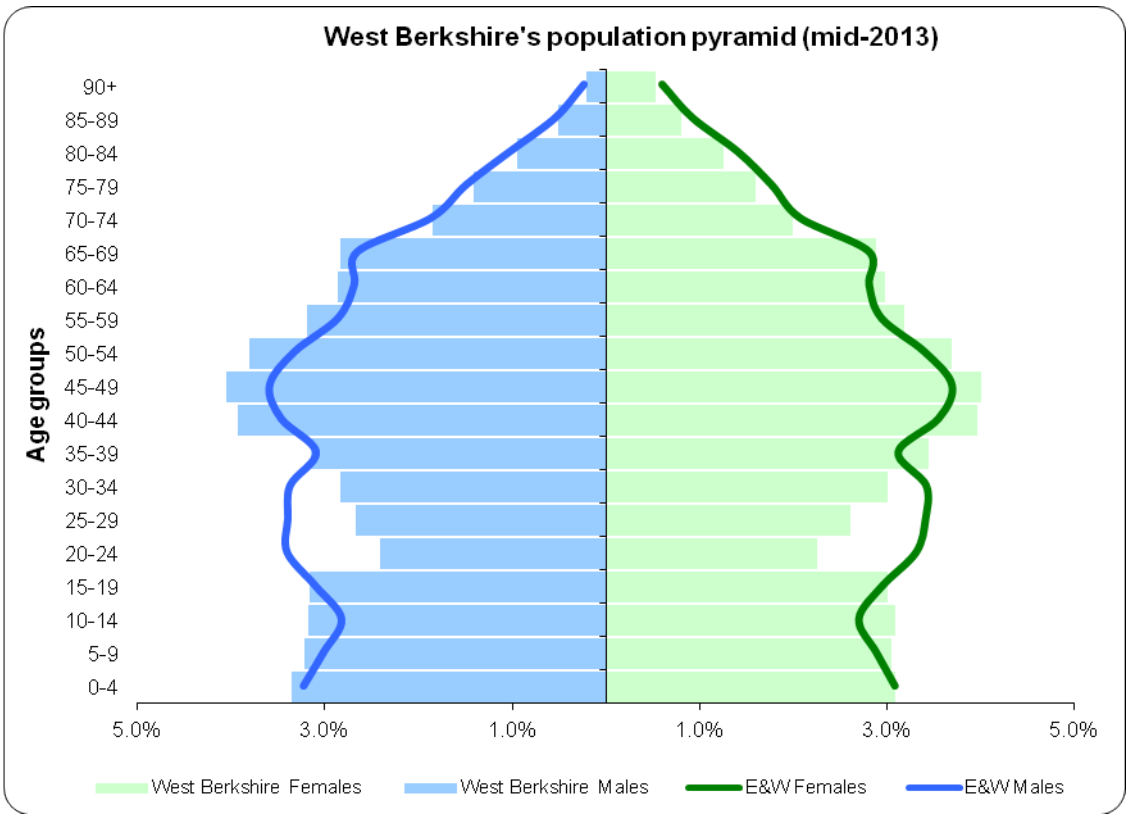
Demography.

This section has been updated using statistics from the District Profile and the Public Health Shared Team. See appendix 1 Additional data on deprivation in the district has been added from the new Index of Multiple Deprivation published in September 2015. See appendix 2

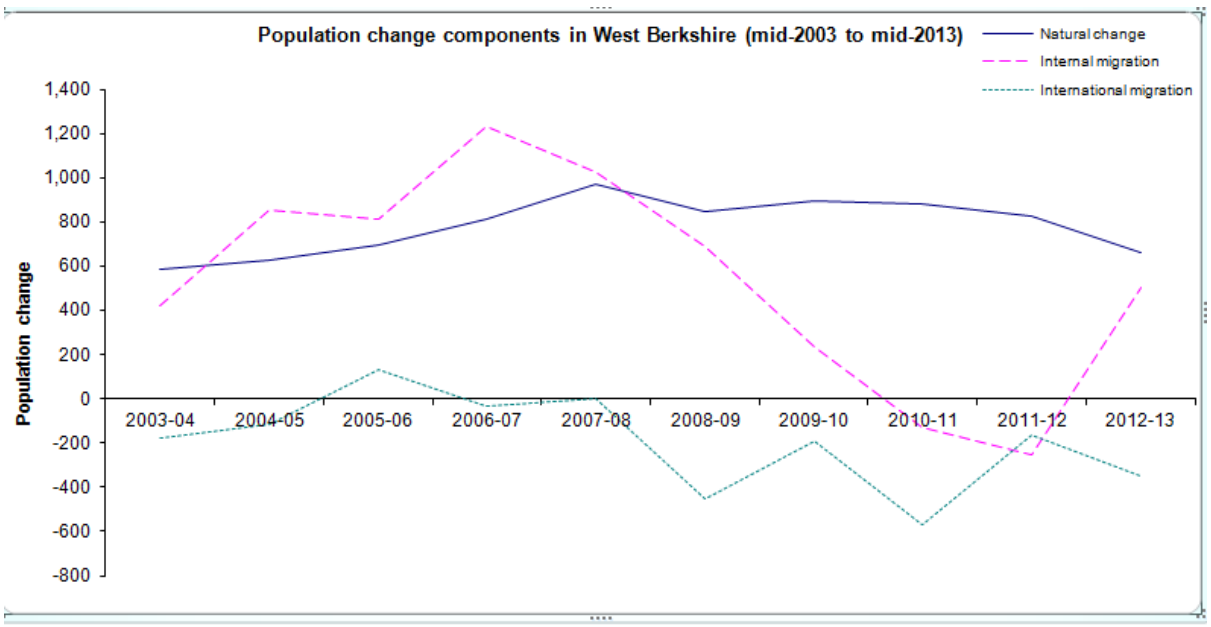
The ONS (Office for National Statistics) annual midyear population estimates (2013) showed West Berkshire's population was estimated at 155,392 in mid 2013. West Berkshire's proportion of children aged 5-14 and adults aged 40-64 are higher than the national profile. In contrast, there is a lower proportion of adults aged 20-34 living in the Borough.

There were 1,851 births and 1,193 deaths from mid-2012 to mid-2013. The main contributor to population growth from 2012 to 2013 was natural change. This made up 73% of the overall growth. The overall change to the population was 906 people The population did reduce from international migration over the year with 500 people moving into the district from elsewhere in the UK and 350 people migrated internationally.





Ward level data will be available early in November and new ward profiles are being produced jointly by PH Shared Team and West Berkshire Council as part of the District Needs Analysis.



Source: Office for National Statistics, Annual Mid-Year Population Estimates (2013)

The trends for West Berkshire over the last 10 years show international migration and natural change as relatively stable with internal migration decreasing from 06/07 to 11/12 with a considerable upturn from 11/12 to 12/13.

The overall change in this 10 year period is not significant.

Life expectancy is reported in three different ways:

Life expectancy at birth – the average number of years a new born baby would expect to live (based on a particular area where the person lives and a particular time period)

Healthy Life expectancy at birth – the average number of years a new born baby would expect to live in good health (based on a particular area where the person lives and a particular time period)

Life expectancy at age 65 – the average number of years a 65 year old person would expect to live (based on a particular area where the person lives and a particular time period)

Indicator	Gender	West Berkshire	England
Healthy life expectancy at birth	Males	68.38	63.27
	Females	69.26	63.95
Life expectancy at birth	Males	80.70	79.41
	Females	84.20	83.12
Life expectancy at age 65	Males	19.40	18.67
	Females	22.00	21.13

Life expectancy for all measures are higher in West Berkshire than for England as a whole.

Starting well Headline updates (0-5)

Infant mortality

Infant mortality statistics are reported on 3 year rolling averages since the numbers are so small. They are expressed as a rate per 1000 live births. Stillbirth rates are higher in the UK than many other countries of similar income distribution and rates have changed little in the last 2 decades.

In West Berkshire the stillbirth rate is 4.2 per 1000 (2011-13) Eng av – 4.9

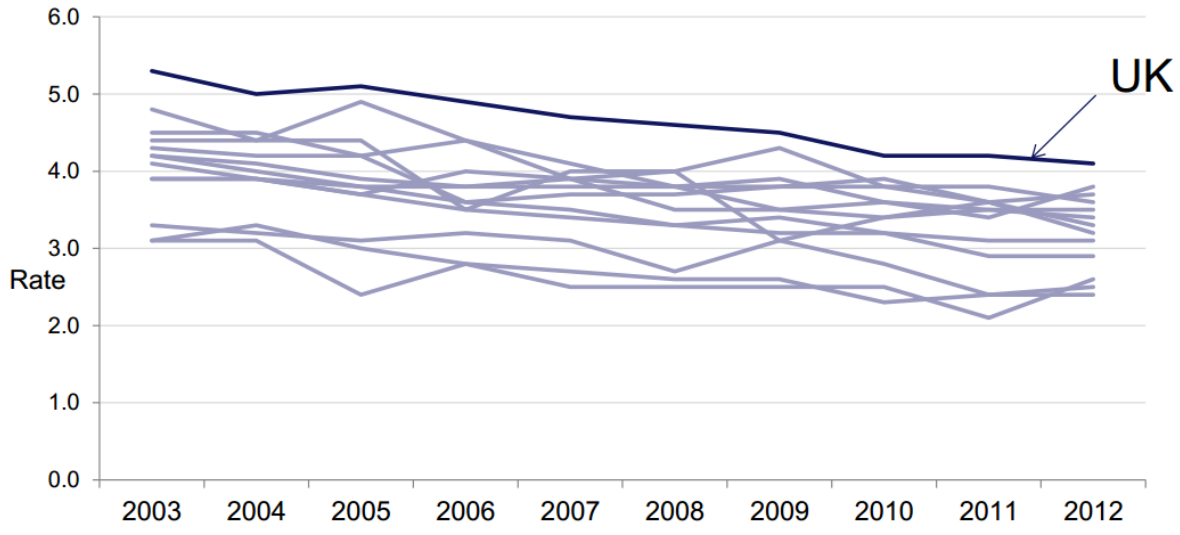
Perinatal mortality is 6.4 (2011-13) the number of stillbirths and deaths in the first six postnatal days per 1,000 total births – Eng av – 7.1
Neonatal mortality is 2.1 (2009-2013) the number of infants dying in the first 27 postnatal days per 1,000 live births - Eng av – 2.9
Post neonatal mortality is 1 per 1000(2009-2013) the number of infants dying at 28 days and over but under one year per 1,000 live births – Eng av – 1.3

Infant mortality is 3.4 (2011-13) the number of infants dying before their first birthday per 1,000 live births – Eng av – 4.1

Infant mortality is an important PH issue in that 61% of deaths nationally in children (0-18) are in infants. Many of the stillbirths and deaths that occur are preventable.

Infant mortality trends and compared to other countries.

Source: Eurostat



UK shown compared to Belgium, Denmark, Germany, Spain, France, Italy, Netherlands, Austria, Finland, Sweden, Norway and Switzerland.

Childhood immunizations

Children are immunized for a range of infectious diseases as an infant, between 2-3 years and at 5 years. The national target coverage for all childhood immunizations is 95%.

The West Berkshire figures for 2013/14 are estimated and based on a average of the overall figures for West Berkshire, Reading and Wokingham. They may therefore be an over or underrepresentation. West Berkshire met the national target of 95% for two of the childhood immunisations in 2013/14 (24 months: DTaP/IPV/Hib primary; 5 years: DTaP/IPV/Hib primary). The rest of the immunisations are very similar to the England averages. The figures for DTaP/IPV/Hib booster at 5 years and the MMR second dose at 5 years are 87.3% and 89.7% respectively.

Foundation Stage attainment

In 2014, 64.9% of West Berkshire's pupils achieved a good level of development at the end of reception. This was a significant increase on 2013's figures and remains significantly
better than the national average of 60.4%.

36.1% of children eligible for free school meals in West Berkshire achieved a good level of development in 2014. This is a reduction on 2013's figures and is now significantly worse than the national average of 44.8%. The gap between FSM pupils and non-FSM children was 28.9% points in West Berkshire, compared to 15.6% points nationally. It is important to

note that the number of children eligible for FSM in Reception is relatively small in West Berkshire (169 in 2014) and any slight annual change can skew the figures.

73% of girls and 57% of boys in West Berkshire achieved a good level of development at the end of Reception. The gender gap was 16%, the same as the England average.

The inequality gap between the average score for pupils in West Berkshire and the average of the lowest 20% of achievers was 24.7%. This compares to the England average of 33.9%.

8.2% of Reception pupils in West Berkshire did not have English as a first language in 2014, compared to 17.7% in England. In West Berkshire there was a 14% point gap in good level of development between pupils who had English as a first language and those that did not. This is greater than the 10% point gap identified nationally.

Smoking in pregnancy

This figure is smoking status at time of delivery. 10/11 to 12/13 data are an average based on aggregated data for Wokingham, Reading and West Berkshire LAs. This could therefore be an over/under estimation for the actual local authority. The data for 2013/14 is based on the women resident in West Berkshire and cannot be directly compared with previous year's figures.

In 2013/14, 1,789 mothers resident in West Berkshire delivered a baby. 8.7% (155) of these mothers were smokers. This is significantly better than the England average of 12.0%.

Developing well (5-19) Headline updates

Youth Offending

Nationally there was a 20% reduction in young people receiving a substantive outcome* between 2012/13 and 2013/14. 81% of young people receiving a substantive outcome were male and 75% were from a white Ethnic background.

The main types of offences committed by young people were; violence against the person (22%), thef and handling (18%), and criminal damage (11%)

The average population of young people in custody fell by 21% from 2012/13 to 2013/14 and has fallen by 56% since 2003/04. There were 20% fewer first time entrants into the system between 2012/13 and 2013/14

Characteristic	% of custody population
BME background	41%
Disability	19%
From Local Authority care	33%
Have children	11%
Special education needs	17%
School exclusions	88% males and 74% females

Self harm	20%
Require accommodation	63%

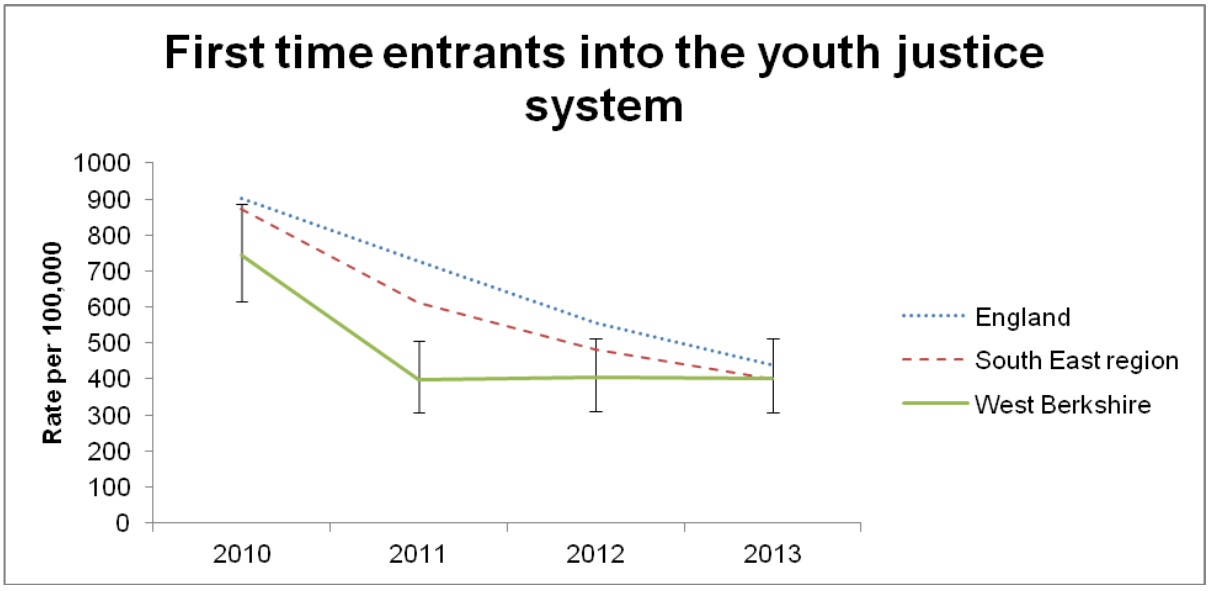
Source: Ministry of Justice and Youth Justice Board for England and Wales

In West Berkshire There were a total of 91 young people who received a substantive outcome in 2013/14

78% of these were male and 98% were from a White Ethnic background.

The main type of offence committed was Theft And Handling Stolen Goods which accounted for 21%
of offences committed.

There were 0.06 custodial sentences per 1,000 people aged 0 to 17 years of age (compared to 0.53 in England and 0.29 in the South East)



Looked After Children

Nationally the number of Looked After Children continues to rise steadily over the last 5 years. In England the rate is 60/10,000. Almost two thirds are looked after due to abuse or neglect and over one third are aged between 10 and 15 years. Around 75% of looked after children nationally are white British.

In West Berkshire there were 160 looked after children as of 31 March 2014, an increase of 10% (145) compared to 31 March 2013 and an increase of 28% (125) compared to 31 March 2010. Similar to the national picture the number of looked after children has increased steadily over the past five years and is now at its highest. The local rate of looked after children is 45/10,000. 48% were provided a service due to abuse or neglect and this has changed little since 2010. 86% are from a white British background. 44% are aged between 10 and 15 years. There has been a slight increase of 1-4 yos and 5-9 yos since 2010 and this is in line with the age profile of the district.

Teenage pregnancy

The number of teenage pregnancies is reported as a three year rolling average due to yearly fluctuations. The number of under 16 conceptions for 2011/13 was 42 with a rate of 4.4 per 1000. This has increased from 2010-2012 with 36 conceptions and a rate of 3.9/1000. This does compare favourably with the England average rate in 2011/13 of 5.5/1000.

The number of under 18 conceptions for 2011/13 was 203 with a rate of 21.8/1000. This is a decrease from 2010/12 with 217 conceptions and a rate of 23/1000. The England rate for 2011/13 was 27.6/1000. (The rate is number of live births, stillbirths or abortions in all women aged 15-17 years)

Teenage pregnancy is higher in areas of deprivation and the wards that are reporting higher numbers and rates per 1000 of under 18 conceptions in West Berkshire are Clay Hill, Greenham, Thatcham Central, Thatcham West, Calcot, Victoria and Speen.

NEETS

This is a measure of the number of 16-18 year olds not in education, employment or training. The figures nationally continue to show a downward trend. Evidence shows that there are a range of factors that can affect the proportion of NEETs and the Department of Education have developed a 'NEET scorecard' to compile data that puts the headline NEET figure into context by setting it alongside a range of other related information.

% NEET	% in 2013	% pt change since 2012
% 16-18 year olds NEET	6.3%	-2.1%
% 16 year old NEET	3.2%	-1.6%
% 17 year old NEET	7.5%	-0.3%
% 18 year old NEET	8.7%	-3.7%

LA support	% in 2013	% pt change since 2012
% 16-17 year olds made offer of an education place under September Guarantee	93.4%	1.7%
% 16-18 year olds whose activity is known to the local authority	96.6%	-0.8%
% 16-18 year olds NEET re-engaging in EET	9.7%	No comparison data

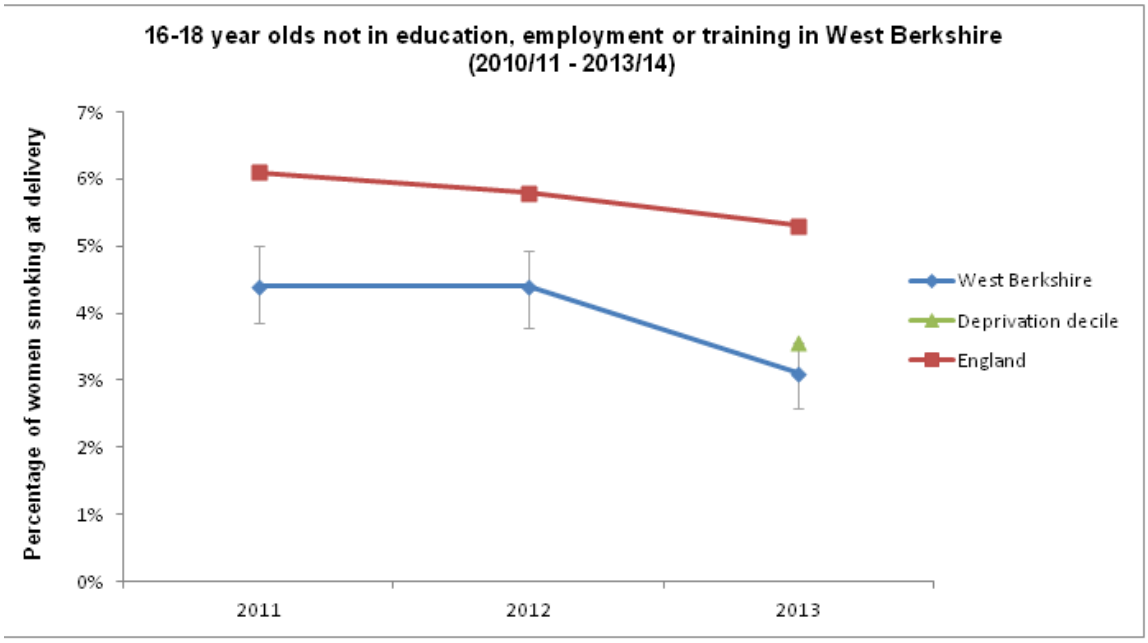
Outcomes	% in 2013	% pt change since 2012
% 16-17 year olds participating in education and training	88.3%	1.2%
- full-time education	81.2%	-1.5%
- apprenticeships	3.8%	1.0%
- other education and training	3.3%	1.7%
% 19 year olds achieving level 3	57.6%	3.1%
% 19 year olds achieving GCSE A*-C English and maths between ages 16 and 19	15.9%	1.0%

Contextual information (based on 2012/13)

GCSE attainment: 5 or more GCSEs at A*-C inc.English and Maths:	63.6%	Overall absence (% of sessions):	5.6%
GCSE attainment: 1 or more GCSEs at A*-G:	99.3%	Persistent absentees:	6.2%

Source: Department for Education; Young people NEET comparative scorecard (published December 2014)

The picture in West Berkshire is largely better that the national picture on most indicators.



Source: Public Health England; Public Health Outcomes Framework indicators 1.05

Long Term Conditions in Children

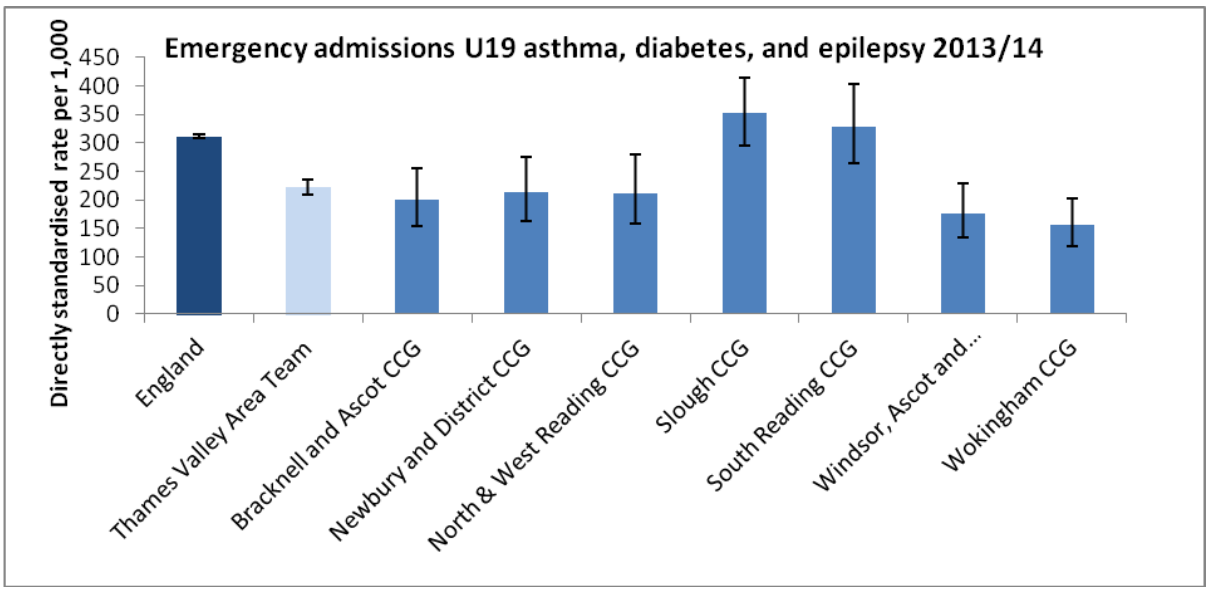
The three conditions reported in this section are diabetes, asthma and epilepsy. 96% of those under 19 years have type 1 diabetes. Nationally the current prevalence estimate of Type 1 diabetes in children under the age of 19 in the UK is 1 per 430 to 530 children (Diabetes UK, 2014). 1 in 11 children are currently receiving treatment for asthma (NHS Choices) and almost 24,000 children aged less than 16 in England were admitted to hospital due to asthma during 2012/13 (Health and Social Care Information Centre). The prevalence of epilepsy in the UK in children aged under 16 years is estimated at 1 in 240 (Epilepsy Action)

In West Berkshire
it is estimated that there are between 88 and 71 children under the age of 19 with diabetes living in West Berkshire

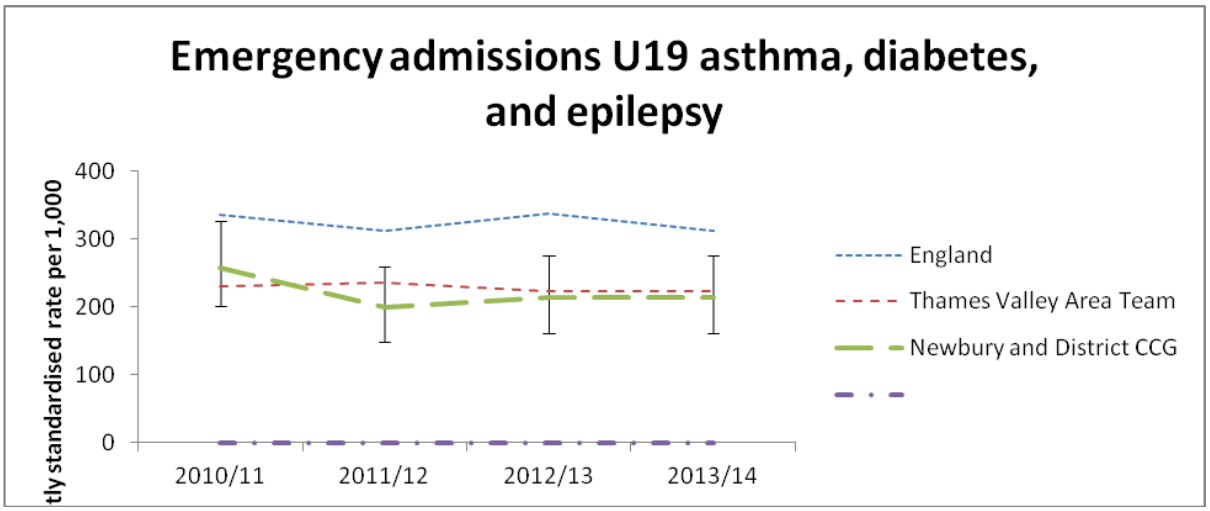
It is estimated that there are 2869 children under the age of 16 with asthma living in West Berkshire.

It is estimated that there are 131 children under the age of 16 with epilepsy living in West Berkshire.

Estimates based on applying national prevalence estimates to local population (ONS 2013)



One of the NHS Outcome Framework Indicators measures potentially avoidable emergency hospital admission for asthma, diabetes, and epilepsy in under 19 year olds. During 2013/14, 58 children from Newbury and District CCG were admitted for these conditions.



Smoking in young people

New indicators on smoking in 15 year olds have been added to the nationally produced Local Tobacco Control Profiles at local authority level from the What About Youth (WAY) survey. These are modeled estimates based on the survey. Interestingly West Berkshire figures are higher than the national figures for young people. Our own local smoking survey results will need to be compared as they should give a more accurate figure.

	Period	Local value	Eng. value	Eng. worst	Eng. best
Smoking Prevalence (%)	2013	15.39	18.45	29.4	10.5
Smoking status at time of delivery (%)	2013/14	8.66	12.00	27.5	1.9
Low birth weight of term babies (%)	2012	1.63	2.80	5.0	1.5
Smoking prevalence modelled estimates – % regular smokers aged 11-15 years	2009-12	3.33	3.1	4.7	1.1
Smoking prevalence modelled estimates – % regular smokers aged 15 years	2009-12	1.87	1.4	2.0	0.5
Smoking prevalence modelled estimates – % regular smokers aged 16-17 years	2009-12	9.24	8.7	12.7	3.2
Smoking prevalence modelled estimates – % occasional smokers aged 11-15 years	2009-12	5.06	3.9	5.3	1.4
Smoking prevalence modelled estimates – % occasional smokers aged 15 years	2009-12	15.62	14.7	20.7	5.7
Smoking prevalence modelled estimates – % occasional smokers aged 16-17 years	2009-12	7.46	5.8	7.8	2.2

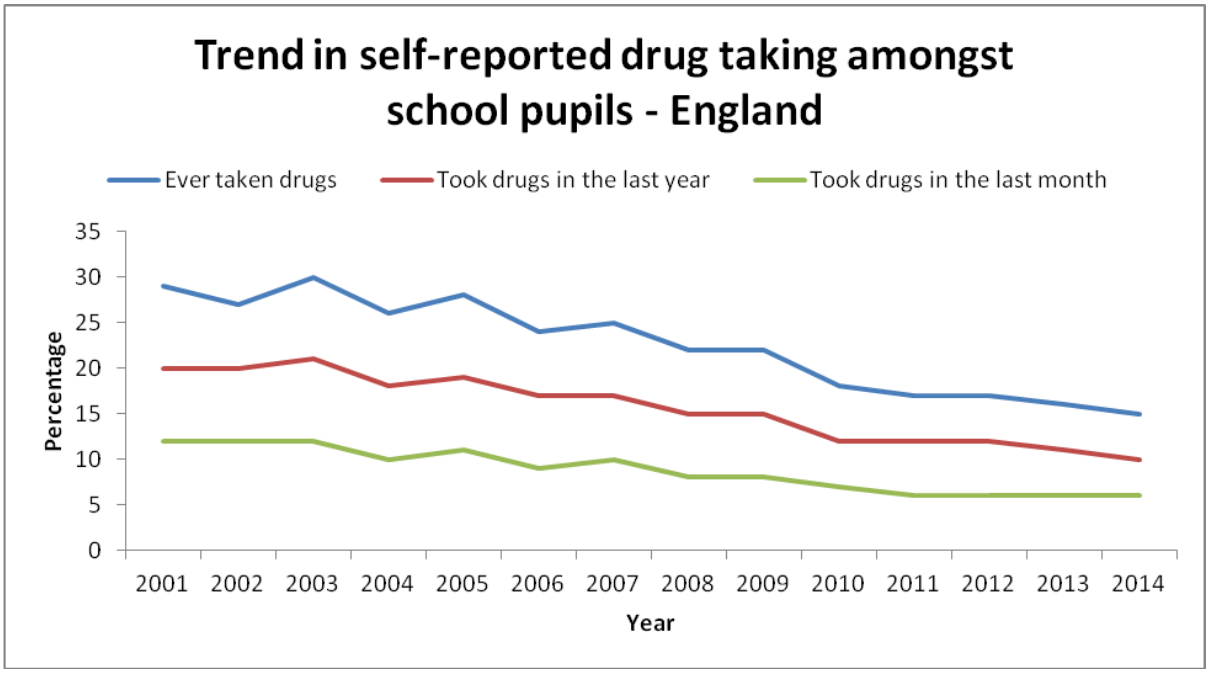
Source: Local Tobacco Control Profiles (October 2014)

Substance misuse in young people

Smoking, Drinking and Drug Use among Young People in England is an annual survey carried out by pupils in years 7-11 in participating schools across England to provide national estimates and information on the smoking, drinking and drug use behaviours of young people aged 11-15. The survey has been carried out since 2004.

	Ever taken drugs %	Taken drugs in the past year %	Taken drugs in the past month %	Ever taken drugs Count	Taken drugs in the past year Count	Taken drugs in the past month Count
Boys						
11 years	7	5	3	75	54	32
12 years	7	4	2	70	40	20
13 years	13	8	5	144	89	55
14 years	18	12	8	206	137	91
15 years	27	20	12	313	232	139
Total	**16**	**11**	**6**	**876**	**602**	**328**
Girls						
11 years	5	3	2	54	32	21
12 years	7	4	3	72	41	31
13 years	10	6	2	107	64	21
14 years	19	15	7	224	177	83
15 years	22	17	11	258	200	129
Total	**13**	**10**	**6**	**717**	**552**	**331**
Total						
11 years	6	4	2	129	86	43
12 years	7	4	2	141	81	40
13 years	11	7	4	239	152	87
14 years	19	14	8	442	325	186
15 years	24	19	12	560	443	280
Total	**15**	**10**	**6**	**1649**	**1099**	**660**

Data is also available for young people who use substance misuse services locally from NDTMS (National Drug Treatment Monitoring System). This data however is restricted and is provided by PHE for management, quality assurance, and briefing purposes only. The data cannot be released into the public domain prior to official publication planned for December 2015.



Source: Health and Social Care Information Centre

Treands in self reported drug taking have continued to decrease nationally and locally.

School Life

A number of indicators are available from the Department of Education to show how well children are doing at school. This includes the following data sets: GCSE stage 4, pupil absence, number of schools/pupils, schools by religious character, free school meals, ethnicity, first language, SEN and level 2/3.

GCSE and equivalent results of pupils at the end of key stage 4

		Percentage of pupils at the end of key stage 4 achieving at GCSE and equivalents:				
	Number of end of key stage 4 pupils	5+ A*-C including English & mathematics GCSEs			English Baccalaureate	
		All	Boys	Girls	Percentage entered	Percentage achieved
England	618,585	53.4	48.2	58.9	36.3	22.9
West Berkshire	1,916	61.1	49.2	29.4	49.2	29.4

Source: 2013/14 key stage 4 attainment data (Revised)

The % of persistent pupil absences for West Berkshire in all state funded primary and secondary schools and all special schools by residence is 2.9%. This compares well with the South East – 3.7% and for England – 3.6%. In Pupil Referral Units this % rises to 33.6% for West Berkshire, 42.1% for the South east and 37.6% for England.

The % of children known to be eligible for and claiming free school meals from the 2015 school census was 14%. The % for England was 29.5% and 20% for the South east.

Percentage of 19 year olds qualified to Level 2, by FSM eligibility and Local Authority

	Not eligible for FSM	Eligible for FSM	All
England	88	71	86
West Berkshire	87	59	85

Percentage of 19 year olds qualified to Level 3, by FSM eligibility and Local Authority

	Not eligible for FSM	Eligible for FSM	All
England	60	36	57
West Berkshire	63	28	61

Source: DfE 2015

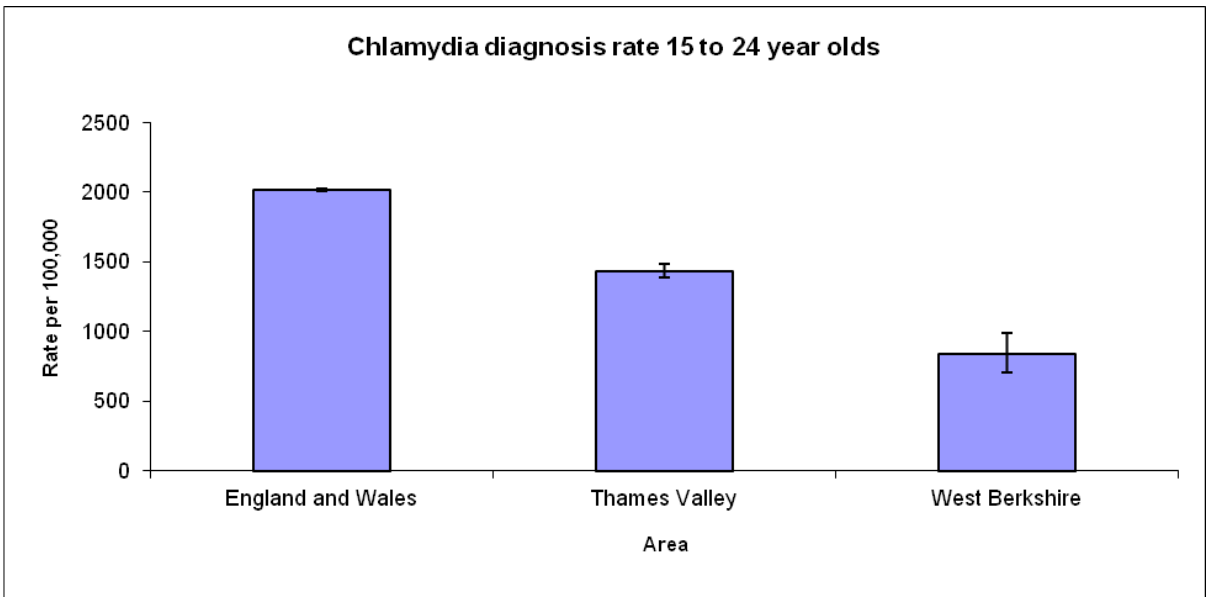
The % qualified to level 2 for the South East was 88% not eligible for FSM and 66% eligible for FSM.
The % qualified to level 3 for the South East was 61% not eligible for FSM and 29% eligible for FSM.

The % of pupils whose first language was known or believed to be other than English was 11.7% in the South east and 12% in West Berkshire. The England figure was 17.4%.

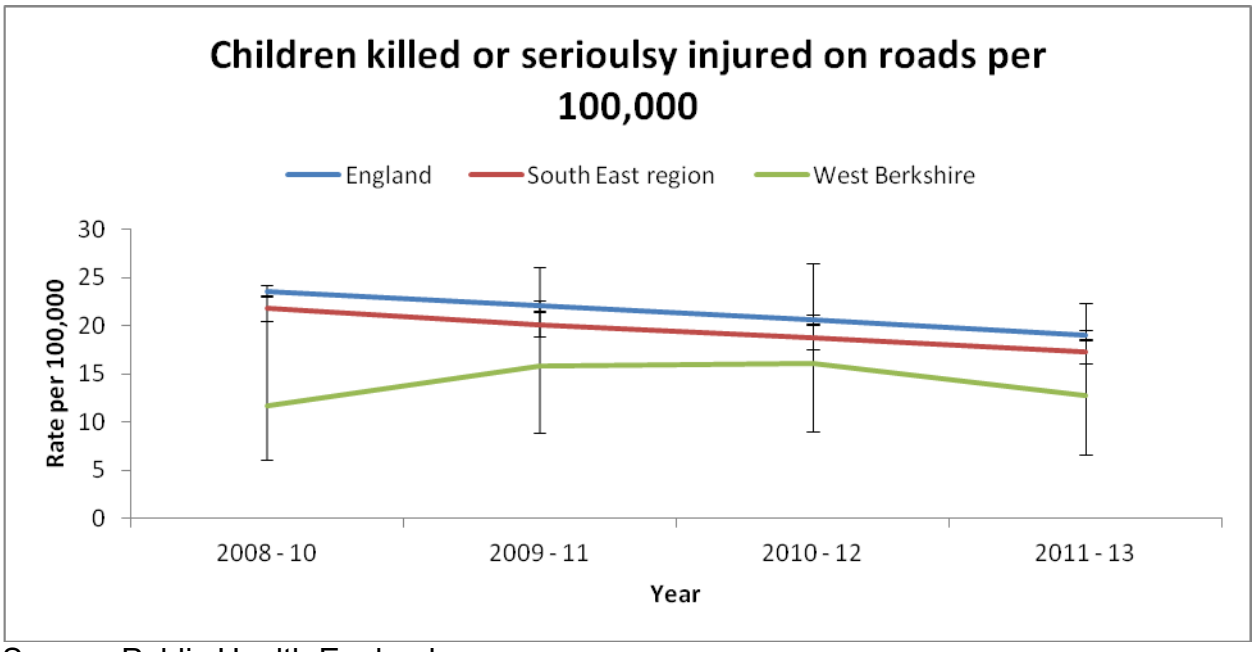
Chlamydia
Chlamydia screening is available for all 1 year olds and is carried out to decrease the transmission of this sexually transmitted infection that can cause infertility and pelvic inflammatory disease in women. It is often asymptomatic and once diagnosed is easily treated with antibiotics.

In West Berkshire 10.6% of the eligible population were tested for chlamydia during 2013, compared to 24.9% in England and 7.9% of these tests were positive. This is a decrease on 9.7% positive tests in 2012. 20-24 year olds were most likely to be tested (68.2% of all tests) and 71% of all those tested were female.

The diagnosis rate nationally was 2016 per 100,000 however due to the low numbers tested in West Berkshire the diagnosis rate was only 945 per 100,000. There have been problems with the screening tests being attributed to Reading since that is the location of the NHS lab where the tests are analysed.



Children killed or seriously injured on the roads
These data are done on a three year rolling average to even out fluctuations and due to relatively small numbers. They refer to under 16s.



Source: Public Health England

The overall rate has decreased from 16.1 per 100,000 in 2010-2012 to 12.8 in 2011-13.

Living and working well

Adult obesity
The estimation of the percentage of adults who are overweight or obese comes from the Sport England telephone survey The Active People Survey, thus it is based on self reported height and weight. There is an additional data source which is the percentage of patients recorded as obese in GP practices. This data does not include those who have

not visited their GP and not all patients are weighed and measured, so this data is also incomplete.

In 2012, 65.5% of people aged 16 or over in West Berkshire were classified as being overweight or obese. This was similar to the England and deprivation decile figures of 63.8% and 61.5% respectively. 18.5% of West Berkshire's population aged 16 or over were classified as obese, compared to 22.9% in England. (Active People Survey)

On 31/3/2014, 7,416 patients in Newbury & District CCG were on the GP Obesity Register. This was 8.0% of the population aged 16 or over and was significantly higher than the Comparator CCG Group. In contrast, the obesity prevalence in North & West Reading CCG was significantly lower than its comparator group at 7.7%. Both CCG's had a significantly lower prevalence of obesity compared with the national level of 9.4%.

Source: Health & Social Care Information Centre, Quality Outcomes Framework (2014)

The percentage of people who are physically active in West Berkshire went from 55.4% in 2013 to 61.6% in 2014.

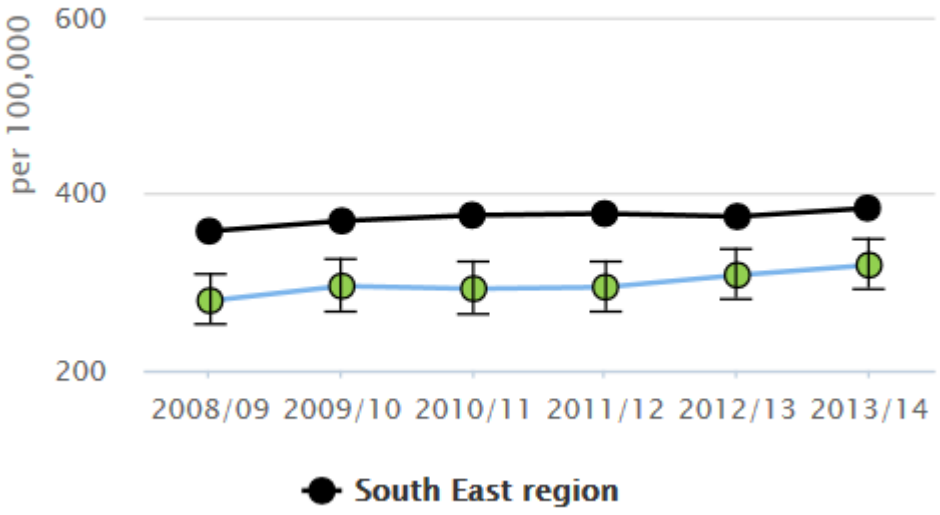
The percentage of people who were physically inactive in West Berkshire went from 26.3% in 2013 to 24.4% in 2014. Both these figures are similar to the South East and England averages

Adult and alcohol
Alcohol consumption is a contributing factor to hospital admissions and deaths from a diverse range of conditions. Alcohol misuse is estimated to cost the NHS about £3.5 billion per year and society as a whole £21 billion annually.

There are a variety of measures related to health and alcohol consumption. The PHE alcohol profiles contain data on the following indicators: months of life lost due to alcohol, alcohol related and alcohol specific mortality, mortality due to chronic liver disease, a variety of hospital admission data due to different causes and all related to alcohol and numbers in treatment for alcohol problems.

West Berkshire compares favourably with other LAs in the South east for hospital admissions and is in the top quartile for 12 of the 16 indicators. For alcohol specific hospital admissions in the under 18s the rate has gone up slightly from 17.9/100,000 for the 3 year pooled period 2010/11 to 2012/13 to 20.6/100,000 for the period 2011/12 to 2013/14. This remains lower than the South East and England averages.

Alcohol related hospital admissions (narrow) have been gradually increasing since 2008/9 till 2013/14 (this is a hospital admission where the primary reason or secondary reason for admission can be attributed in some way to alcohol). This is a similar pattern for the South east and England



Alcohol related mortality is similar or slightly better than the South east rates.

Smoking in adults

Smoking prevalence in West Berkshire has decreased in 2012 from 2013 from 18.8% to 15.4%. Prevalence in routine and manual groups has gone from 31% in 2012 to 25.9% in 2013. The quit rate (the number of successful 4 week quitters out of the total number of smokers times 100,000) for West Berkshire residents was 3,190 (13th out of 19 LAs in the South East)

Smoking attributable hospital admissions have increased from 1,110 per 100,000 (count = 909) in 2012/13 to 1,245 per 100,000 (count = 1052) in 2013/14. England continued to decrease.

Smoking attributable mortality also increased slightly from 232.9 per 100,000 in 2010-12 to 242.4 in 2011-13. England continued to decrease.

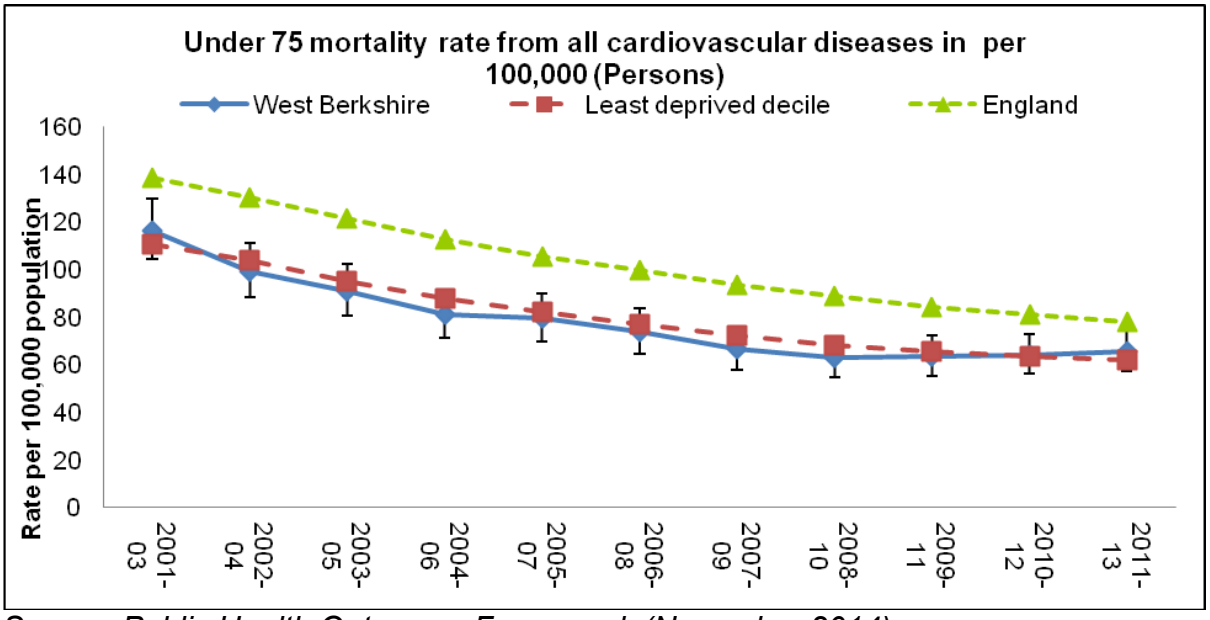
	Period	Local value	Eng. value	Eng. worst	Eng. best
Smoking Prevalence (IHS)	2013	15.39	18.45	29.4	10.5
Successful quitters at 4 weeks	2013/14	3189.51	3524.14	1251	8946
Smoking status at time of delivery	2013/14	8.66	11.99	27.5	1.9
Low birth weight of term babies	2012	1.63	2.80	5.0	1.5
Lung cancer registrations	2009-11	58.27	75.47	144.2	42.1
Deaths from lung cancer	2011-13	47.94	60.19	111.6	32.3
Deaths from chronic obstructive pulmonary disease	2011-13	41.50	51.47	101.0	26.8
Smoking attributable mortality	2011-13	242.38	288.66	471.6	186.6
Smoking attributable deaths from heart disease	2011-13	28.84	32.67	65.5	20.6
Smoking attributable deaths from stroke	2011-13	8.20	10.96	21.5	7.2
Smoking attributable hospital admissions	2012-13	1109.99	1687.60	2884	906
Cost per capita of smoking attributable hospital admissions	2010/11	27.31	36.92	61.7	15.6
Indicative tobacco sales figures (£ millions)	2013	36.40	15446.14	440.2	13.2

Circulatory diseases
Cardiovascular disease (CVD) includes coronary heart disease, myocardial infarction (MI), hypertension, stroke, atrial fibrillation, chronic kidney disease (CKD).
Data on prevalence of CVD conditions The Quality Outcome Framework measures the recorded prevalence of different conditions and is based on the number of people on GP registers at the end of March. A recorded prevalence rate for West Berkshire has been estimated by using the data from GPs in the Local Authority boundary. The following prevalences were recorded in March 2014:

Atrial fibrillation - 1.5% (Eng = 1.6%)
Coronary Heart Disease - 2.5% (Eng = 3.3%)
Stroke or TIA - 1.4% (Eng = 1.7%)
Heart failure - 0.5% (Eng = 0.7%)
Hypertension - 12.9% (Eng = 13.7%)

Hypertension is the most prevalent cardiovascular condition in West Berkshire (12.9%), followed by Coronary Heart Disease (2.5%). This mirrors the national picture.

The under 75 mortality rate for cardiovascular disease in England has steadily decreased since 2001. In 2011/13, 78.2 per 100,000 people aged under 75 died from a cardiovascular disease, compared with 138.7 in 2001/03. In West Berkshire in 2011-13, there were 252 premature deaths from cardiovascular diseases. This is a rate of 66 per 100,000 people aged under 75, which is significantly better than the national rate and similar to the deprivation decile rate.



Source: Public Health Outcomes Framework (November 2014)

The rate of under 75 mortality from all CVD in males in West Berkshire has slightly increased over the last 2 years from 87.9 per 100,000 in 2009-11 to 95.1 per 100,000 in 2011-13. This is 182 deaths. This rate is considerably higher than the females which was 36.5 per 100,000 in 2011-13.

The under 75s mortality rate from CVD considered preventable in West Berkshire in 2011-13 for all persons was 47.3 per 100,000. This has gone up slightly from 37.9 in 2008-2010. In males the rate has risen to 75.3 in 2011-13 which is above the South east rate of 64.5.

Diabetes
In March 2014, West Berkshire's recorded prevalence rates of diabetes on the Quality Outcome Framework in people aged 17 and over was 4.6%. This is significantly lower than England's rate of 6.2%.
Source PHE, Diabetes data tool (updated November 2014)

The National Diabetes Audit (NDA) provides information on diabetes care across England and Wales. This includes an analysis of the National Health & Care Excellence (NICE) recommended care processes, which are the annual checks for the effectiveness of diabetes treatment that all diabetes patients should receive (for example: blood pressure, body mass index, smoking, cholesterol and foot surveillance). In 2012/13, North & West Reading CCG completed all eight of the NICE care processes for 63.7% of their registered diabetes patients, compared with 67.8% in Newbury & District CCG. These are both higher than the national completion rate of 59.9%.

In 2010-12, there was an average of 25 deaths from diabetes in West Berkshire each year (7.2 per 100,000 population). 5 of these were for people aged under 75 (1.3 per 100,000 population). These rates are not significantly different to the national figures.

Source: Health & Social Care Information Centre; NHS Indicator Portal

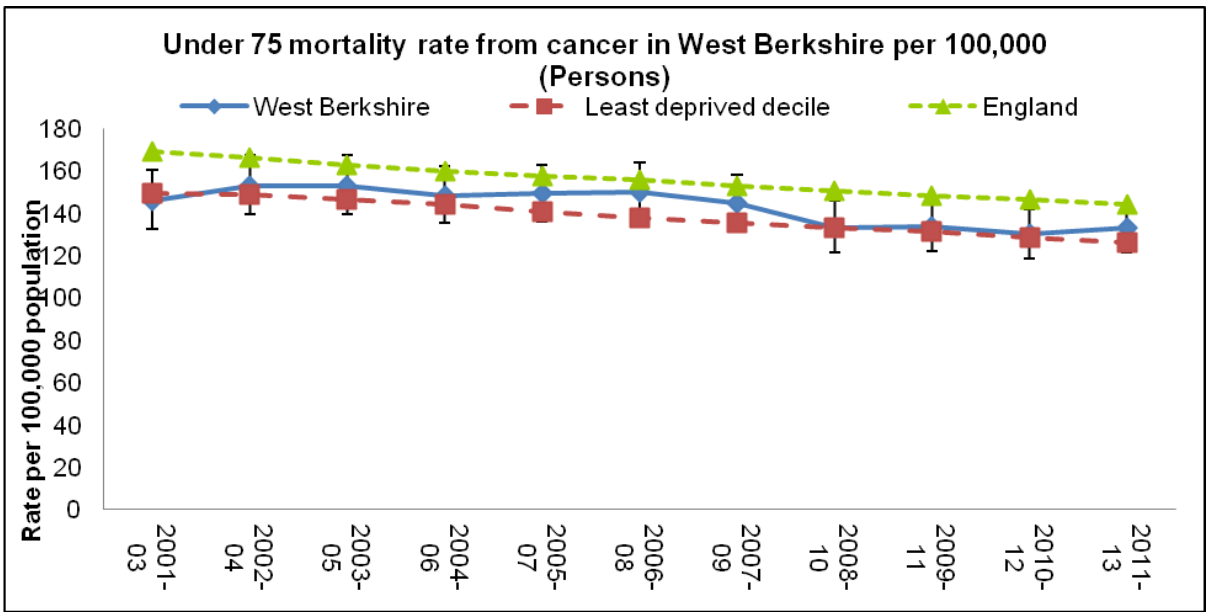
Cancer
Cancer incidence is the number of people who are diagnosed with cancer during a given time period. As the number of people diagnosed with cancer in an area will be influenced by the age and gender of the population these factors are controlled for through standardisation and presented as a rate per 100,000. This allows for a more direct comparison between areas which have different population structures. The rates of different cancer incidences is:

Breast cancer – 168 per100,000 with an increase over the past seventeen years.
Prostate cancer – 110 per 100,000 with a very slight increase over the past seventeen years.
Colorectal cancer – 78 per100,000 remaining constant over the past seventeen years.
Lung cancer – 62 per 100,000 with a very slight decrease over the past seventeen years.
Bladder cancer – 24 per 100,000 with a slight decrease over the past seventeen years.
Malignant melanoma – 15 per 100,000 with a slight decrease over the past seventeen years

Approximately 568 in every 100,000 people in West Berkshire will be diagnosed with cancer every year. The rate of diagnosis is slightly higher than the England average and has seen a slight increase over the past seventeen years.

Source: Public Health Outcomes Framework (November 2014)

The mortality rate from cancer in West Berkshire is lower than England and similar to LAs in the same the deprivation decile. The rate has not decreased since 2008-10 (133 per 100,000)



Public Health Outcomes Framework 2014

The under 75s mortality rate from cancer for females has not decreased since 2008-10 and the 2011-13 rate is 125.2 per 100,000.

The under 75s mortality rate from cancer considered preventable shows a similar picture with no decrease since 2008-10. Rate in 2011-13 is 76.7 per 100,000

One year cancer survival is 69% in Newbury and District CCG and 68% in North and West Reading CCG. This is similar to the England average of 68%.

Conclusion The updates to the JSNA chapters presented in this paper account for only a proportion of all the chapters contained within the needs assessment. The updates include demography, children 0-5, children 5-19 and adults. The remaining chapters: more on children and adults, vulnerable groups and wider determinants will be presented at the next Health and Wellbeing Board.

The merging of the JSNA and the District Profile will enable the sections on the wider determinants of health to give a more detailed and robust picture of the needs of the district. The timescale for this work to be completed is February 2016.

2. Equalities

2.1 This item is not relevant to equality.

Appendices

Appendix A – Update from the 2015 Index of Multiple Deprivation for West Berkshire
Appendix B – Summary (Will follow within a supplement pack)

Appendix 1

The English Index of Multiple Deprivation (IMD) 2015

- Overall, West Berkshire district ranks 291 out of 326 local authorities areas (35th least deprived district in England). The previous position was the 38th least deprived district **but is not directly comparable**.

- Only one LSOA (Lower-layer Super Output Area) The Nightingales, Equine Way (Greenham) is ranked in the 20% most derived of LSOAs nationally. An LSOA is an area of approximately 1500 people.

- The LSOAs in West Berkshire with the lowest rank of the overall IMD are:

Index of Multiple Deprivation (IMD) Decile (where 1 is most deprived 10% of LSOAs)	**Ward**	**Area**
2	Greenham	The Nightingales, Equine Way
3	Thatcham N	Park Avenue, The Henrys
4	Calcot	Royal Ave
4	Speen	Brummell Road
4	Victoria	London Road, Faraday Road, Hambridge Road
4	Victoria	Town centre

The 7 domains (types) of deprivation included in the Index

- The overall rank for each domain of deprivation of the 326 district authorities (where 1 is the most deprived area) is:

Domain of deprivation	Rank out of 326 LAs	Deprivation Decile
Barriers to housing and services	144	5th
Crime	172	6th
Education	250	9th
Living environment	275	8th
Income	284	9th
Employment	292	9th
Health	316	10th

- The main domain **Income** has one supplementary index for Income Deprivation Affecting Children Index (IDACI) and one for Income Deprivation Affecting Older People Index (IDAOPI). West Berkshire Council area ranks as follows:

  IDACI (children) 274

  IDAOPI (older people) 289

- None of the LSOAs in West Berkshire are ranked on the 'overall IMD' within the 10% most deprived LSOAs in England. However, an analysis of ranking of LSOAs for each domain of deprivation shows that some of the areas for particular domains of deprivation are within the 10% most deprived in England:

DOMAIN: Barriers to Housing and Services			
Ward	Area (LSOA)	Rank (where 1 is most deprived) of 32,844 LSOA	Decile (where 1 is most deprived 10% of LSOAs)
Downlands	Brightwalton, Chaddleworth, Catmore, West Ilsley, Farnborough, Fawley	128	1
Downlands	Leckhampstead, Peasemore, Stanmore, Beedon, East Ilsley	417	1
Speen	Stockcross, Wickham Heath, Winterbourne	1047	1
Bucklebury	Bradfield and Stanford Dingley	1278	1
Kintbury	Avington, Halfway, Wickham, Combe, Welford	1592	1
Compton	Hamstead Norreys, Ashampstead, Yattendon	1691	1
Basildon	Aldworth and Streatley	2644	1
Mortimer	Padworth, Ufton Nervet, Aldermaston Wharf, Wokefield Park	2891	1
Chieveley	Chieveley and Downend	2984	1
Sulhamstead	Beenham	3279	1

DOMAIN: Education, Skills and Training			
Ward	Area (LSOA)	Rank (where 1 is most deprived) of 32,844 LSOA	Decile (where 1 is most deprived 10% of LSOAs)
Greenham	The Nightingales, Equine Way	1962	1

- One LSOA is within the 10% most deprived areas in the country for the IDACI (the supplementary index of the Income Domain - Income Deprivation Affecting Children Index

SPPLEMENTARY INDEX for the INCOME DOMAIN: Income Deprivation Affecting Children Index (IDACI)			
Ward	Area (LSOA)	Rank (where 1 is most deprived) of 32,844 LSOA	Decile (where 1 is most deprived 10% of LSOAs)
Greenham	The Nightingales, Equine Way	2735	1

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Title of Report:	**HWB Community Engagement Strategy**
Report to be considered by:	The Health and Wellbeing Board
Date of Meeting:	26th November 2015

Purpose of Report: **To agree a strategy for community engagement**

Recommended Action: **To adopt the strategy**

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 At its meeting on 24th July 2014, the West Berkshire Health and Wellbeing Board agreed a protocol that committed the partners to work co-operatively together on community engagement and agreed that a strategy for the development of community engagement should be drawn up.

1.2 The strategy identifies shared aims amongst the HWB partners and a path towards working in partnership to achieve them.

1.3 The Board is asked to adopt the strategy.

2. Equalities

2.1 This item is not relevant to equality.

Appendices

Appendix A – Draft Community Engagement Strategy

Consultees

Local Stakeholders: Public Engagement Group, Health and Wellbeing Management Group.

Draft Joint HWB Community Engagement Strategy for West Berkshire

(V.5 October 2015)

1. Executive Summary

Our vision is for community engagement that drives change for the benefit of patients, service users and the public as a whole.

That means that the engagement must:

- be honest and genuine – really listening, with the public and statutory bodies working together as equal partners engaging in ongoing dialogue
- be open to anyone and everyone and not exclude or marginalise any particular groups
- be representative of the whole community, not presenting a biased or distorted picture
- be built on real experience and hard evidence

That can only be achieved by the partner bodies on the Health and Wellbeing Board – and over time, with others – working co-operatively together, while recognising their different roles and independence. This strategy sets out a high level approach for how they can work together and reach those objectives.

To achieve that, the key themes underpinning the strategy are:

- building **trust**, between organisations and the individuals within them, at all levels
- developing **cultures** that support co-operative working throughout each of the agencies
- developing **processes** that work in practice and are sustainable, so everyone feels they are getting a benefit from partnership working and it is not taking up more time and resources than it saves
- developing the **knowledge** of the public and particular cohorts amongst the public, including the spread of different views, wishes, needs, experiences etc. amongst different groups
- developing the **knowledge** about each of the partners and of other public and voluntary agencies – how each other works, what their key areas of interest are etc.
- developing the **systems and infrastructure** to support partnership working, such as sharing data and information
- building in **learning** from each other and also collectively over time.

The specific ways to achieve those things appear to be simple, but in practice require skill, patience and endurance.

There is no magic formula or blueprint to make those things happen and there will be a need to be flexible and to adapt. However some of the things that

can be put in place to support and facilitate other aspects of change in the shorter term include:

- Regular meetings of those people in each of the partner bodies who are planning and organising engagement
- An annual planning meeting to share and co-ordinate plans (early enough in the cycle to make changes). This could helpfully incorporate a review of the previous year and a consideration of the longer term trajectory of the partnership.
- Identification of shared or overlapping priorities where we are more likely to work collaboratively on engagement
- Having a common, publicly accessible register of consultations and engagement
- Wider meetings of those likely to be involved in engagement, from a wider range of services and organisations, possibly on a themed basis.

Things which may not come to fruition until the medium or longer term might include:

- greater sharing of information and data, and ultimately perhaps creating a joint repository
- undertaking more ambitious engagement activities such as larger scale engagements and deliberative events
- involving a wider range of organisations and services, particularly those with considerable potential to influence health and wellbeing, in areas such as housing, environment, transport, criminal justice, leisure, etc.

To be successful, this strategy will have to address a number of challenges, relating to: developing concerns in the health and wellbeing system; inherent difficulties in getting good community engagement; and the nature of partnership itself:

Both health and social care face severe resource restrictions in the next five years alongside increasing demands from an ageing population and enduring health inequalities. Meeting these demands will require reconfiguration of services and new ways of working with patients, care users and the public. While this has the potential for making big changes for the better, it could also put tremendous strain on the relationships between the partner bodies. This increases the importance of bringing, and keeping, everyone on board through strong personal relationships but also recognising and respecting the interests of each of the organisations.

The ideal community engagement described above – open, inclusive, representative, informed and honest – will take time to develop. That will require a lot of learning from evidence and experience, which will require time and patience. It also requires an acceptance of some failure, but to build on that to move forward.

The nature of partnership working itself is difficult. Few would object to it in principle, but commitment to it and the resulting benefits are less forthcoming

in practice. There is a risk of trying to achieve too much through partnership working, and then giving up if it doesn't deliver results, on the one hand, or there being insufficient and inconsistent commitment on the other. This means steering a careful course which builds on successes but does not stretch partners' commitment and resources too fast, too quickly.

It is proposed that the Health and Wellbeing Board delegate the implementation of this policy to the existing working group made up of those responsible for planning and managing community engagement in the CCG, Healthwatch and the Council, with clear terms of reference and governance arrangements.

Learning about what works is an important part of the strategy and it will need to be regularly reviewed. It is proposed that the working group review the strategy each year and report back to the Health and Wellbeing Board as appropriate or as requested.

2. Scope, Remit

2.1 Background and purpose

At its meeting on 24th July 2014, the West Berkshire Health and Wellbeing Board agreed a protocol that committed the partners to work co-operatively together on community engagement and agreed that a strategy for the development of community engagement should be drawn up.

The benefits of community engagement identified in the report included:

- improvements to health and social care services and the public's health and wellbeing more generally
- democracy and accountability
- direct benefits to participants from engaging
- improved social capital
- releasing resources through co-production.

The benefits of the partners working together on community engagement were identified as to:

- **save money**, by reducing duplication and exploiting economies of scale
- **increase effectiveness** by sharing skills and capacity and exploiting synergies
- **do things which would not otherwise be possible** (e.g. because individual bodies don't have the necessary resources or skills)
- **develop deeper insight** into the needs and views of patients, care users and the public, by pooling the intelligence of each of the parties
- **reduce 'consultation fatigue'** by not repeatedly approaching the same sections of the public for feedback
- **open up other opportunities for collaboration** if co-operation proves fruitful in this area.

Conversely, these are mirrored by the risks of inaction and continuing with fragmented and duplicated communications. As well as missing out on opportunities for more effective engagement, 'consultation fatigue' is becoming very real and already leading to lower turnout to public events in other areas.

2.2 Nature of the strategy

This is a joint community engagement strategy for the West Berkshire Health and Wellbeing Board (HWB). As such, it is about health and wellbeing and the HWB's role, but recognising that not all engagement will be done or commissioned by the Board itself, so it shouldn't ignore other engagement (e.g. by CCGs, social care, housing, leisure, planning, voluntary sector organisations, Healthwatch etc.).

Each of the partners may also have their own community engagement strategies and plans.

This is a strategy, not a plan or blueprint. It takes a high level, longer term view, looking at the principles underpinning how the partners will work together, and at the changes we intend to make in that over the next five to ten years, rather than identifying specific engagement opportunities to be undertaken over, say, the next year. Strategy and practice can iteratively influence each other, so the strategy will evolve over time.

2.3 Types of partnership and co-operation

The protocol and this strategy do not propose that the partners always work jointly all of the time. Although it usually makes sense to consider co-operation, the conclusion of that consideration may sometimes be that it is better in any particular case for the partners to operate independently.

There are broadly three sorts of co-operative working:

- **co-ordinating** activities in the light of what the others are doing, making mutual adjustments, such as not holding a meeting with the same section of the public in the same area on the same day
- **contributing** or sharing resources, skills or information, such as providing staff to help facilitate at someone else's event, adding a question to someone else's survey or allowing another body access to detailed (but anonymised) survey results. Another example would be using the council tax leaflet for shared partner messages or to ask for feedback
- **collaborating,** or undertaking activities jointly, such as running an event together, doing a joint survey or jointly commissioning a third party to do work on behalf of some or all of the partners.

'Partnership' is used here to refer to any or a combination of these. Partnership working, therefore, does not mean that everything has to be a joint activity. However, it is generally helpful for relevant bodies, in this case the HWB members, to be aware of each other's activities to avoid conflict and duplication and allow for any synergies between them.

3. Vision and Objectives

Our vision is for community engagement that drives change for the benefit of patients, service users and the public as a whole. The public, individually and collectively, will be able to participate as equal partners in the development of their own health and wellbeing and of the overall health and wellbeing system.

Community engagement should be:

- **Open**: Everyone should have an opportunity to have a say. It is not limited to particular groups such as patients or voluntary groups. Sometimes it will include the whole population. People should feel they have had an opportunity to have their say if they want to.
- **Inclusive**: It will not exclude marginalised groups and those who are 'seldom heard' and will particularly target those groups prioritised in the Health and Wellbeing Strategy
- **Representative**: It provides a fair representation of the whole community rather than being biased in any way.
- **Informed**: The views heard should be based on people's experience and/or sound evidence. It is important to respect what people actually think now, but engagement should also help people acquire more information and to debate issues so as to develop and enrich understanding and opinions.
- **Two way**: It should be a two way dialogue, not just telling or listening. The public should be able to influence what is discussed, not just respond to other people's agendas. The agencies should demonstrate how they have heard people and what they are doing about it ('you said, 'we did'), while being clear that there will always be things that people want that cannot be delivered.
- **Regular and ongoing**: It should be ongoing, not just a series of separate consultations. It should allow, over time, for people to listen to each other and modify their views.
- **Impactful**: It must make a difference, or else why do it?

These are our aspirations for engagement, but practicalities and resource constraints will limit our ability achieve them completely. However, working in partnership should increase our ability achieve more.

4. The Approach to Achieving the Objectives and Vision

The journey to co-operative partnership will need to address: attitudes and culture; knowledge, skills and capacity; and systems and infrastructure.

- Amongst the attitudinal issues are: awareness of the problems; the commitment to make changes; development of trust; and a developing culture which values and encourages co-operation.
- There is a need for both individual and organisational capacity, encompassing knowledge (such as about each other's business) and skills (such as those required to work collaboratively and skills in different forms of engagement).
- The infrastructure, processes, procedures, technology and systems include such things as arrangements when undertaking engagement, financial processes, a consultation register and a data repository.

To make the change happen requires a driving force spread across the partner bodies, not necessarily from formal leaders but from people who are committed and able to make things happen. (Whilst essential to success,

such things are not easily amenable to being legislated for through a strategy.)

The key themes underpinning the strategy are

- Building **trust**. Much depends on the trust between the partners. This is not just about a few people getting on with each other. It includes personal relationships, but across a wide range of people from each organisation. It is also more subtle than just personal relationships: it includes understanding what matters to each other, what the drivers are and where the red lines are.
- Developing **cultures** that support co-operative working throughout each of the agencies
- Developing **processes** that work in practice and are sustainable. It is easy, for instance, to set up a regular series of meetings, but harder to make sure they are worthwhile so the right people continue to attend. It is not always more effective to work together, and it will take time to understand when it is and isn't worth it.
- Developing the **knowledge about each of the partners** and of other public and voluntary agencies – how each other works, what their key areas of interest are etc.
- Developing **knowledge about the public** and the spread of different views, wishes, needs, experiences etc. amongst different sub-sections
- Developing the **systems and infrastructure**, for instance which allow data and information to be shared.
- Build in **learning**. Establish the mechanisms to learn from each but also to learn collectively over time.

5. Challenges and How to Meet Them

There are three areas of challenge that the strategy needs to address:

- the health and wellbeing system and how to improve people's health and wellbeing and reduce health inequalities in the context of restricted resources
- inherent problems with getting good community engagement
- partnership working and how to improve co-operative working between he partners.

These are now each addressed in turn.

5.1 The health and wellbeing system

The first group of challenges are in relation to health and wellbeing more generally, including the following:

- financial pressures – how to find the local proportion of the £30bn funding gap (by 2020) identified in the Five Year Forward View

- an ageing population
- 'social disease' (obesity, inactivity, harmful behaviours, the impact of deprivation etc.)
- enduring health inequalities
- lack of integration, across health and between health and social care
- making an impact on the social determinants of health
- getting parity of esteem for physical and mental health.

Meeting these demands will require reconfiguration of services and new ways of working with patients, care users and the public. It is also likely to require some hard choices to be made. While this has the potential for making significant improvements in the long run, it could also put tremendous strain on the relationships between the partner bodies. This increases the importance of bringing, and keeping, everyone on board through strong personal relationships but also recognising and respecting the interests of each of the organisations. While partnership working can produce better overall social outcomes, it sometimes comes at the expense of one organisation benefiting while another pays more (in time or money). This can be dealt with by give and take, knowing that an extra contribution now might be matched by a bigger benefit in some other, future project. However, it will also sometimes need to be addressed head-on and the particular interests of each of the partners explicitly recognised. One approach to dealing with such issues is through pooled budgets.

5.2 Good community engagement

Opportunities:

- Most people want to be kept informed, and to have a say – if there's something they want to have a say about
- There are legal requirements on the main statutory bodies to consult patients and the public
- Technology potentially makes engagement much cheaper (but not everyone has access)

Potential difficulties

- The community is too big and diverse – we can't talk to everyone
- Most people aren't interested all the time (but most are sometimes)
- People don't believe public bodies really listen and act
- Most people don't know much about the subject
- We only ever hear from 'the usual suspects'
- We have limited resources
- how to broaden awareness amongst the public of the HWB and the issues it is addressing
- how to increase local people's understanding of the various health and wellbeing challenges that the local area faces (for the community as a whole, but also, through the use of deliberative techniques, to hear the informed view of particular sections of it).

There will also be challenges in relation to the different sorts of engagement identified above, such as engaging through the commissioning cycle, including the alignment of timescales.

There are ways of meeting each of these needs, described in more detail in Appendix 2, - Approaches to Meeting the Challenges of Community Engagement such as getting representative views by using random samples and using deliberative techniques to hear what people think when they know more about the subject.

However achieving a good balance of such approaches across the range of engagement undertaken will take time and effort. It will require a lot of learning from evidence and experience, which will require time and patience. It also requires an acceptance of some failure, but to build on that to move forward.

5.3 Making partnership working work

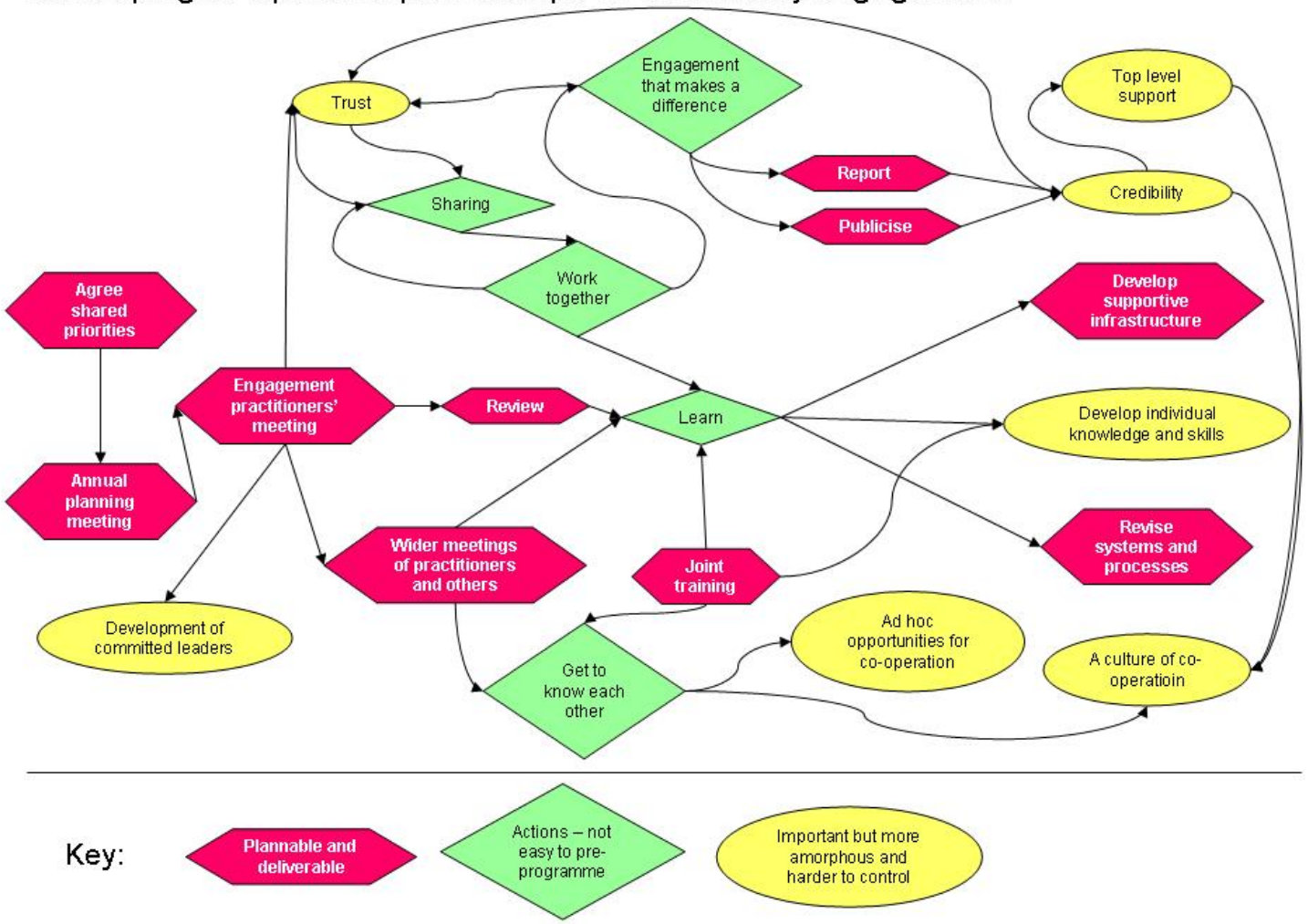
The third set of challenges relate to the difficulties of working in partnership. Partnership working is generally welcomed in principle: few people feel able to disagree with it. In practice, though it is often not successful. It may take more time than the benefits it brings. People may feel they are putting too much in (either of time or money) while others are reaping the rewards. Improvements for the public as a whole may be at the expense of particular organisations or individuals. Partnership working is particularly hard at times of reduced resources and institutional change, both of which are likely over the next five years.

There is a risk of trying to achieve too much through partnership working, and then giving up if it doesn't deliver results, on the one hand, or there being insufficient and inconsistent commitment on the other. This means steering a careful course which encourages realistic commitment, which builds on successes but which does not stretch partners' commitment and resources too fast, too quickly.

6. Analysis / choice of path

Dealing with those challenges will require a careful balance of approaches, drawn from the themes identified above – building trust, culture, knowledge, processes, systems and infrastructure, and learning. Given that this is a complex system, it is not possible to plan and predict an exact path, so there will have to be adaptation as the strategy progresses. However, the following diagram tries to bring some of the elements together and show, in a simplified way, how they might reinforce each other.

Developing co-operative partnerships for community engagement



7. Actions

Following that broad approach, a rough plan of action is given below.

Years 1-2

- The relevant members of the partner organisations regularly meet, particularly the communications and engagement teams (the people responsible for planning and organising engagement). These meetings should scan for opportunities; plan for the period ahead; organise specific co-operation (or delegate to project groups); and review previous working.
- Improve co-ordination of activities – relevant meetings (e.g. the Hot Focus sessions), aligning of annual plans, co-ordinating calendars. Common use of the Council's online list of consultations
- Having a common, publicly accessible register of consultations and engagement
- Stakeholder mapping
- Identify common priorities or overlapping interests and approaches, e.g. in terms of: questions and issues on which we want to engage; target audiences (including seldom heard); engagement mechanisms
- Quick wins, e.g. making existing events joint where appropriate
- Agree common standards for engagement including agreed timetables for individual organisational work, ensuring we co-ordinate activity and do not overwhelm people
- Early public engagement on key strategic issues (e.g. health and wellbeing strategy, Better Care Fund, new models of care). More information giving and discussions with particular groups than with the population as a whole at this stage.
- To have at least one joint consultation exercise in the first year.
- Start the work for things to be achieved in the next period
- Wider meetings of those likely to be involved in engagement, from a wider range of services and organisations,

Years 3-5

- Shared information and data (such as the results of consultation and engagement)
- Involving a wider range of services and activities (e.g. other parts of the council such as leisure, environment, trading standards, and other organisations such as housing associations, health providers). Meetings to involve people could be on a themed basis. As well as being an opportunity to get to know each other, these should also have a practical purpose (such as event planning, training or hearing from an outside speaker).
- Step change in the public's understanding of the key issues related to health and wellbeing

Years 5-10

- Developing more ambitious approaches to engagement – e.g. joint citizens' panel, deliberative events etc.
- Create a common repository for information and data.

8. Implementation

While not wishing to over formalise the process, there will be a need for clear governance and accountability.

Those directly responsible for planning and managing engagement in the CCG, Healthwatch and the Council have already been meeting together. It is recommended that the Health and Wellbeing Board delegate the implementation of the strategy to this group, reporting back to the Board as appropriate.

Improvements to joint working should develop organically as the partners increasingly plan and work together. However some elements will need more conscious reflection and choice. The bigger steps forward will therefore tend to take place as part of annual planning cycles.

The strategy is in many ways provisional. It is hard to predict the future and we don't know how successful our efforts will be. However having an idea of what we are trying to achieve, and how, should help us better keep track of our success and adapt to challenges. As noted above, continual learning will be key to its success.

It is therefore proposed that there should be a minor review of the strategy every year and a more substantial review every three years.

Appendix 1 - Principles for Joint Working

The principles committed to by the partners in the protocol were:

" What we commit to

In the light of all of the above, we commit in good faith, to:

- *maintain communications between the parties and particularly those directly involved in community engagement (whether that is as part of their ongoing role or ad hoc)*
- *keep each other informed as to what community engagement they are planning*
- *when there is a net social benefit to doing so, to:*
  - *take account of each other's engagement and where appropriate adjust plans and activities to take account those of the other parties*
  - *provide mutual support where possible and appropriate, within resource limitations*
  - *work together (subject to any other constraints).*

Shared principles in relation to community engagement

The parties jointly and severally commit to the following principles in relation to community engagement, in order to maintain the highest standards locally:

- *We regard engagement as a two way process and recognise that it may be initiated by the public as well as by public or voluntary bodies*
- *We will engage with the public as early as possible in any decision making process to allow for the greatest involvement and influence*
- *We will only consult with a purpose*
- *We will be open, transparent and genuine*
- *We will let those we are engaging with know what we will do with the consultation and what part it will play in final decision making*
- *We will aim for technical quality (the most effective techniques, properly used, tailored to local circumstances)*
- *We will allow sufficient time in any consultation for all relevant sections of the community to respond*
- *We will be inclusive and aim to hear from all sections of the community*
- *We will report back the feedback we have heard* [add: 'at the earliest opportunity']
- *We will act ethically, follow legal requirements and relevant codes of conduct"*

Appendix 2 - Approaches to Meeting the Challenges of Community Engagement

There are ways of achieving the objectives outlined above (under Visions and Objectives, namely for engagement to be: open, inclusive, representative, informed, two-way, regular and ongoing and impactful), but it is difficult to achieve them all simultaneously. For instance, the public as a whole can be invited to respond to a consultation but there will be a self-selection as to who takes part which could leave it open to bias. You can get a representative view by using a random sample, but then it is not open. If you ask people about, say, their experience in hospital, then their views will be well informed, because they are based on their experience. However, if you ask them about the future configuration of health and care, they are unlikely to the information necessary to give an informed view – unless you help provide that information through deliberative events.

- Random sampling can be used to get a reasonably accurate view of the whole community, (in the way opinion polls work).
- Lack of expertise can be addressed on a small scale by providing information to groups of people and engaging in dialogue before asking for their views. If this were done with a statistically representative sample, it should give an informed, representative view. Over the longer term, information can be provided to the population as a whole to gradually increase people's awareness and knowledge of key issues.
- However it is also important that people feel, and are, able to contribute their views (rather than just relying on samples) so open, inclusive consultation is also important.
- People are already organised into many groups (social, interest, lobbying) and many of these provide a ready made route to reaching people with an interest, and often knowledge, of particular issues.

Whilst those approaches relate to community engagement as a whole, in practice, specific methods of engagement are chosen to meet specific objectives or meet particular needs.

The purposes of engagement form a spectrum, with strategic, commissioning and accountability at one end, through to feedback and service improvement at the other. The bigger, strategic issues generally require the view of the whole community and they are issues on which the community is unlikely to have expertise. The more concrete issues – improving services or issues relating to particular conditions – tend to have a more specific target audience, who already know something about the issue (e.g. through their experience as patients). Different sets of techniques are needed to meet these different requirements.

Title of Report:	**Healthwatch West Berkshire Update**
Report to be considered by:	The Health and Wellbeing Board
Date of Meeting:	26th November 2015

Purpose of Report: **To inform the Board on Healthwatch West Berkshire's activities and plans for the coming year.**

Recommended Action: **For information.**

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 Healthwatch West Berkshire (HWWB) is the statutory independent voice and people's champion for Health and Social Care, set up by the Care Act 2012. The current contract was granted on May 1st 2015 to seAp, a renowned Advocacy Services Charity, as a joint contract to include NHS Complaints, Independent Mental Health Advocacy, Safeguarding Advocacy and Healthwatch West Berkshire.

1.2 With no staff retained from the previous Healthwatch Provider a transitional period of three months was agreed to establish the 'new' Healthwatch West Berkshire. An interim manager was appointed to maintain a service and aid in recruiting a new team that would fulfil the remit for HWWB. This is the first update from that point.*

2. Equalities

2.1 The recruitment of the new members of staff was conducted in line with seAp's equality and diversity policy, which included anonymous CV screening and a recruitment panel.

3. Staff Recruitment

3.1 A new team has been recruited with the final member of staff in post mid-October. The team is led by Andrew Sharp, former Lay Member of Newbury and District CCG, in the position of Chief Officer P/T with two Development Officers P/T and an Admin and Information Officer P/T.

4.0 Board Structure, Governance and Champions Advisory group

4.1 Two interim board meetings have been held on September 4th and October 21st to clarify the working structures of a newly constituted board and governance structures going forward and the creation of a new more focussed work plan for HWWB. Agendas and Minutes of these meetings are available on the Healthwatch West Berkshire Website www.HealthwatchWestBerks.org.uk

4.2 The Champions' Advisory Board has also changed, with some existing members leaving and some new members from a broader cross section of the Voluntary Sector being recruited. It currently stands at 12 active members and may expand if additional members are thought to improve the wider representation of the population.

5. Engagement and Collaboration

5.1 Meetings have been held with key health and social care providers, commissioners including: The Newbury and District CCG, Berkshire Healthcare NHS Foundation Trust, Royal Berkshire NHS Foundation Trust and other Healthwatch's from bordering areas that share key services. This has included: Healthwatch Swindon, Hampshire, Reading, Oxfordshire and Wokingham. Healthwatch West Berkshire has also attended key meetings of the Thames Valley Healthwatch Group and the Healthwatch England Annual Conference and Report launch.

5.2 HWWB have also agreed some joint working with Healthwatch Reading, Wokingham and Swindon to ensure our work is as comprehensive as possible and produces meaningful qualitative reports and recommendations.

Public Engagement Activities Undertaken

2015	Event	Where	Approx. Face to Face no.
August			
19th	Blue Bird Event for the Elderly	Hungerford	40
September			
11th	Walking for Health	Thatcham	8
15th	Newbury College Fresher's Fayre	Newbury	80
16th	Mental Health Carer's Support Group	Thatcham	12
23rd	Loose Ends Visit	Newbury	15
29th	Age UK, Older Persons' Day, Fair Close	Newbury	100
October			
7th	WIBLIN networking event	Newbury	25
7th	Cold Ash WI, Dementia Friends	Cold Ash	18
9th	World Mental Health Day	Newbury	100
19th	Memory Café	Newbury	10
Total			**408**

5.3 We have kept our social media up to date and actively tried to increase its reach. HWWB's Twitter following has increased from 940 followers to 1073 +14%, Facebook from 209 to 274 +31%

5.4 We have changed the HWWB url address to www.HealtwatchWestBerks.org.uk to make it shorter, as well as easier to remember and use.

5.5 The Website has been updated and all the forms and contact details are now correct, so the public can get in touch with us easily.

6. Work Plan and Reporting

6.1 To create our first work plan, we have worked with an industry expert on PPE (Patient & Public Engagement), who was contracted to set up Staffordshire Healthwatch and has worked with 50 + other Healthwatch's across the UK. Combined with the input from our Champions, HWWB Board and first few months of gathering information, we have just completed our first plan of work, which we will be launching early November. Although it sets up our direction of travel it should be seen as a fluid document, which will also have input directly from the public and all our key 'touch' points continually. This will ensure we do not miss key issues that arise, but also help provide a focus for our activity with limited resources.

6.2 We have secured an earlier than expected deployment of the custom built Healthwatch England CRM (Customer Relationship Management) system that is

being used from the start of November. Additional training is planned but it is a very intuitive system that will aid reporting across a range of metrics.

7. Cases and Enquiries

7.1 While the team has been recruited and trained we have maintained the HWWB service using seAp's fully 'manned' call centre, managing calls using a local number 01635 886 210, retained from the previous contract. We have dealt with a small number of cases from the call centre and gathered further evidence from our engagement activity - but its very early days for this new version of HWWB.

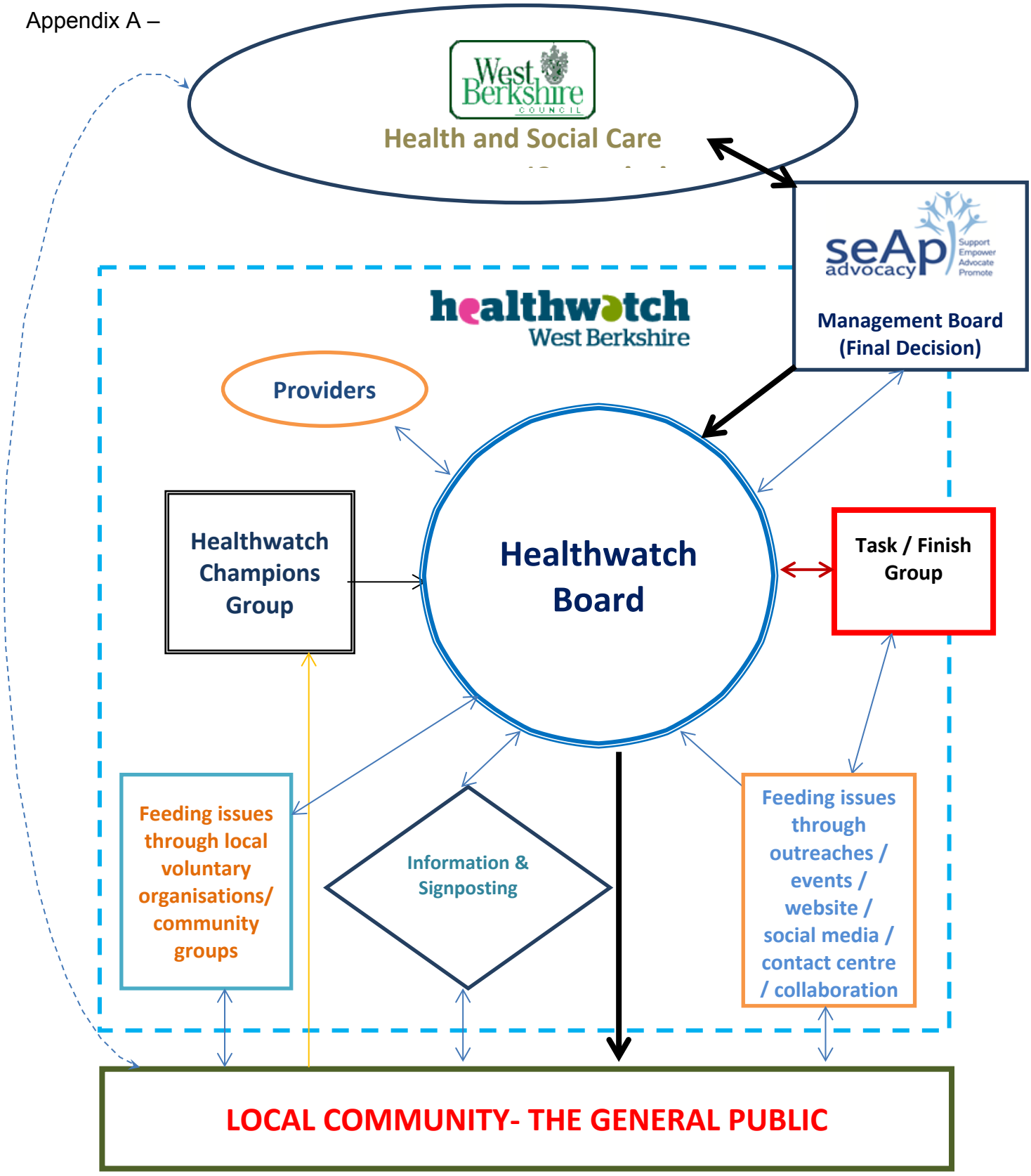
7.2 We to this point have not actively marketed HWWB, so as not to create a demand that could not be managed professionally. With the team and systems now in place we will be heavily marketing HWWB via GP Surgeries, Hospitals, Dentists, and social care services, as well as the local media.

Appendices

Appendix A – Healthwatch West Berkshire Structure Diagram

Appendices

Appendix A –



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Title of Report:	**Update on Health and Wellbeing Delivery Groups and Delivery Plans**
Report to be considered by:	The Health and Wellbeing Board
Date of Meeting:	November 26th 2015

Purpose of Report: **To update the Board on progress made on the establishment of Delivery Groups and the development of Delivery plans to demonstrate progress on addressing the 11 priorities in the Health and Wellbeing Strategy**

Recommended Action: **The Board to note the progress made and for Board members to support the Delivery Groups and encourage the finalisation of Delivery plans as outlined in paragraph 2.**

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.:	Graham Jones – Tel 07767 690228
E-mail Address:	gjones@westberks.gov.uk

Contact Officer Details	
Name:	Lesley Wyman
Job Title:	Head of Health and Wellbeing
E-mail Address:	lwyman@westberks.gov.uk

Executive Report

1. Introduction

1.1 The Health and Wellbeing Strategy has 11 priorities and in June 2015 individuals were asked to establish Delivery Groups and to develop Delivery Plans to demonstrate to the Board how each of the priority areas would be addressed. These plans should include actions that are already in place in addition to any new actions that the multi-agency groups.

1.2 Terms of reference for the Delivery Groups were sent out and a Delivery Plan template for each of the priorities. Where possible priorities were grouped. The following leads were identified at a meeting with Head of Public Health and Wellbeing, Head of Adult Social Care and Director of Operations, Newbury and District CCG:

Dementia Lead: West Berkshire Council Dementia Team Leader supported by PH Programme Officer

Mental Health and Wellbeing – adults Lead: PH Programme Officer

Children and Young People - Lead: Head of Children's Services

Carers - Lead: Adult Social Care Service Manager supported by PH Programme Officer

Health Damaging Behaviours - Lead: Head of Health and Wellbeing

Healthy weight and physical activity - Lead: PH Programme Manager

Cardiovascular disease and cancer - Lead: Director of Operations, NDCCG supported by Head of PH and Wellbeing

Long Term Conditions, Falls Prevention and EOL Care Lead: Head of Adult Social Care

1.3 Progress has been variable across the priorities and where groups have already been in existence this has usually been beneficial. This has certainly been the case for the following:

(1) Carers Strategy Group

(2) Mental Health Collaborative

(3) Healthy Lifestyles Network

(4) Newbury Dementia Action Alliance

1.4 The Children and Young People's Group is being set up initially by the Head of Prevention and Community Resilience, West Berkshire Council. The first meeting will be on November 24th. The group will link into the existing School's Health and Wellbeing group. It was agreed by the HWBB at an earlier meeting that the Children and Young People Delivery Group will address the 3 priorities relating to the health

and well being of young people: promoting emotional wellbeing in all children and young people, improving health and educational outcomes of looked after children and closing the attainment gap between children on free school meals and all other children. There have been discussions about the possibility of addressing children and young people's mental and emotional wellbeing through the Mental Health Collaborative, however this has currently not been completely agreed and is still under consideration.

1.5 A Delivery Groups for Health Damaging Behaviours has yet to be set up. Substance misuse services for adults are currently commissioned by Public Health and a Delivery Plan for alcohol and drugs can be provided for the HWBB. A new PH and Wellbeing Programme Officer has recently been appointed and she will be tasked with working closely with all relevant partners to ensure that a strategic approach is taken to providing services for those with substance misuse issues and to preventing the numbers of people who need these services. It may be unnecessary to establish a Substance Misuse Delivery Group, but these discussions are currently under way.

1.6 A Delivery Group has yet to be set up for Long Term Conditions, Falls Prevention and End of Life Care. There is a CCG Federation Long Term Conditions Board for the West that can advise on the development of local indicators. In addition the recent Falls Prevention Hot Focus session has provided much information on falls prevention services that are already being provided locally and this can be woven into the Delivery Plan once it is set up. It is also suggested by Dr Barbara Barrie, NWRCCG that End of Life services should be discussed at a HWBB meeting to help the understanding of the Board on what is available and what should be developed for West Berkshire.

1.7 A Delivery Group has yet to be set up for cardiovascular disease and cancer. It was proposed that this group should be led by the CCGs who commission secondary care services for residents with these conditions. The prevention of cancer and cardiovascular disease through healthy lifestyles including obesity, physical activity, smoking and alcohol is already being addressed through the work of the Healthy Lifestyles Network. However the priority also cites **early identification of cardiovascular disease and cancer in primary care and community settings through the provision of NHS health checks and screening and ensuring the provision of high quality secondary care services**. Public Health commissions NHS Health Checks locally and most of these are delivered though Primary Care. It would be useful for the Board to be updated on how this part of the priority is being delivered.

2. Recommendation

2.1 Since there has been such a diverse response to the setting up of Delivery Groups and the development of Delivery Plans it is suggested that a new deadline for draft Delivery Plans be set by the Health and Wellbeing Board with a requirement for these to be submitted to inform the Board of progress on all the priorities.

3. Equalities

3.1 This item is not relevant to equality.

Appendices

There are no Appendices to this report.

Consultees

Local Stakeholders: Health and Wellbeing Management Group

Title of Report:	**Emotional Health Tier 2 design proposals**
Report to be considered by:	The Health and Wellbeing Board
Date of Meeting:	26th November 2015

Purpose of Report:

1.1 To update the Health and Well-Being Board on the Building Community Together emotional health re-design proposals for children and young people's emotional health services.
1.2 To inform Health and Well-Being Board members that the West Berkshire Transformation Plan for emotional health services submitted to the Department of Health on Friday 16th October, included explicit commitment to the creation of the Emotional Health Academy in West Berkshire.

Recommended Action:

That the Health & Well-Being Board members note the strategic development of the Emotional Health Academy and approve in retrospect, the strategic commitments to improving child and adolescent mental health support in the West Berkshire Transformation Plan.

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.:	Graham Jones – Tel 07767 690228
E-mail Address:	gjones@westberks.gov.uk

Contact Officer Details	
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Job Title:	Head of Service, Prevention and Building Community Resilience
Tel. No.:	01635 519723
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Executive Report

1. Introduction

1.1 The Good Childhood Report (Children's Society August 2015) reports that UK children are among the unhappiest worldwide. Emotional health need is one of the most common early indications of additional need; left unsupported, early emotional health difficulties can rapidly develop into a diagnosed mental health condition.

1.2 The majority of children and young people contacting specialist Tier 3 CAMHS for support/help in West Berkshire do not receive a service, because they do not meet the threshold for Tier 3 services.

1.3 The vast majority of our children subject to Child Protection Plans and those open to the Youth Offending Team have emotional health needs and many have mental health disorders.

1.4 Many children are waiting over a year to be seen by a mental health professional and some are waiting over two years; for most children and young people, their condition deteriorates significantly in that time. Currently the longest waits are for the ASD diagnostic pathway which accounts for more than 50% of the current waiting list.

1.5 There is now a new national requirement for system wide transformation of emotional and mental health services for children and young people over a 5 year period. A local Transformation Plan must be developed and submitted for each of the Local Authority areas. Once the plan has been assured by the regional team, additional funding will be released to the CCG. These Local Transformation Plans must be signed off by the Health and Wellbeing Board. The local Transformation Plan is found in Appendix A of this document. The plan describes the role of the Emotional Health Academy in delivering sustainable changes to improve the emotional health and wellbeing of children and young people in West Berkshire. An oversight group has been set up across Berkshire West to monitor and facilitate implementation of the Transformation Plan.

1.6 In summary West Berkshire partner agencies want to:

1) Create an Emotional Health Academy where:

- **children will be seen in a week, rather than waiting a year - t**ake newly qualified psychology graduates and other emotional health qualified staff and train them to work with children and families in the communities in which they live.
- **We'll work in partnership** – to ensure that these staff work closely with schools, with GP surgeries, with Children's Centres, the Police and crucially with voluntary sector

- **We'll look at the needs of the whole family, not just the child** - by testing a new way of working with adult services, to see how we can work more effectively with whole families; where both adults and children are affected by emotional health needs

- **Sustaining good heath** – we'll support children and young people to develop sustainable strategies to keep themselves well and promote their long-term well-being; by drawing on their own resources, the resources of their friends and family; by utilizing and creating community led resources.

- **Getting to children early will reduce the pressure on child protection services later**

1.7 Commission specialist voluntary sector providers - to provide more non-stigmatising care in, and to, our communities in close partnership with the Academy.

2. Equalities

2.1 These proposals have been subject to significant consultation with partner agencies and have been directly informed by the views of children and young people. The proposals are explicitly designed to facilitate more proactive access to emotional health services, in the communities in which families who require this help and support live.

3. Conclusion

3.1 Since the last meeting of the Health and Wellbeing Board, we have been required to submit the transformation plan. It was not possible to convene a special meeting of the Board in the time available and therefore an informal meeting was held and the Director of Public Health subsequently submitted this on behalf of the Board on the basis that retrospective approval was obtained from the Board at its next meeting.

3.2 **Recommendation:** The Board is requested to retrospectively approve the Transformational Plan being submitted to the Department of Health.

Appendices

Appendix A – West Berkshire Transformation Plan
Appendix B – West Berkshire Emotional Health re-design proposals

Consultees

Local Stakeholders: Representatives from 50 partner agencies contributed to the co-design of these proposals on a partnership awayday on the 3rd July 2015. This included representation from public health; schools; General Practice; Berkshire Healthcare Foundation Trust; voluntary, community and faith sector partners; Thames Valley Police; Sovereign housing; Safer Communities Partnership; children's and adult's services within West Berkshire Council.

Officers Consulted:	Heads of Service, Service Managers and Team Managers from services including Children's Services, Adult Social Care, CMHT, Safer Communities have contributed to this co-design work.
Other:	Children and young people have directly contributed to the design of these proposals, through the Brilliant West Berkshire: Building Community Together participation activity.

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NHS Newbury and District Clinical Commissioning Group

NHS North and West Reading Clinical Commissioning Group

NHS South Reading Clinical Commissioning Group

NHS Wokingham Clinical Commissioning Group

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

West Berkshire Health and Wellbeing Board and Local Authority area

Version 5 13 October 2015

Contents

1. **High level summary of the Local Transformation Plan (Annex 1 in the guidance)**

Annex 1: West Berkshire Local Transformation Plan for Children and Young People's Mental Health

Developing your local offer to secure improvements in children and young people's mental health outcomes and release the additional funding: high level summary

Q1. Who is leading the development of this Plan? (Please identify the lead accountable commissioning body for children and young people's mental health at local level. We envisage in most cases this will be the CCG working in close collaboration with Local Authorities and other partners. Please list wider partnerships in place, including with the voluntary sector and include the name and contact details of a single senior person best able to field queries about the application.)
Lead commissioning body-NHS Berkshire West CCGs working in collaboration with West Berkshire Council, Public Health, NHS England Specialised Commissioning and Health and Justice Commissioning. Partners including the voluntary sector, NHS providers, referrers, schools, the universal and targeted children's workforce, service users and their families have shaped these plans. Implementation of the Transformation Plan will be overseen by the Berkshire West Mental Health and Wellbeing Transformation group. See section X Berkshire West already has a number of governance structures in place that will provide a solid foundation of support for the Transformation Plan. These include Berkshire West Integration Board Berkshire West Children's Commissioning Strategy Group Brilliant West Berkshire: Building Community Together- Local Authority led **For queries contact** Gabrielle Alford Director of Joint Commissioning Sally Murray Head of Children's Commissioning NHS Berkshire West CCGs 57- 59 Bath Road, Reading, RG30 2BA sally.murray2@nhs.net
Q2. What are you trying to do? (Please outline your main objectives, and the principal changes you are planning to make to secure and sustain improvements in children and young people's mental health outcomes. What will the

local offer look like for children and young people in your community and for your staff?). Please tell us in no more than 300 words

Our main objective is to integrate and build resources within the local community so that emotional health and wellbeing support is offered at the earliest opportunity thereby reducing the number of children and mothers at the perinatal stage whose needs escalate to require a specialist intervention, a crisis response or admission to an in-patient facility.

This means that

- Good emotional health and wellbeing is promoted from the earliest age
- Children, young people and their families are emotionally resilient
- The whole children's workforce including teachers, early years providers and GPs are able to identify issues early, enable families to find solutions, provide advice and access help
- Help is provided in a coordinated, easy to access way. All services in the local area work together so that children and young people get the best possible help at the right time and in the right place. The help provided takes account of the family's circumstances and the child or young person's views.
- Women with emerging perinatal mental health problems access help quickly and effectively
- Vulnerable children access the help that they need easily. This includes developing Liaison and Diversion services and better links with SARCs.
- Fewer children and young people escalate into crisis. Fewer children and young people require in patient admission.
- If a child or young person's needs escalate into crisis, good quality care will be available quickly and will be delivered in a safe place. After the crisis the child or young person will be supported to recover in the least restrictive environment possible, as close to home as possible.
- When young a person requires residential, secure or in patient care, this is provided as close to home as possible. Local services support timely transition back into the local area.
- More young people and families report a positive experience of transition.

Q3. Where have you got to?

(Please summarise the main concrete steps or achievements you have already made towards developing your local offer in line with the national ambition set out in *Future in Mind* e.g. progress made since publication in March 2015.) Please tell us in no more than 300 words

- In 2014 a substantial engagement was undertaken with comprehensive Berkshire CAMHs service users, families, referrers, practitioners and other stakeholders led by an independent consultant.
- A local action plan in response to the engagement findings was developed and enacted prior to publication of Future In Mind. This includes a number of pilot projects on transition, perinatal mental health, self-care and improving care for the most vulnerable
- West Berkshire partner agencies have committed to work together to achieve a shared strategic vision summarized as 'Brilliant West Berkshire: Building Community Together'
- Commissioning of Berkshire Adolescent Unit has transferred to NHS England. The unit has

been re-designated as a 24/ 7 Tier 4 resource. Bed capacity is due to increase this autumn.

- Operational resilience resources funded a trial of extended CAMHs opening times which reduced the number of children and young people whose needs escalated into crisis. This is now being mainstreamed.
- Operational resilience resources funded an enhanced Early Intervention in Psychosis service. This has now been mainstreamed.
- Crisis Care Concordat action plan is in place and being delivered. Psychological Medicines Service, ambulance triage and street triage services are in place.
- Berkshire West CCGs have increased the investment in specialist CAMHs by £1M recurrently. Up to an additional 500K is available non recurrently to fund agency staff while substantive posts are recruited to. The initial focus is on reducing waiting times, piloting a Short Term Care Team to follow up young people who presented with urgent care needs and delivering PPEP Care training to primary care and schools
- Redesign of the community Eating Disorders service is underway
- Young SHaRON online platform has been developed. This will go live this Autumn.
- Children and Young People's Integrated Therapies toolkit is being expanded to include mental health and emotional development
- A Mental Health and Wellbeing Transformation group has being convened.

Q4. Where do you think you could get to by April 2016?

(Please describe the changes, realistically, that could be achieved by then.) Please tell us in no more than 300 words

- Reduced waiting times for specialist CAMHs
- Reduction in crisis presentations due to better risk mitigation
- Common Point of Entry will be open Monday to Friday 8am until 8pm
- Workforce development plan for emotional health and wellbeing being implemented across partners
- Joint commissioning of voluntary sector counselling where the Local Authority and CCG are currently commissioning independently
- Evaluation of the CAMHs Short Term Care team
- Launch of Young SHaRON- online platform for service users
- Increase number of in-patient beds at Berkshire Adolescent Unit
- Improved perinatal mental health service will be providing better access to advice and help for mothers
- Outcome framework developed and agreed across partners. To be implemented in all contracts from 1 April 2016.
- Neurodevelopmental pathway developed within BHFT
- Children's toolkit expanded to include mental health and wellbeing
- Learning from the Strengths and Difficulties pilot will have been shared and will be shaping service provision
- Enhanced Liaison Mental Health service for under 18s will have been trailed at RBFT (subject to funding through Liaison Mental Health)
- Commission enhanced Eating Disorders service. Start delivery

Q5. What do you want from a structured programme of transformation support? Please tell us in no more than 300 words
• Additional funding in order to meet all the requirements of Future In Mind • Events held in the Thames Valley to develop the workforce, commissioner and provider skills • On line resources-e.g. concise “how to “ guides linked to the evidence base • Simple and easy to use trackers and pro-formas • Support to enable implementation of a core outcomes framework across all partners

2. Self-assessment checklist for the assurance process (Annex 2 in the guidance)

Please complete the self-assurance checklist designed to make sure that Local Transformation Plans for Children and Young People's Mental Health and Wellbeing are aligned with the national ambition and key high level principles set out in *Future in Mind* and summarised in this guidance

PLEASE NOTE: Your supporting evidence should be provided in the form of specific paragraph number references to the evidence in your Local Transformation Plans – not as free text

Theme	Y/N	Evidence by reference to relevant paragraph(s) in Local Transformation Plans
Engagement and partnership		
Please confirm that your plans are based on developing clear coordinated whole system pathways and that they:		
1. Have been designed with, and are built around the needs of, CYP and their families	Y	4.6 8.3 section 5
2. provide evidence of effective joint working both within and across all sectors including NHS, Public Health, LA, local Healthwatch, social care, Youth, education and the voluntary sector	Y	8.1 8.2 Sections 4 and 6
3. include evidence that plans have been developed collaboratively with NHS E Specialist and Health and Justice Commissioning teams,	Y	4.9 Sections 10 and 11
4. promote collaborative commissioning approaches within and between sectors	Y	Sections 4, 10, 14
Are you part of an existing CYP IAPT collaborative?	Y	4.4
If not, are you intending to join an existing CYP IAPT collaborative in 2015/16?	N/A	
Transparency		
Please confirm that your Local Transformation Plan includes:		
1. The mental health needs of children and young people within your local population	Y	4.5 Section 5
2. The level of investment by all local partners commissioning children and young people's mental health services	Y	Section 6
3. The plans and declaration will be	Y	4.5

published on the websites for the CCG, Local Authority and any other local partners		
Level of ambition		
Please confirm that your plans are:		
4. based on delivering evidence based practice	Y	7.1 Sections 8, 11
5. focused on demonstrating improved outcomes	Y	7.11 Sections 8 and 11
Equality and Health Inequalities		
Please confirm that your plans make explicit how you are promoting equality and addressing health inequalities	Y	7.4 Sections 8,9,10,11
Governance		
Please confirm that you have arrangements in place to hold multi-agency boards for delivery	Y	Section 14
Please confirm that you have set up local implementation / delivery groups to monitor progress against your plans, including risks	Y	Section 14
Measuring Outcomes (progress)		
Please confirm that you have published and included your baselines as required by this guidance and the trackers in the assurance process	Y	Section 15
Please confirm that your plans include measurable, ambitious KPIs and are linked to the trackers	Y	Sections 13, 15
Finance		
Please confirm that:		
6. Your plans have been costed	Y	Section 15
7. that they are aligned to the funding allocation that you will receive	Y	Section 15
8. take into account the existing different and previous funding streams including the MH resilience funding (Parity of Esteem)	Y	Section 15

……dr lise Llewellyn director of public health .

Name, signature and position of person who has signed off Plan on behalf of local partners

……..
Name signature and position of person who has signed off Plan on behalf of NHS Specialised Commissioning.

3. Locality information

This local Transformation Plan relates to the West Berkshire Local Authority area.

Two CCGs serve the population of West Berkshire Council. These are Newbury and District CCG and North and West Reading CCG.

There are four CCGs in Berkshire West. The four CCGs work collaboratively with a single contract with Berkshire Healthcare Foundation Trust (BHFT) for specialist CAMHs, mental and physical health services.

West Berkshire Local Authority currently commissions a small Primary CAMHs service from BHFT as part of the targeted CAMHs offer. Health Visiting and School Nursing are also provided by BHFT.

Berkshire West CCGs and West Berkshire Council commission a range of voluntary sector organisations through grants.

Royal Berkshire Hospital Foundation Trust (RBFT) is the main acute general hospital in the area.

South Central Ambulance Service (SCAS) is the patient transport provider.

The Berkshire Adolescent Unit (BAU) is the only NHS inpatient CAMHs facility in Berkshire. It is commissioned by NHS England.

4. Engagement and partnership (groups)

4.1 The four Berkshire West CCGs work in partnership with the 3 Local Authorities (West Berkshire Council, Reading Borough Council and Wokingham Borough Council), Berkshire Healthcare Foundation Trust, Royal Berkshire Hospital Foundation Trust and South Central Ambulance Service to form the Berkshire West Integration Board.

4.2 Implementation of the Transformation Plans will be overseen by a new Berkshire West Children and Young People's Mental Health and Wellbeing Transformation group, attended by multiagency partners (see section 14) The Transformation group will report to the Berkshire West Integration Board.

4.3Berkshire West Children's Commissioning Strategy Group meets monthly to collaboratively improve the health and wellbeing outcomes for Berkshire West Children and Young People and their families through developing and overseeing the commissioning of health, social care and education support services. Membership comprises of CCG, Public Health and Local Authority Children's commissioning leads and Local Authority Children's Services leads.

4.4 Berkshire CAMHs are already part of a CYP IAPT collaborative. The service has a dedicated service user engagement and participation lead. Services users, parents and carers are engaged in service development at all levels. Routine Outcome Measures are used across the service.

4.5 The West Berkshire Health and Wellbeing Board have received regular updates on the status of emotional health and wellbeing services for children and young people. The latest paper was discussed at the HWB held on 30 July 2015. Arrangements are in train for this Transformation Plan to be signed off by the HWB prior to the 16 October 2015 deadline. The Transformation Plans will be published on CCG, Local Authority and partner agency websites once the plans have been approved by NHS England.

4.6 In developing this local Transformation Plan there has been extensive engagement and joint working with service users, families, referrers, practitioners and other stakeholders to benchmark the current provision of services across comprehensive CAMHs and to identify opportunities to develop the service to better meet local needs.

http://www.newburyanddistrictccg.nhs.uk/news/entry/review-of-children-and-adolescent-mental-health-services-camhs-in-berkshire

4.7 Voluntary sector youth counselling organisations across Berkshire have met together and have fed back their perspective on how they can contribute to meeting the recommendations of Future In Mind as well as their views on developing an outcomes framework. Voluntary sector organisations were also involved in the 'Brilliant West Berkshire: Building Community Together'- see section 5.

4.8 Voluntary sector representation is sought on the Berkshire West Mental Health and Wellbeing Transformation group.

4.9 In developing these plans there has been collaboration with NHS England Specialist and Health and Justice Commissioning teams.

5. Transparency- need

The Joint Strategic Needs Assessment is found here

http://info.westberks.gov.uk/index.aspx?articleid=30214

The CAMHs Needs Assessment for West Berkshire is found here

CCSG15-08
CAMHS_Needs_Asses

In 2014/15 there were 571 children and young people referred to the CAMHs Common Point of Entry from Newbury and District CCG and 554 referrals from North and West Reading CCGs.

During this period there were 5868 specialist CAMHs contacts with children and young people from these two CCGs.

On the Berkshire specialist CAMHS caseload, 39 children from Newbury and District CCGs were either Looked After or subject to child protection plans and the same number were from North and West Reading CCGs. Looked After Children from these CCGs who are placed out of area are not included in these figures.

Waiting times for Tier 3 CAMHs services in Berkshire West CCGs at the end of June 2015

- 100% of children with urgent needs were seen within 24 hours
- 53% of Tier 3 CAMHS patients (excluding ASD) waited less than 6 weeks to be seen
- 11% of Berkshire West CAMHS ASD patients waited less than 12 weeks to be seen
- Currently the longest waits continue to be in the ASD diagnostic pathway which accounts for more than 50% of current waiting list. In Berkshire West some children wait up to 2 years for an ASD diagnosis, once they have been referred to specialist CAMHs. The National Autistic Society gives an average waiting time for an ASD diagnosis in children as 3.5 years.

The latest West Berkshire JSNA estimates that 30 children and young people aged 17 years and below from the local authority area will require a Tier 4 admission per year. In 14/15 twelve young people from West Berkshire attended the Berkshire Adolescent Service. A further XXX children and young people from West Berkshire were admitted to a Tier 4 facility outside Berkshire. (Data awaited from Louise Doughty- specialist commissioning). The Berkshire Adolescent Unit has 9 in-patient beds (as of autumn 2015). Scoping work that took place in 2014 estimates that Berkshire requires between 12 and 15 Tier 4 beds.

6. Transparency- resources

West Berkshire Council funding

West Berkshire council currently invests £120,000 in Primary Mental Health Workers and Help for Families therapeutic resources.

Grants awarded 2015/16:

Relate - £6K
Time to Talk - £27K
Homestart - £17K
Mental Health First Aid - £10K
Maternal mental health counselling group - £10K
Friends in Need - £25K

Tier 3 (specialist CAMHs) funding arrangements from Berkshire West CCGs as a whole, that is, Newbury & District, North & West Reading, South Reading, and Wokingham CCGs

	Funding allocation	Includes BAU*?	Includes YP placed out of area by NHSE at Tier 4?
2014/15	£4,649,251 plus £300K Operational Resilience funding.	yes	no
2015/16	£6,166,360 plus additional £249,535 allocated to transforming community Eating Disorder services. Up to £500K is available non recurrently in order to reduce waiting times through use of agency staff while new posts are recruited to.	no	no

*In 2014/15 the Berkshire Adolescent Unit (BAU) was commissioned as a Tier 3 facility. In 2015/16 the Berkshire Adolescent Unit was re-designated as a Tier 4 facility and transferred to NHS England, Financial resources transferred with the unit to NHS England.

A CAMHs worker is employed in the Youth Offending team. Half of these sessions are provided through the CCG funded block contract with BHFT.

CCG Partnership Development Grants

A number of voluntary sector organisations are commissioned through CCG Partnership Development Grants to provide counselling, parenting support and input for children and Young People with ASD and/ or Special Educational Needs and Disabilities. In 14/15 the spend was as follows

Organisation Name	Category	% Coverage Each Area	PANEL FUNDING PROPOSAL
Berkshire Autistic Society	HWB/ Mental health/ Children and Young people/ Carers	West Berks 22.5%, Reading 42%, Wokingham 35.5%	£27,300.00
Children on the Autistic Spectrum Young People's Project (CATSYPP)	Children and Young people/Mental Health	West Berks 5%, Reading 77%, Wokingham 18%	£5,650.00
Home-Start West Berkshire	Children and Young people/Mental Health	West Berks 100%	£19,892.00
Newbury Family Counselling Service	Mental health/Children/HWB	West Berks 100%	£20,735.00
Parenting Special Children	Mental Health/ Children and Young people/Carers	West Berks 30%, Reading 35%, Wokingham 35% (BME = 45%)	£18,835.00
Time to Talk (previously known as 14-21 Time to Talk)	HWB/ Young people/Mental Health / Urgent Care	West Berks 100%	£24,557.00

NHS England funding 2014/15

Out of area spend (Young People from North and West Reading CCG and Newbury and District CCG who were placed out of area) £1,121,745

7. Work undertaken to date across Berkshire West

7.1 Berkshire CAMHs is already part of the Children and Young People's Improving Access to Psychological Therapies (IAPT) collaborative. As a result of the CYP IAPT training, staff within all localities across Berkshire and in Primary CAMHS where BHFT are the providers, provide evidence based CBT interventions for anxiety and depression as part of their everyday work. CYP IAPT Routine Outcome Measures are an integral part of these interventions and are being rolled out across all other clinical activity. CYP IAPT trained supervisors provide clinical supervision in all localities and clinical leads who have undertaken the CYP IAPT transformational leadership training are working with CAMH Service managers to continue to develop CAMHs. The service has a dedicated service user engagement and participation lead. Services users, parents and carers are engaged in service development at all levels.

7.2 BHFT CAMHs are currently participating in the Department for Health trial of the CAMHSWeb/ Include Me interactive shared decision making portal.

7.3 In 2014 a substantial engagement was undertaken with comprehensive Berkshire CAMHs service users, families, referrers, practitioners and other stakeholders led by an independent consultant. This was published on CCG websites along with an update in December 2014 which outlines changes planned or made to local services in response to the engagement work.

http://www.newburyanddistrictccg.nhs.uk/news/entry/review-of-children-and-adolescent-mental-health-services-camhs-in-berkshire

In response to the engagement, local action plans were developed and implemented. This Transformation Plan builds on the original plans.

7.4 During 2014/15, a number of local pilot projects commenced. Learning from the pilot projects will be disseminated across Berkshire West CCGs and Local Authorities:

- a review of the use of nationally mandated Strengths and Difficulties Questionnaire (SDQ) assessments in Looked After Children and children at risk of exclusion. The aim of the project is to inform local policies and procedures in the improvement of screening for mental health needs in vulnerable groups of children and young people.
- a review of blockages to vulnerable women accessing perinatal mental health services. This project is also reviewing training packages for prevention, identification and intervention in

perinatal mental illness across the children's workforce. A project worker has been employed to address issues

- a review of the perinatal mental health pathway led by a midwife at Royal Berkshire Hospital. A business case is currently being considered to enhance perinatal mental health support for women and their families in Berkshire West CCGs.
- a review of transition pathways into adult services. A CQIN on patient experience of transition into adult services is in the 15/16 BHFT contract
- a trial of school based ADHD clinics in Reading. Learning from this pilot is feeding into a revised neurodevelopmental pathway that is being developed across Berkshire West.
- the development and trial of PPEPCare training modules in primary care and schools. This initiative is supported by Thames Valley Strategic Clinic Network and the Charlie Waller Institute
  http://tvscn.nhs.uk/psychological-perspectives-in-education-and-primary-care-ppep-care/

7.5 Over the winter of 14/15, additional Operational Resilience funding was secured to pilot a number of initiatives which aimed to

- improve responsiveness to escalating mental health needs thereby reducing risk,
- improve early identification of psychosis
- reduce waiting times.

7.6 In March the Berkshire Crisis Care Concordat Action Plan was published. Partners meet quarterly to review progress.

Berkshire-Mental-He
alth-Crisis-Care-Conc

7.7 The CCGs increased funding to BHFT CAMHs in Berkshire West by £1M recurrently and up to £500K non recurrently for 15/16. The initial focus for the additional investment is building on the successful Operational Resilience projects on a more sustainable basis; reducing waiting times; reduction in crisis presentations due to better risk mitigation; delivering PPEP care workforce training into targeted schools and GP practices and developing sustainable care pathways.

7.8 Berkshire West CCGs have also increased funding into the all age Early Intervention in Psychosis service as part of the wider Parity of Esteem investment. BHFT are meeting the 2 week Waiting Time standards, with 85% of cases referred to EIP being allocated care co-ordinators within 2 weeks. The average time to allocation is 8 days from the point of referral.

It should be noted however the new guidance confirms that the 2 week RTT starts at referral and assessments within a dedicated EIP team, cases are allocated to an EIP care coordinator and then RTT concludes with treatments commencing using a NICE concordant package that meets the 8 quality standards. At this stage BHFT is not able to meet these standards fully but through the new

Parity of Esteem investments will recruit additional staff to deliver these packages of care and the elements within the standards. An update is provided here

EIP update
commissioners Sept 2

7.9 In July and August CCG commissioners worked with BHFT, voluntary sector and Local Authority partners to identify key areas of improvement for the next 5 years, building on the intelligence gained from the local engagement initiatives as described in section 4 and service pilots described above. This included consideration of what an improved Eating Disorder service might comprise of and how physical and mental health services could become more aligned and "whole person" focussed.

7.10 In August BHFT specialist CAMHs received a Quality Assurance visit from the CCG which demonstrated that good progress had been made in improving the patient environment, staff morale and recruitment to achieve targets against the new investment.

7.11 Discussions are currently underway between agencies to agree an outcomes reporting framework, for use in all emotional health and wellbeing contracts from April 2016.

8. Local aspiration and vision for prevention, building resilience, earlier identification, earlier intervention and better whole system working

8.1 'Brilliant West Berkshire: Building Community Together'

West Berkshire partner agencies (including representatives from NHS providers, CCGs, education services, police force, social care services, housing services, early help services and voluntary community and faith sectors), have committed to work together to achieve a shared strategic vision summarized as 'Brilliant West Berkshire: Building Community Together' – a vision which focuses on:

- working differently with communities, not doing 'for' and not doing 'to'
- providing help and support early in communities, built on the assets, strengths and needs of individual communities
- finding solutions and seeking different ways to say 'yes'.

8.2 Representatives of these partner agencies came together on 3rd July 15 to discuss opportunities for the development of Tier 2 emotional health and wellbeing services. Service redesign options are now being considered and refined. A paper was taken to the July Health and Wellbeing Board.

JOINT REPORT
FROM West berkshire

8.3 This section provides a summary of discussions and proposals.

In West Berkshire, children can wait up to a year to receive individual therapeutic care at Tier 2. Some families report a two year wait for an ASD diagnosis. While additional funding has recently been made available by Berkshire West CCGs to reduce pressures at Tier 3, there remains an early intervention gap in service so that families can access early support while waiting for a diagnosis.

The national requirement for local Children and Young People's Mental Health and Wellbeing Transformation Plans provides an opportunity to increase the early intervention resources available to respond to emotional health and wellbeing within the community.

The key strands of this proposal arise from those partnership discussions and co-design activity.

The strands are:

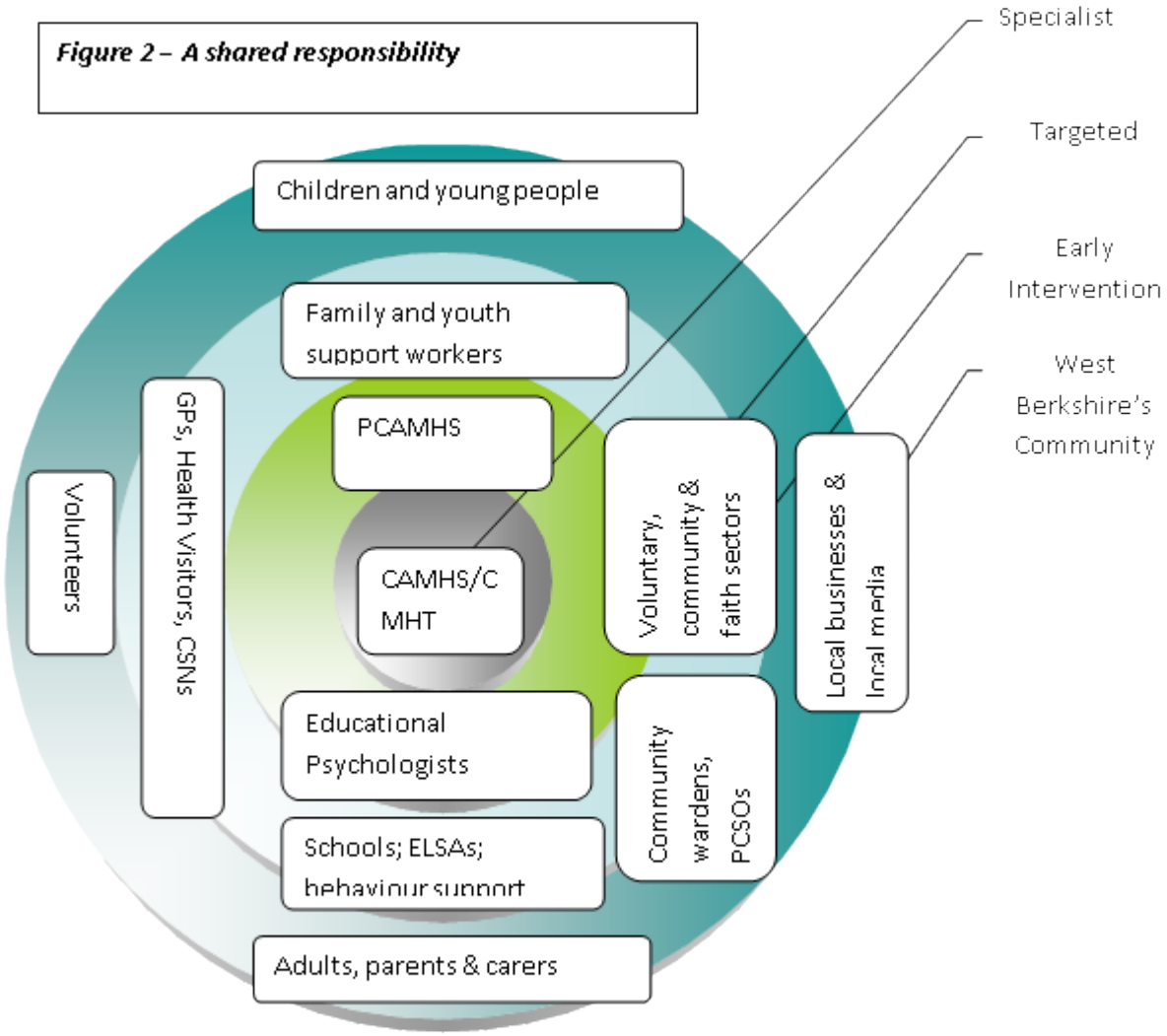
a) Establishing a strategic framework and series of principles for emotional health and well-being at Tier 2, that involves all partner agencies and establishes a foundation for the local 'Transformation Plan'

b) Establishing an emotional health academy which will seek emotional health workers to train in Tier 2 emotional health and wellbeing support and intervention skills. These workers will work alongside Universal and Targeted workers in the community

c) Investing in voluntary, community and faith sector delivery. This will include working in partnership to seek national sources of funding that are only open to the sector. This will in turn increase the community based provision.

Rather than simply describing 'levels of need' or 'thresholds' associated with care, where only a few services can provide interventions, this model enables the community itself and the range of volunteer and professionally led-services within West Berkshire to play an active role.

Figure 2 – A shared responsibility



8.4 What difference will these proposals make to West Berkshire children and young people?

- This model will enable support to be offered at the earliest opportunity and work to prevent the escalation of need. Fewer children and young people will require support from specialist CAMHs or an admission to an in- patient facility.

- Currently children can wait up to 18 months for an appointment. This model will enable children to be supported quickly, in their local communities without needing to negotiate different referral systems and different thresholds for services

- Currently some children have to travel across West Berkshire and sometimes out of area to access support, advice and care. This model will enable more children to receive early help, advice and support within the communities in which they live

- Children and families often identify that they feel 'done to' and confused by the system. Working restoratively with children and families will increase the opportunities for children and families to feel listened to, feel able to achieve things or manage situations that previously felt too difficult and thereby experience a renewed sense of hope that change is possible

- Currently a significant number of children and young people are referred again to emotional and mental health services after completing their package of care or support. By working restoratively with children and families, overtly focussing on strengths and interventions that bring resilience and sustainable change, involving 'significant others' around a child or family, repeat referrals will reduce

- Vulnerable children known to specialist and acute services all receive separate services from each agency individually. The level of co-ordination is variable- some of our most vulnerable children wait significant lengths of time for emotional health and wellbeing support. The new model will ensure that vulnerable children receive priority support in their local area in which professional analysis of risk is brought together. This will enable the agreement of one shared set of outcomes with children and families that everyone works to

- Currently there are only a few types of support available to children and families in West Berkshire. There will be a wider range of evidence based support and interventions for children and families and these resources will be shared with all partner agencies working in those communities. This will include training being available to these partners and increased choice for children and families

- The current models of support are offered council wide with little opportunity to respond to individual needs and circumstances. Support will be individually tailored to the needs of the child, family and community

- Children and families currently experience changes in professionals as their needs are assessed and transferred to different teams and departments which to cover large council

areas. In future children and families would have more opportunity to build relationships of trust with these keyworkers in their local community

- We know that young people often feel 'let down' or confused at the point of transition to adult services. We will work in partnership with adult service colleagues to consider how we could work differently together with these families
- We know that mothers experiencing maternal depression find it hard to access help and support. We will work in partnership to ensure that families experiencing these needs have several places in their local community to go to for help and support. The new emotional health academy will assure quality of service provision
- Children and families with emotional health and wellbeing needs often find themselves receiving inconsistent advice, help and support from different partner agencies; or being passed between agencies, with no one agency providing leadership. The emotional health academy will seek to develop greater consistency, shared planning and accountability for families and one point of contact (i.e. keyworker) for children and families needing this support.

8.5 What are the functions of the Academy?

- To recruit, train and retain emotional health and wellbeing workers
- To coordinate an emotional health and wellbeing network for schools, GPs and community organisations
- To work in partnership with schools, GPs and the voluntary sector within local communities to extend emotional health and wellbeing support for children, young people and families
- To work in partnership with other agencies e.g. Police, Social Care, Youth Offending and CAMHs
- To provide and coordinate training for Local Authority colleagues, schools and local communities
- To deliver evidence based practice, with quality assurance, evaluation and stakeholder involvement and review.

In order to make best use of limited resources, the professional skills of Clinical and Educational Psychologists will be partially deployed through the Emotional Health Academy, in each community to:

i) Provide training to universal staff and volunteers

ii) Professionally supervise staff and oversee the activity of volunteers

iii) Analyse school and community needs and develop group or peer-to-peer led care to respond to needs

iv) Provide 1 to 1 care

v) Maintain the rigour and robustness of evidence-based practice, solution-focused thinking and restorative approaches.

8.6 What are the roles of the emotional health workers?

1. To participate in a local triage system for children, young people and families, as set up by the community
2. To work directly (supervised) with children, young people and families with emotional health and wellbeing needs, delivering evidence based interventions
3. To offer advice and support to schools and GPs on emotional health and wellbeing issues
4. To deliver emotional health and wellbeing awareness training to a variety of settings
5. To deliver training on specific emotional health and wellbeing issues
6. To provide supported group work for children and young people on emotional health and wellbeing issues e.g. anxiety, anger, friendships, social skills, self esteem
7. To mentor and support families and work alongside children's centre colleagues
8. To work alongside voluntary groups to ensure full involvement of community resources wherever possible
9. To work alongside peer mentors to develop peer support for emotional health and wellbeing issues
10. To help develop community awareness, through signposting, of the wide range of emotional health and wellbeing resources available locally and nationally to schools, GPs and communities
11. To create an emotional health and wellbeing toolkit for young people
12. To promote preventative and early intervention approaches in collaboration with other colleagues and communities
13. To promote, signpost and develop a range of online resources for young people to access
14. To design and deliver a robust evaluation of outcomes, involving stakeholders and children, young people and families

15. To review early intervention emotional health and wellbeing support, and the role of the Emotional Health Academy, in light of evaluations, and to participate in the continuous review of effectiveness and co-design.

9. Self-assessment

NHS England requires a self-assessment to be undertaken as part of the assurance process. In light of the short timescale and availability of partners in August, CCG commissioners and BHFT undertook a self-assessment using a process provided by the Thames Valley Strategic Clinical Network. The self-assessment process took account of knowledge gained through the partnership work to develop local emotional health and wellbeing services that been undertaken in the previous 12 months.

The self-assessment identified workforce development, care for the most vulnerable and improving access as the most challenging aspects of Future In Mind for Berkshire West. It was felt that there is a will across the system to make change happen and that Berkshire West has made much recent progress in accountability and transparency across the system.

Copy of Future in mind_ADS Self Assess

10. Overview of Local Transformation Plan priorities and outline timescales (subject to confirmation by Berkshire West Mental Health and Wellbeing Transformation group)

2015/16

- Recruit and train additional staff
- Reduce waiting times
- Reduce inappropriate/avoidable presentations to A&E – data to be collected from September 2015
- Reduction in crisis presentations due to better risk mitigation
- Common Point of Entry will be open Monday to Friday 8am until 8pm
- Workforce development plan for improving emotional health and wellbeing developed and starting to be implemented across partners
- Joint commissioning of voluntary sector counselling where the Local Authority and CCG are currently commissioning independently
- Evaluation of the CAMHs Short Term Care team
- Launch of Young SHaRON- online platform for service users
- Increase number of in-patient beds at Berkshire Adolescent Unit
- Commission improved perinatal mental health service to provide better access to advice and help for mothers

- Outcome framework developed and agreed across partners. To be implemented in all contracts from 1 April 2016.
- Neurodevelopmental pathway (ADHD and ASD) developed within BHFT
- Children's toolkit expanded to include mental health and wellbeing
- Learning from the Strengths and Difficulties pilot will be shared and will be shaping service provision
- Enhanced Liaison Mental Health service for under 18s will be trailed at RBFT (subject to funding through Liaison Mental Health)
- University of Reading study to commence
- Commission enhanced Eating Disorders service. Start service delivery
- CQIN for service user satisfaction following transition into adult services

2016/17

- Reduce waiting times
- Launch of the West Berkshire Emotional Health Academy
- Workforce development- develop role of schools, primary care, early year's settings, wider children's workforce
- Map collective resilience, prevention and early intervention offers. Consider how we make the system easier to navigate.
- Review current Common Point of Entry and access arrangements into CAMHs services, ensuring access for the most vulnerable (includes step down from in-patient units, links to SARCs, Looked After Children's services, emerging Liaison and Diversion services for under 18's, forensic services, provision for children and young people with LD and ASD)
- Consider whether to commission a crisis home treatment or enhanced step up/step down service following a review of the impact of the Short Term Care team and enhanced Liaison Mental Health services on reducing admissions to Tier 4.
- Enhance provision across the system for children and young people with ASD and Learning Difficulties
- Roll out of enhanced perinatal service
- Consider impact of any developments in NHSE commissioning of Secure CAMHs Outreach Service (Thames Valley and Wessex) and all age Liaison and Diversion schemes.
- Implement Eating Disorders service

2017/18

- Maintain or further reduce waiting times
- Workforce development
- Implement 24/7 crisis home treatment or step up/step down service, depending on findings of the review
- Develop conduct disorder/ challenging behaviour pathway across the system. Consider implications for children and young people with LD and ASD.

- Consider availability of provision for young people stepping down from Tier 4 facilities
- Consider impact of any developments in NHSE commissioning of Secure CAMHs Outreach Service (Thames Valley and Wessex) and all age Liaison and Diversion schemes.

2018/19

- Workforce development
- Implement conduct disorder/ challenging behaviour pathway across the system
- Consider impact of any developments in NHSE commissioning of Secure CAMHs Outreach Service (Thames Valley and Wessex) and all age Liaison and Diversion schemes.

11. Detailed Local Transformation Plan

Key areas to be addressed in the Berkshire West Local Transformation Plans and proposal of an order in which changes might be worked through

Future In Mind (FIM) priority

R= Resilience, Prevention and early intervention for the mental well-being of children and young people (chapter 4)

A= Improving access to effective support (chapter 5)

V= Caring for the most vulnerable (chapter 6)

AT= To be accountable and transparent (chapter 7)

W= Developing the workforce (chapter 8)

Issue/ recommendation from Future In Mind	Actions/ Key Lines of Enquiry	Suggested date	FIM priority
Improving the access to help, preventing young people being lost or having to wait a long time for service delivery.	Recruit BHFT staff CPE open longer hours Technology development and roll out Introduce the new Tier 2 emotional health and wellbeing service in West Berkshire Introduce waiting time standards across CAMHs and Early Intervention in Psychosis services	15/16 15/16 onwards 15/16 onwards 15/16 onwards	A A A A, V, W A

Reduce number of YP whose needs escalate to crisis	Trial short term care team (follow up of YP who have attended A and E in crisis) Prioritise higher risk cases, paying particular attention to Children in Care Ongoing risk review of those on waiting list Collect data from RBH on A and E attendances, wait times- identify any trends What can we learn as a system from YP who escalated into Tier 4? Those who stepped down from Tier 4? Ensuring the support and intervention for young people being planned in the Mental Health Crisis Care Concordat is implemented. Use of on line platforms such as SHaRON and Young SHaRON	15/16 15/16 15/16 From Q3 15/16 and 16/17 16/17 15/16 onwards 15/16 onwards	A A A A, AT A, V A, AT, V A
Reduce delays in accessing MH assessments once YP is medically fit and has presented at RBH	CPE open longer hours-staff available for longer Embed new care pathway Scope a trial of an enhanced liaison mental health service for under 18s to be trailed at RBFT	15/16 15/16 onwards Q3 and 4 15/16	A A A, V
Is there a need for a local intensive crisis home treatment team for CYP?	Evaluate learning and data from initiatives above Establish the interface with the transformed Eating Disorders service Develop options appraisal Commission and implement service	Late 16/17 17/18	A
By co-commissioning community mental health and inpatient care between	Berkshire Adolescent Unit transfer to NHSE- MOU implemented	15/16	AT

local areas and NHS England to ensure smooth care pathways to prevent inappropriate admission and facilitate safe and timely discharge.	See also "Is there a need for a local intensive crisis home treatment team for CYP?" above Consider step down arrangements for young people being discharged from in patient units- is there a case for a local facility as an alternative to out of area residential placements? Also links with Transforming Care Implement changes to community Eating Disorder services	 17/18 15/16 onwards	 V A
Enhancing existing maternal, perinatal and early years health services and parenting programmes to strengthen attachment between parent and child, avoid early trauma, build resilience and improve behaviour by ensuring parents have access to evidence-based programmes of intervention and support. Improving the skills of staff working with children and young people with mental health problems by working with the professional bodies, NHS England, PHE, HEE to ensure that staff are more aware of the impact that trauma has on MH and on the wider use of appropriate evidence-based interventions	Evaluate perinatal MH pilots in the community/ children's centres. Impact on take up of services for new mothers? Consider the recommendations. Commission enhanced perinatal MH service- RBH working with BHFT Participate in University of Reading clinical trial-improved treatment for severe conduct disorders in young children LAs evaluate behaviour support programmes and services to include SEN, Troubled Families, therapeutic fostering and YOS arrangements Develop conduct disorder/ behaviour pathway building on learning from trials and evidence across the system Roll out conduct disorder/ behaviour pathway Introduce the new Tier 2 emotional health and wellbeing service in West Berkshire Publicise and promote attendance	15/16 15/16 Q4 15/16 16/17 TBC 17/18 18/19 15/16 onwards 15/16	R, W R A, R,W, V AT, W, V A, AT, V A, W, V, R A, V, W W

	at the Thames Valley trauma conference		
How far can we push integration? Enabling single points of access to increasingly become a key part of the local offer, harnessing the vital contribution of the voluntary sector. Move away from tiered working. For the most vulnerable young people with multiple and complex needs, strengthening the lead professional approach to co-ordinate support and services to prevent them falling between services. Improving the care of children and young people who are most excluded from society, such as those involved in gangs, those who are homeless or sexually exploited, looked-after children and/or those in contact with the youth justice system, by embedding mental health practitioners in services or teams working with them.	Review current CPE and local triage arrangements- should a single point of access/ localised triage system be developed in each LA where the family's holistic needs are considered prior to referral to CAMHs? Should this also consider physical healthcare e.g. therapies? How does this differ to existing MASH and Early Help hubs? How does the current system link to SARCs, YOS and the Troubled families programme? Consider the feasibility of changes on a Berkshire West only basis How does a "Tier 2 or 3" child present? Unpick clinical thresholds and agree how cases are stepped up and down between universal, targeted, specialist and acute service providers. Identify the skills needed in the workforce in order to respond to different levels of need/ complexity What can we learn from successful YOS and Troubled Families services re approach? Overcome information sharing/ data collection issues between agencies Roll out changes Is there a case to develop a regional Thames Valley service for certain groups e.g. children with sexually problematic behaviour?	16/17 15/16 16/17 Early 16/17 15/16 Late 16/17, early 17/18 16/17	A, V A, W, AT A, V, W A, V A, V A, V A, V, R

	Services for LAC placed out of area but within the Thames Valley? YP who have been sexually exploited?		
	Work with commissioners across the Thames Valley to maintain a Secure CAMHS Outreach service in the event of this moving from Specialised Commissioning across to CCGs	15/16 onwards	W, AT, V,A
	Implement all age liaison and diversion scheme when it is developed by NHSE	TBC	A, V
	Ensure all services understand and demonstrate a shared responsibility for the emotional health and well-being, and are supported with the skills and training development to fulfil those roles effectively e.g. West Berkshire Emotional Health Academy	16/17	V
	Improve links with SARCs	16/17	V
Improving communications, referrals and access to support through every area having named points of contact in specialist mental health services and schools, single points of access and one-stop-shop services, as a key part of any universal local offer.	Linked to CPE work above BHFT working with service users to improve communications	15/16	A
	Will schools commit to having MH lead?	16/17	A, W
	Agree interface between BHFT and local services- clinical supervision, training	16/17	A,W,V, AT
	Do we as a system understand what we currently collectively offer with regard to resilience, prevention and early intervention?	16/17	AT, R
	How do we make the offer easy to navigate?	16/17	AT, R, A
Making sure that children, young people or their parents who do not attend appointments are not discharged from services. Instead, their reasons for	CCG assurance visit	15/16	V, A
	Consider whether a local single point of access in each LA and having a MH link in schools where the family's holistic needs are	16/17	V,A

not attending should be actively followed up and they should be offered further support to help them to engage.	considered might improve access for these groups.		
Online support for CYP and families	Young SHaRON roll out, to include platforms for Looked After Children, carers, families	15/16	A, R, V
Strengthen links between physical health, mental health and support for children with SEN	BHFT expand children's toolkit to include Mental Health Consider whether current emotional wellbeing support for children and young people with long term conditions is sufficient BHFT to develop internal workforce	15/16 and 16/17 16/17 15/16 onwards	A, R A, V W
System wide ASD and ADHD pathway- strengthening the links between mental health, learning difficulties and services for children with Special Educational Needs and Disabilities (SEND)	ASD diagnostic waiting time standard in contract 15/16 Recruitment underway BHFT 15/16 DH guidance on LD and ASD expected. BHFT expand children's toolkit to include ASD and ADHD BHFT develop internal neurodevelopmental pathway. Link with schools, LAs, vol sector. Linkages between ASD, ADHD, SEND, behaviour? Schools role? Who does what? What do we commission from voluntary sector? Thresholds /acceptance criteria? How do agencies communicate/ key workers? Develop pathway across the system. Workforce training Link to Transforming Care initiatives to ensure that local	15/16 Q2 15/16 Q2 15/16 Q3 and 4 15/16 Q3 and 4 15/16 15/16/17 16/17 16/17 onwards	A A, W AT A, R, W AT, A, W, V A, AT, W W A,V

	services are available for young people with challenging behaviour and learning disabilities and or ASD		
Supporting self-care	Expansion of children's toolkit to include MH	15/16 and early 16/17	R, A
	Publicise Puffell apps developed in Berkshire once accredited	15/16	R, A
	Reading pupils given MH self-care booklets- other areas to consider whether they wish to adopt this approach	15/16	R, A
		15/16 onwards	R, A
	Launch Young SHaRON	15/16	R,A,V
Promoting implementation of best practice in transition, including ending arbitrary cut-off dates based on a particular age.	Transition into adult services project	15/16	A
	Consideration of access to specialist Eating Disorders services for older teenagers/ less mature older teenagers	15/16 onwards	A
	Embed changes	15/16 onwards	A
Developing a joint training programme to support lead contacts in specialist children and young people's mental health services and schools.	PPEPCare training to primary care and selected schools	15/16	W, R
	If bid successful, roll out school link pilot	15/16	W, R
	West Berkshire core workforce training	15/16 onwards	W, R
Continuing to develop whole school approaches to promoting mental health and wellbeing, including building on the Department for Education's current work on character and resilience, PSHE and counselling services in schools.	Workforce needs to be developed continuously. If current CPE arrangements change, will require extensive training and publicity	15/16 onwards to 19/20	W
	Consider whether to continue PPEPCare roll out into 16/17 Local initiatives and leads???	16/17	W
	Scope whether HVs and School Nurses could drive improvements. If this were adopted enact commissioning changes/ service changes	16/17	W, R, A, AT, V
Promoting and driving			

established requirements and programmes of work on prevention and early intervention, including harnessing learning from the new 0-2 year old early intervention pilots. Building on the success of the existing anti-stigma campaign led by Time to Change, and approaches piloted in 2014/15, to promote a broader national conversation about, and raise awareness of mental health issues for children and young people.	Scope LA, school and voluntary sector issues/ workforce development	16/17	W, R, A, AT, V
Establishing a local Transformation Plan in each area during 2015/16 to deliver a local offer in line with the national ambition. Conditions would be attached to completion of these Plans in the form of access to specific additional national investment, already committed at the time of the Autumn Statement 2014. Health and Wellbeing Boards ensuring that both the Joint Strategic Needs Assessments and the Health and Wellbeing Strategies address the mental and physical health needs of children, young people and their families, effectively and comprehensively.	Develop Transformation Plan, HWBs to approve plans HWBs to delegate authority to implement Transformation plans to BW CAMHs Transformation Group, Transformation Plans submitted to NHSE JSNA Eating Disorders plans developed and incorporated in Transition Plans (pan Berkshire ED plan) NHSE approve plans and release funding	Aug/ Sept 15 Sept 15 Sept 15 Q3 15/16 Aug- Oct 15 Q3 15/16	AT AT AT AT AT AT
Developing and implementing a detailed	Implement Open Rio (BHFT)	15/16	AT

and transparent set of measures covering access, waiting times and outcomes to allow benchmarking of local services at national level, in line with the vision set out in Achieving Better Access to Mental Health Services by 2020.	Start collecting data in accordance with new CAMHs minimum data set Develop outcomes framework across all providers and commissioners Implement outcomes framework across all contracts and SLAs. Offer Open Rio access to the voluntary sector once new system is gremlin free Outcomes and progress to be reported up to HWB	From Jan 16 Q4 15/16 16/17 16/17 15/16 onwards	AT AT, W AT, W AT, W AT
Making the investment of those who commission children and young people's mental health services fully transparent.	How do schools spend their pupil premium? What outcomes do they achieve? Transparency of CCG financial arrangements Transparency of LA financial arrangements	16/17 15/16 15/16	AT, R AT AT
Commissioning of third sector organisations	Where LAs and CCG are commissioning the same organisations, streamline arrangements via joint commissioning Consider the support that voluntary sector organisations might require in order to successfully bid for pots of money that is not open to the statutory sector. Linked to vol sector demonstrating outcomes and being able to provide data	For 16/17 contract 16/17	AT, A A, AT
Having lead commissioning arrangements in every area for children and young people's mental health and	Links to Commissioning of third sector organisations section above Agree TOR for Berkshire West	 Q2/3	 AT

wellbeing services with aligned or pooled budgets by developing a single integrated plan for child mental health services in each area, supported by a strong Joint Strategic Needs Assessment.	CAMHs oversight group JSNA update	15/16 Q3 15/16	 AT

12. Eating Disorders plan to date

CCGs in Berkshire West and Berkshire East will jointly commission a revised Eating Disorder pathway in order to meet the new access and waiting time standard. The current provider, Berkshire Healthcare Foundation Trust, has carried out some initial work to describe what a future service might look like. This document is a descriptor of the intended service to indicate how the recommendations within the Access and Waiting Time Standard for Children and Young People with Eating Disorders may be met within Berkshire. A business case has also been produced.

Eating disorder descriptor document

Eating Disorders Business Case FINAL

13. Measuring outcomes (KPIs)

There is agreement amongst partners in Berkshire West that a core set of emotional health and wellbeing outcome measures should be developed that every provider will use and report on.

These would link to any nationally agreed outcome measures.

This has been included in the action plan.

KPIs for Tier 2 services commissioned by West Berkshire Council

To date top level indicators only have been agreed with elected members as follows-

i) Reduction in referrals to Tier 3 mental health services
ii) Increase of referrals into Tier 2
iii) Sustained measures of improved emotional health and well-being at Tier 2
iv) Reduced presentations of children and young people in child protection and youth offending services, with hitherto undiagnosed and untreated emotional health needs.

Key Performance Indicators in the Specialist CAMHs 15/16 contract

Ref	Indicator	Threshold	Method of measurement
Waiting list reduction (as per Quality Schedule)	% of Berkshire West CAMHS patients (excluding ASD) that are seen within 6 weeks for reporting period	October - 75% November - 75% December - 80% January - 85% February - 90% March - 95%	Reported within monthly quality schedule report
Waiting list reduction (as per Quality Schedule)	% of Berkshire West CAMHS patients (excluding ASD) that are waiting at the end of the reporting period that have waited less than 6 weeks	October - 75% November - 75% December - 80% January - 85% February - 90% March - 95%	Reported within monthly quality schedule report
Waiting list reduction (as per Quality Schedule)	Number of Berkshire West CAMHS patients (excluding ASD) waiting longer than 12 weeks as at the last day of the month	0 from October 2015	Reported within the monthly quality schedule report
Waiting list reduction (as per Quality Schedule)	% of Berkshire West CAMHS ASD patients that are seen within 12 weeks for reporting period	October - 75% November - 75% December - 80% January - 85% February - 90% March - 95%	Reported within monthly quality schedule report
Waiting list reduction (as per Quality Schedule)	% of Berkshire West CAMHS ASD patients that are waiting at the end of the reporting period that have waited less than 12 weeks	October - 75% November - 75% December - 80% January - 85% February - 90% March - 95%	Reported within monthly quality schedule report

Ref	Indicator	Threshold	Method of measurement
Waiting list reduction (as per Quality Schedule)	Number of Berkshire West ASD patients waiting longer than 18 weeks as at the last day of the month	0 from December 2015	Reported within the monthly quality schedule report
Waiting list reduction (as per Quality Schedule)	Number of Berkshire West patients waiting on the total CAMHS waiting list	Q2 = Q1 minus 20% Q3 = Q2 minus 20% Q4 = Q3 minus 20%	Reported within the monthly quality schedule report
1.	Extension of CPE to 8am - 8pm model	CPE will be open 8am until 8pm on working days Monday to Friday by the end of Quarter 2.	Reported quarterly form the end of Q2
2.	Reduction in inappropriate/avoidable presentations to A&E	Baseline data to be captured from September 2015. Seasonal trends to be mapped over 15/16 and into 16/17	Data to be reported monthly from September 2015 using the following methodology: 1: Numbers who present to A+E who are receiving active treatment from CAMHS 2: Numbers who present to A+E who are on a waiting list and not receiving active treatment 3: Numbers who present to A+E who are not known to BHFT CAMHS who need a CAMHs service (1+2 are the groups with potential to avoid presentations regardless of presentation or who recommends them going to A+E)
3.	Reduction in time from referral to assessment in A&E – within 4 hours.	BHFT to develop a system to collect baseline data in-year.	Data collection to start from 1 September 2015.
4.	Reduction in complaints that relate to waits longer than agreed targets for relevant team/pathway	25% reduction	To be reported quarterly from Q3
5.	Throughput measure by service line (measuring how many waiting, seen and discharged	BHFT to develop a system to collect baseline data in-year.	Tableau reporting from Q4

Ref	Indicator	Threshold	Method of measurement
6.	Implementation of Routine Outcome Measures	BHFT to continue to trial CAMHsWeb. BHFT to develop meaningful reportable outcome measures throughout 15/16 and to demonstrate how reports are being used to improve the service.  ROMS.docx	A report is to be provided in Q4 which will include narrative on how the outcome measures are in line with the CAMHs core data set requirements. For 2016/17
7.	Educational support programmes to key stakeholders – number of sessions to be agreed with commissioners	BHFT will participate in the development and implementation of a CAMHs transformation plan in line with the findings of "Future In Mind" via a partnership between commissioners and providers from the NHS, Local Authorities, schools and voluntary sector. The transformation plan will make explicit how educational support programmes to key stakeholders will be commissioned and provided. The goal is to improve the availability and effectiveness of early intervention and prevention that is being delivered by the wider children's workforce. It is anticipated that educational support to key stakeholders will build on PPEP care training that is being delivered in 15/16.	To be articulated in the CAMHS Transformation plan
8.	Evidence of the use of technological adjuncts – rollout of Young SHaRON and the Children's toolkit, and use of the NHS England		Provider to provide six-monthly updates on developments. First update required at the mental health contract meeting by the end of September 2015

Ref	Indicator	Threshold	Method of measurement
	App when available.		

14. Governance

Berkshire West Mental Health and Wellbeing Transformation group.

Local Authority leads met with the CCG on 21 August and 27 August to develop plans for an oversight group. The name Berkshire West Mental Health and Wellbeing Transformation group is suggested.

Scope

- to monitor and facilitate implementation of the Transformation Plan
- to make recommendations- not a decision making group
- to provide different perspectives on strategy, service transformation planning and implementation i.e. this is what it feels like from a school (voluntary sector/ service user/ social care/BHFT/parent) perspective
- help to develop strategy
- promote collaboration
- task and finish groups will take on key pieces of work, pulling in additional agencies as required

Proposed membership

- Local Authority children's services x 3 (West Berkshire Council, Reading Borough Council, Wokingham Borough Council)
- Local Authority Public Health lead
- a nominated lead from a voluntary sector counselling organisation (ARC, Number 5, Time To Talk- West Berkshire, Time to Talk- Reading, Changing Arrows). Invite specific voluntary sector representatives for specific agenda items e.g. ASD/ SEN
- University of Reading
- 4 school forum representatives drawn from Early Years, Primary, Secondary and Special Schools across Berkshire West
- Service users
- Young people who are not service users
- Parent / carer
- BHFT CAMHs service manager, clinical lead, lead for children's integration

- RBFT- A & E and paediatrics
- Healthwatch representative
- CCG clinical lead and head of children's commissioning
- NHS England Tier 4 lead

It is envisaged that for some of the partners listed, a representative will provide an insight as to how things feel/ might feel on the ground as service transformation ideas are discussed and implemented. It is hoped that this would enable the group to be an optimal size for meaningful and timely discussion.

It is envisaged that task and finish groups will be required to undertake specific aspects of the transformation work.

Resources

The group will require resources to enable attendance. The group will require communications and secretariat support.

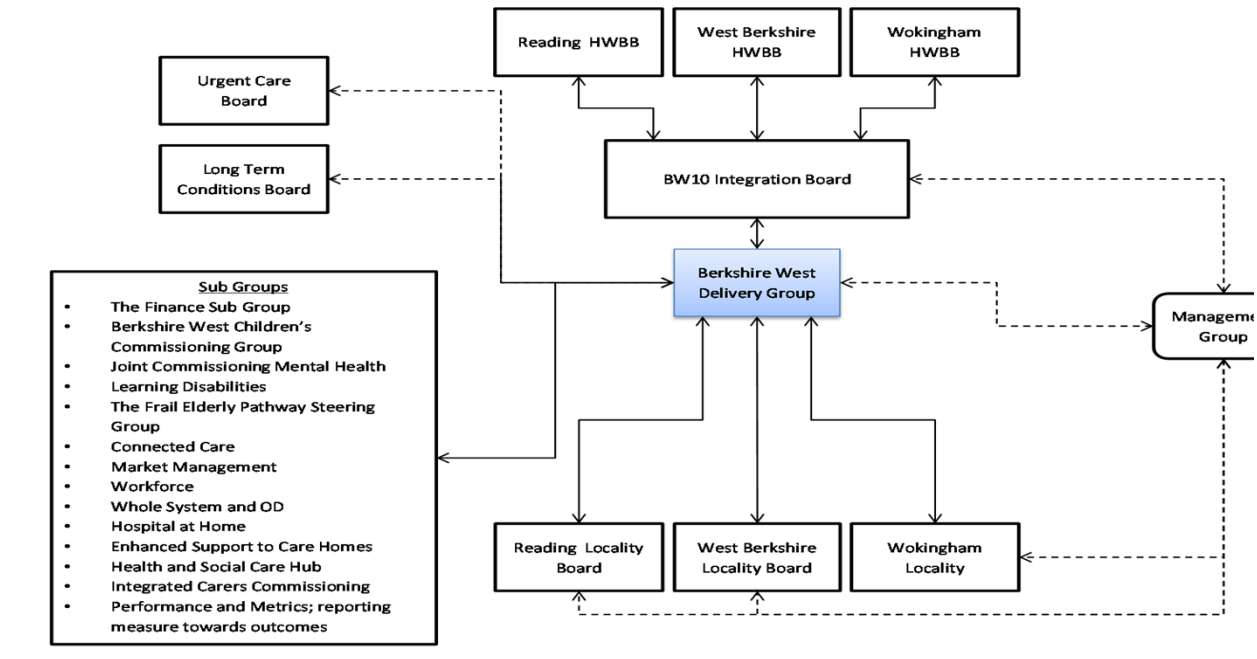
Frequency

Initially monthly, starting November 2015

Reporting arrangements

To report to the Berkshire West Integration Board (Director and Chief executive level)

Respective Health and Wellbeing Boards to delegate authority to the group.



15. Tracking template to monitor and review progress (Annex 3 in the guidance)

In Berkshire West there are four CCGs covering 3 Local Authority areas.
Berkshire West CCGs have submitted 3 Transformation Plans- one for each Local Authority area.

For the Eating Disorder investment, the 4 Berkshire West CCGs has worked with the 3 Berkshire East CCGs.

Here are trackers relating to Newbury and District CCG and North and West Reading CCG


Tracker Newbury and District CCG 14 C


Tracker North and West Reading CCG 1

Emotional Health and Early Intervention re-design proposal

1) West Berkshire Partners - Shared Vision

West Berkshire partner agencies[1], have committed to working together to achieve a shared strategic vision summarized as 'Brilliant West Berkshire: Building Community Together' – a vision which focuses on:

- working differently with communities, not doing 'for' and not doing 'to'
- providing help and support early in communities, built on the assets, strengths and needs of individual communities
- finding solutions and seeking different ways to say 'yes'.

Representatives of these partner agencies came together on 3rd July 15 to discuss opportunities for the development of Tier 2 emotional health services; this document summarises the proposals arising from these discussions.

The key strands of this proposal arise from those partnership discussions and co-design activity; the strands are:

a) Establishing a strategic framework and series of principles for emotional health and well-being at Tier 2, that involves all partner agencies and establishes a foundation for the local 'Transformation Plan'

b) Establishing an emotional health academy e.g. to seek emotional health workers to train and grow in Tier 2 emotional health support and intervention skills; to work out in communities alongside Universal and Tier 2 partners

c) Investing in voluntary, community and faith sector delivery, including working in partnership to seek national sources of funding only open to the sector; to increase the community based provision.

2) The Strategic Context

Emotional health need is one of the most common early indications of additional need; left unsupported, early emotional health difficulties can rapidly develop into a mental health difficulty.

Currently children and young people requiring extra mental health support are referred to a CAMHs single common point of entry (CPE). If they meet the criteria and threshold they are referred to Primary CAMHs workers who work at Tier 2, or for more intense and specialist Tier 3&4 interventions.

[1] including representatives from the health economy, CCGs, education services, police force, social care services, housing services, early help services and voluntary community and faith sectors

West Berkshire's Joint Strategic Needs Analysis: Children and young people in West Berks estimates that the following number of children and young people have a mental health disorder [2]

	5-10yrs	11-16yrs	17-19 yrs
Boys	**580**	**780**	**624**
Girls	**280**	**615**	**480**

In West Berkshire, children are waiting on average a year to receive individual therapeutic care at Tier 2. Some families are reporting two years or more for an appointment to progress an ASD diagnosis; whilst additional funding has recently been made available by Berkshire West CCGs to lessen the pressures at Tier 3; this remains an early intervention gap in service, requiring early support as families await diagnosis.

Last year CPE CAMHS were contacted for help and support 3052 times in Newbury and District (West Berkshire district); and 2816 times in North and West Reading CCG areas (shared between West Berkshire and Reading). Of these contacts 571 and 554 contacts were accepted as referrals into a CAMHS service; subsequently 80% of contacts led to no further action by the CAMHS service and remained in the community for support. In this context, the additional resources made available from CCGs to support Tier 3 services, whilst very valuable, will only be of direct benefit to around 20% of the children requiring help and support. It is therefore perhaps logical, particularly in light of the national call for Transformation Plans for CAMHS services, to increase the early intervention resources available to respond to emotional health within the community.

Schools in particular, find themselves needing to meet the needs of the 80% of children who do not receive Tier 3 support, often with little additional help or support. Schools and other universal services understanding of children with emotional health needs and their families is often not effectively used within the wider referral system, which promotes a 'medical model' of analysis of need; without triangulation with other partner agency information.

A significant proportion of children and young people accessing Tier 3 and 4 services (specialist and acute levels of need) have significant underlying emotional health needs or mental health difficulties.

> *"One in ten children needs support or treatment for mental health problems. Mental health problems in young people can result in lower educational attainment and are strongly associated with behaviours that pose a risk to their health, such as smoking, drug and alcohol abuse and risky sexual behaviour." (Future in Mind 2015)*

[2] Annual modeling based on ChiMat (Children & Maternal Health Intelligence Network)

One in four adults and **one in 10 children** will experience a mental health condition in any one year.

Only a quarter of adults and children with a mental health condition get any treatment for it.

The economic and social cost of mental ill health in England is **£105 billion a year**.

Up to **20% of mothers** develop a mental health condition during pregnancy or within a year of giving birth

Promoting Mental Health 4 Life
Centre for Mental Health with Ed Davie, March 2015

Our current specialist mental health services are over-subscribed and under resourced. In order to meet rising demand and levels of need it is essential that all opportunities are taken to intervene early, and to ensure that the responsibility for improving emotional health and well-being is shared and is not the sole responsibility of specialist mental health services.

> *" The economic case for investment is strong. 75% of mental health problems in adult life start by the age of 18. Failure to support children and young people with mental health needs costs lives and money. Early Intervention avoids young people falling onto crisis and avoids expensive and longer term interventions into adulthood. There is a compelling moral, social and economic case for change." (Future in Mind 2015)*

Only 25% of children with a mental health condition get any professional help

72% of children in care and **95% of young people in custody** have a diagnosable mental health condition

Half of all lifetime mental health conditions first emerge **before the age of 14** and three quarters **by the age of 25**

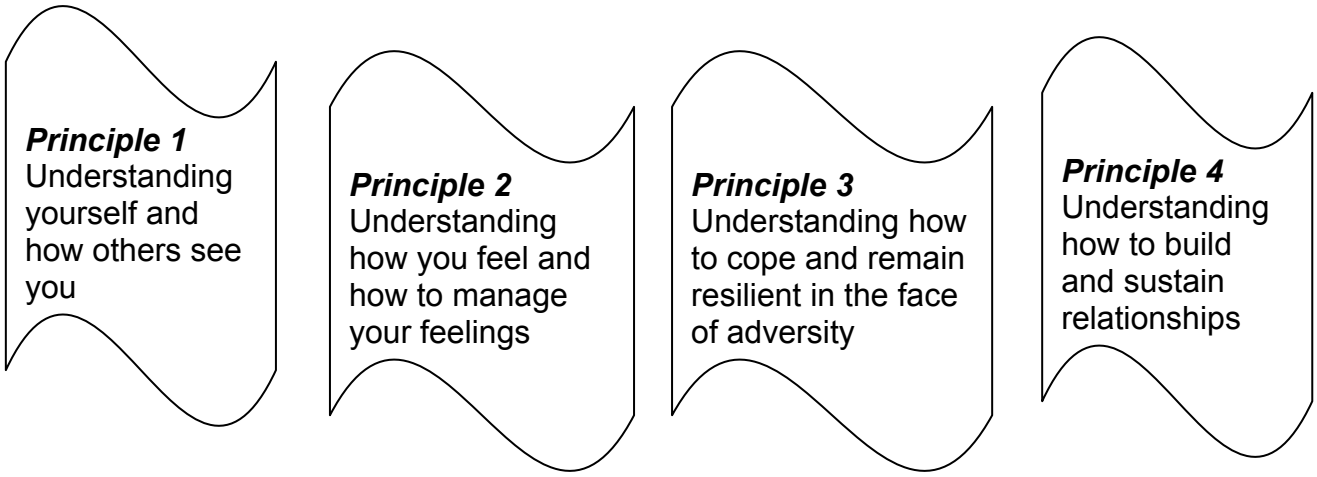
Promoting Mental Health 4 Life
Centre for Mental Health with Ed Davie, March 2015

Nationally, the Mental Health landscape is being positively influenced by, *" Future in Mind,"* a joint report by NHS England and DoH focusing on the transformation of mental health services to children and young people.
It emphasises the following issues as essential to be included in national and local mental health planning:

- Promoting resilience, prevention and early intervention
- Improving access to effective support – a system without tiers
- Care for the most vulnerable
- Accountability and transparency
- Developing the workforce

3) Local strategic approach (West Berkshire Transformation Plan)

West Berkshire's strategic approach to the local Transformation Plan could be summarised includes four simple principles to build self-care skills and promote well-being these strategies form the foundation of the Transformation Plan:



These principles could be applied equally to both building the emotional health and resilience of members of the community; as well as promoting the welfare of the staff and volunteer workforce.

West Berkshire's workforce development strategy supports the wide-spread establishment of these principles through the investment in mindfulness and staff and volunteer training in restorative practices.

Figure 1 – Responding to circumstance and need within a community

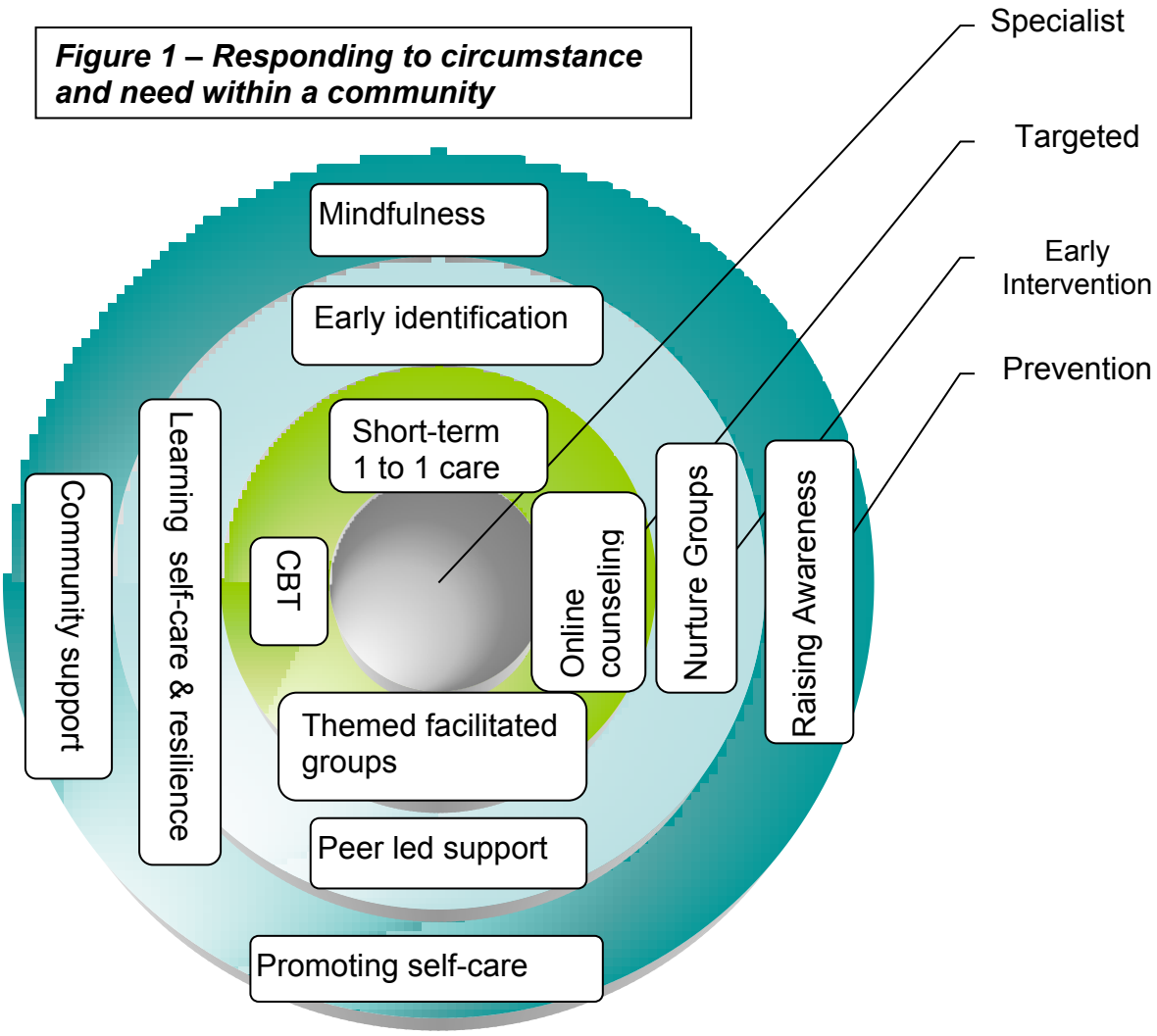


Figure 1 illustrates how the principles to promoting emotional health and well-being can be applied to the particular needs and circumstances of a member of the community. Imagine this diagram as the layers of an onion, or the concentric circles within a tree trunk – the activity in the outer preventative layer is equally relevant to the early intervention and more specialist layers. Continuing the analogy, the more mature a system gets, the more self sustaining it becomes e.g. a thin young tree needs watering and staking and external protection, whereas a larger tree has developed self-protection and maintains itself without outside intervention. This is what we are aiming for – a growing of community resources so that it becomes more self-sustaining and less reliant on outside support.

For example, if a member of the community were to learn short mindfulness meditations as a component of their day-to-day preventative self-care; they could continue to use and grow these skills if they needed additional help or support due to an episode of severe depression; or a sudden bereavement. The evidence would suggest that the skills associated with mindfulness, would reduce the likelihood of a recurrent episode of depression.

If an individual has a history of depressive episodes, the evidence suggests that the routine use of simple mindfulness techniques can reduce the severity or longevity of any subsequent episodes.

> *"Of the treatments specifically designed to reduce relapse group-based mindfulness-based cognitive therapy has the strongest evidence base with evidence that it is likely to be effective in people who have experienced three or more depressive episodes". (NICE 2009.)*

4) <u>Involving the breadth of the community and the workforce</u>

Rather than simply describing 'levels of need' or 'thresholds' associated with care, where only a few services can provide interventions; this model enables the community itself and the range of volunteer and professionally led-services within West Berkshire to play an active role.

Figure 2 illustrates how we can see this as a shared responsibility

Figure 2 – A shared responsibility

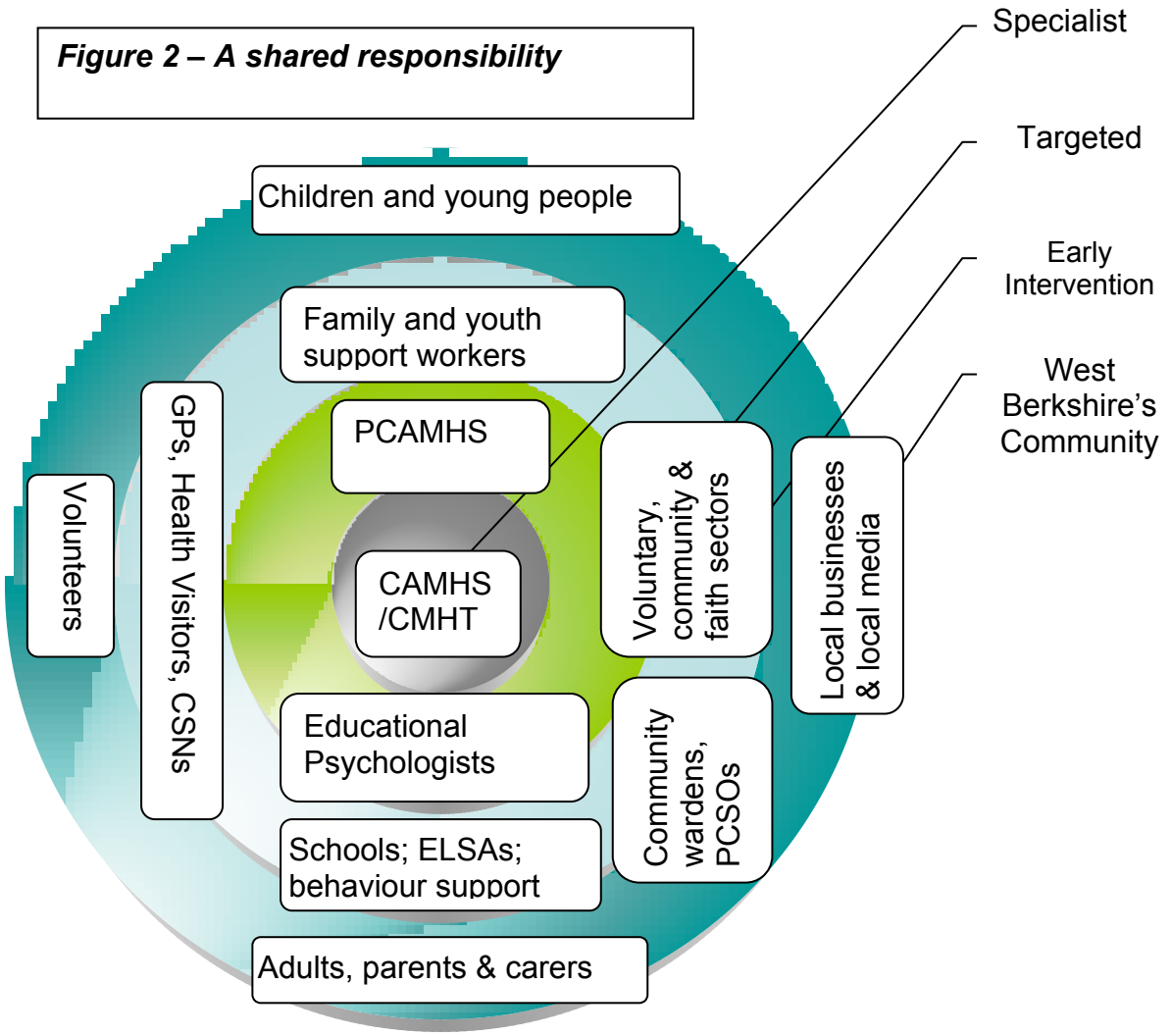


Figure 2 highlights how members of the community can receive care and support from a variety of places and from a variety of people; increasing the chances of reaching those most reluctant or least confident to access traditional services or to interact with statutory partner agencies.

There is particular dependence in this model on the pivotal role of the voluntary, community and faith sectors of reaching out into our community; and on finding volunteers from within communities to take an active role, who would be trained, supported and supervised with a voluntary community and faith sector umbrella and an Academy model.

Research tells us that the most effective way to reach the community with help and support, is by being based within the community itself. This feedback is reflected in the feedback from communities and from front-line staff and volunteers. In the context of austerity and perpetually reducing resources; it is potentially challenging to consider working in this way.

This shared partnership endeavour could be summed up in the following strategic principles:

- Building family resilience and empowering families to make sustainable changes;
- Safeguarding children and young people from harm through effective and early intervention;
- Break cycles of deprivation and poor family outcomes; and
- Reduce escalation to more specialist high cost provision.

5) Providing support frontline in communities

Leaders from schools; General Practice; the voluntary , community and faith sectors; and the Police all describe a lack of emotional health support available in communities. These proposals provide clear commitment for the resource of the Emotional Health Academy[3] to be deployed within communities, on the ground, working in partnership

Our analysis of the levels of need within West Berkshire district demonstrate that the majority of our resources; and in particular our specialist and targeted resources are deployed in the following geographical areas:

1) Calcot
2) Newbury*
3) Thatcham*
4) Greenham*
5) Hungerford & Lambourn
6) Mortimer and Burghfield

[3] See Appendix 1

7) (The Downs)

These areas could become the focus for community resources being delivered within communities. In order to ensure coverage for the breadth of the district; an additional community focus, in the 'Downs' area could be considered. It could be that locality based teams could serve more than one geographical area – for example the * areas above could combine resources in one team.

The analysis of current CAMHS referrals tells us that we have this proportion of referrals spread across the 7 districts:

1) Calcot
2) Newbury*
3) Thatcham*
4) Greenham*
5) Hungerford & Lambourn
6) Mortimer and Burghfield
7) (The Downs)

Newbury and District Clinical Commissioning Group are willing to review their voluntary, community and faith sector funding to see if it can be used to maximize financial investment within the district and be invested where impact on improving outcomes for children and families can most effectively be secured. In this context, the CCGs would also be asked to consider joint funding this emotional health and well-being service.

Longer term, these services and the skill/resources of the Mental HealthAcademy could be sold to other Local Authority areas; to generate income for West Berkshire.

6) <u>What difference will these proposals make to West Berkshire children and young people?</u>

- Currently children have to wait until their needs are 'bad enough' to receive support i.e. meet threshold – this model will enable support to be offered at the earliest opportunity and work to prevent the escalation of need

- Currently children can wait up to 18 months for an appointment – this model will enable children to be supported quickly, in their local communities; without needing to negotiate different referral systems and different thresholds in the sector

- Currently children have to travel across the district and sometimes out of district to access support, advice and care – this model will enable to receive early help, advice and support within the communities in which they live

- Children and families often identify that they feel 'done to' and confused by the system – working restoratively with children and families will increase the opportunities for children and families to feel listened to, feel able to achieve

things, or manage situations, that previously felt too difficult; experience a renewed sense of hope that change is possible

- Currently a significant number of children and young people are referred again to emotional and mental health services after completing their package of care or support – by working restoratively with children and families, and overtly focussing on strengths and interventions that bring resilience and sustainable change, involving 'significant others' around a child or family, repeat referrals will reduce

- Vulnerable children known to specialist and acute services all receive separate services from each agency individually, the level of co-ordination is variable; some of our most vulnerable children wait significant lengths of time for emotional health and support - will receive priority support, in their local area, bringing together professional analysis of risk and enabling the agreement of one shared 'bottom line' with children and families that everyone works to

- Currently we only have a few types of support available to our children and families - There will be a wider range of evidence based support and interventions for children and families; and these resources will be shared with all partner agencies working in those communities – this will include training being available to these partners and increased choice for children and families

- Our current models of support are offered district wide, with little opportunity to respond to individual needs and circumstances - support will be individually tailored to the needs of the child, family and community

- Children and families currently experience changes in professionals as their needs are assessed and transferred to different teams and departments, seeking to cover the district or county – children and families would have more opportunity to build relationships of trust with these keyworkers in their community

- We know that young people often feel 'let down' or confused at the point of transition to adult service – we will work in partnership with adult service colleagues to consider how we could work differently together with these families

- We currently have no local identified lead for perinatal mental health and we know that mothers experiencing maternal depression find it hard to access help and support – we will work in partnership to ensure that families experiencing these needs have several places in their local community to go to for help and support, with minimum standards being overseen in the new emotional health academy

- Children and families with emotional health needs often find themselves receiving inconsistent advice, help and support from different partner agencies; or 'falling between the cracks', between agencies, with no one agency providing

leadership – the emotional health academy will seek to develop greater consistency, shared planning and accountability for families and one point of contact (i.e. keyworker) for children and families needing this support

We will robustly analyse the impact on outcomes that this way of working has on children and young people

7) <u>Increasing capacity in the voluntary, community and faith sectors (VCFS)</u>

Local intelligence, review and evaluation; and national research; tells us that many members of the community will feel most comfortable accessing support from a non-statutory partner agency. For some members of the community, this may be the only option for support that they will consider engaging with voluntarily.

a) Make best use of the existing local resources; including seeking volunteers to engage in services in communities.

b) Seeking national sources of funding to expand the current emotional health services in the district.

c) That the focus would be on delivering emotional health support within communities, enhancing the use of volunteers where possible i.e. be-friending and buddying, etc.

d) A specific co-design session with VCFS partners to agree a range of ‘specifications for the VCFS part of the offer, building on the particular specialisms and expertise of the sector.

e) Ensuring that the proactive engagement with in the region of 600 young people over the course of the next six months via BWB: Building Community Together proactively ensures that the voice and experience of children and young people re: emotional health and well-being directly informs the design and approach of support/services. Children and young people will be given their own commissioning budget.

8) Timeframes

In the short term (Sept 2015– April 2016):

The current system will continue but a multi-agency Triage system will be established. Primary CAMHs workers will be joined in a Triage panel of other professionals and colleagues from WBC and the voluntary sector working in partnership.

This will extend the options available for the young person and family, potentially offering support within their local community and from a variety of sources.

The advantages include:

- ✓ More robust risk assessments
- ✓ Safeguarding as paramount
- ✓ Priority given to most vulnerable children and families
- ✓ Linking in with other agencies
- ✓ Faster response times and reduction in waiting times for children and families
- ✓ Local offers of support
- ✓ Whole family support
- ✓ Reduction of waiting lists
- ✓ More local knowledge
- ✓ Bespoke packages of support
- ✓ Closer communication with school and GP where appropriate

In the longer term (April 2016 onwards):

PCAMHs commissioning will cease.

Subject to sufficient joint funding being agreed by partner agencies; the Emotional Health Academy will be recruited to and established; voluntary community and faith sector provision with professionals in communities will be able to access local support and professional advice in each community, around a school or community hub.

With the introduction of the Emotional Health Academy (see Appendix 3) providing training, resources, coordination and evaluation of outcomes across West Berkshire, emphasis will gradually shift towards prevention and early intervention with a reduction in the need for 1:1 interventions at this level. The advantages include the above and also:

- ✓ Increased support to schools, communities and GPs
- ✓ Trained workers, either as part of school staff or retained centrally.
- ✓ Increased opportunity for high quality training and coaching of staff and community
- ✓ More choice of support and involvement for schools and GPs as commissioners
- ✓ More choice and involvement for the young person and family
- ✓ More effective use of the voluntary sector
- ✓ Community sustainability

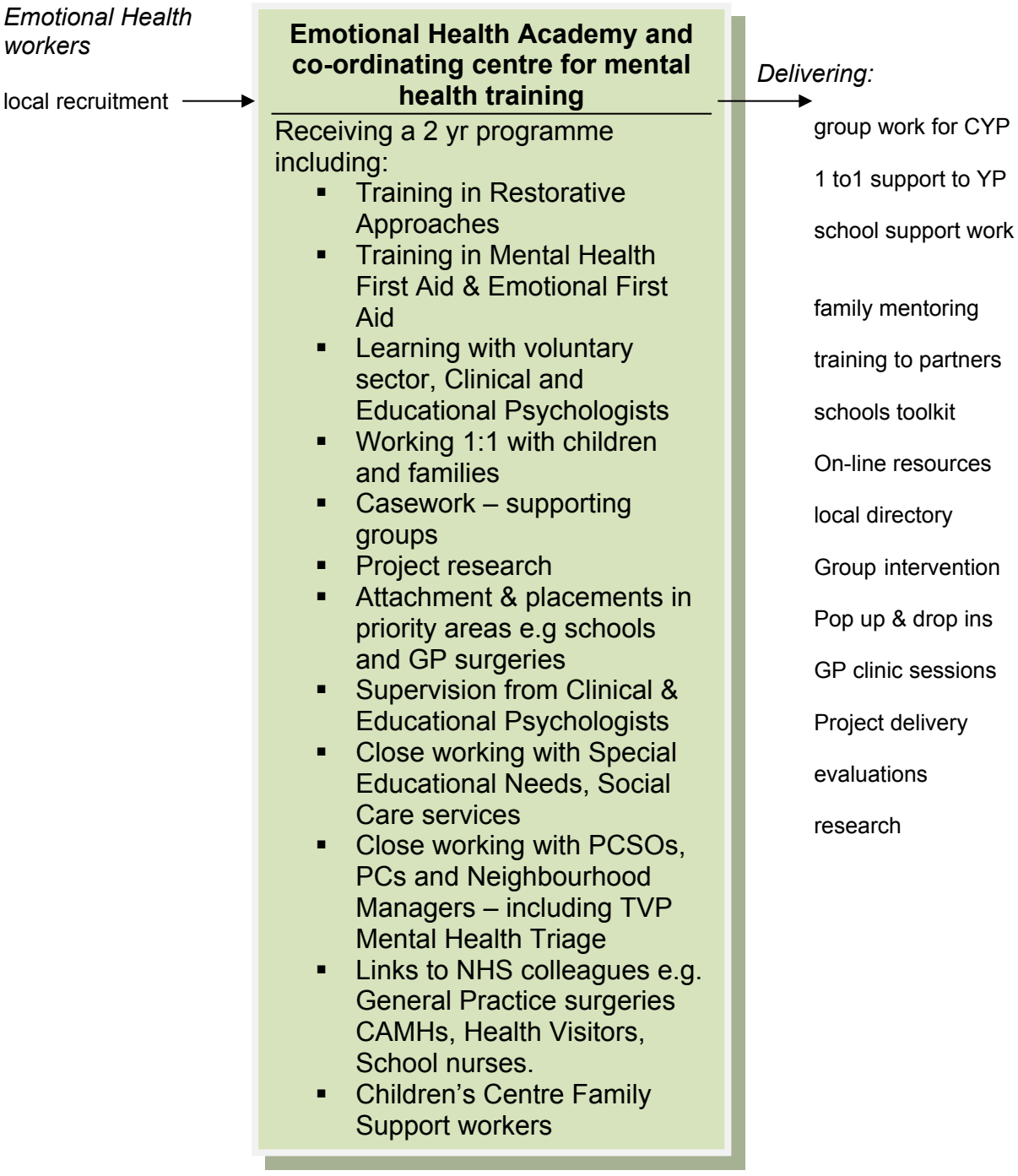
9) Review and evaluation

Academic partnership is currently being sought to external review and evaluate the establishment and impact of the Emotional Health Academy.

Appendix 1 – The Emotional Health Academy

Purpose: to provide timely support to children, young people and families, by *recruiting, training and retaining* high quality Emotional Health workers to build community resilience and support emotional health; within our communities.

Purpose: to co-ordinate information, training, and resources for all partner agencies within local communities



What are the functions of the Academy?

- To recruit, train and retain emotional health workers
- To coordinate an emotional health network for schools, GPs and community organisations
- To work in partnership with schools, GPs and the voluntary sector within local communities to extend emotional health support for children, young people and families
- To work in partnership with other agencies e.g. Police, Social Care, Youth Offending and CAMHs
- To provide and coordinate training for Local Authority colleagues, schools and local communities
- To maintain a high standard of evidence based practice, with quality assurance, evaluation and stakeholder involvement and review.

What are the roles of the emotional health workers?

1. To participate in a local triage system for children, young people and families, as set up by the community
2. To work directly (supervised) with children, young people and families with emotional health needs delivering evidence based interventions
3. To offer advice and support to schools and GPs on emotional health issues
4. To deliver emotional health awareness training to a variety of settings
5. To deliver training on specific emotional health issues
6. To offer supported group work for children and young people on emotional health issues e.g. anxiety, anger, friendships, social skills, self esteem
7. To mentor and support families and work alongside children's centre colleagues
8. To work alongside voluntary groups to ensure full involvement of community resources wherever possible
9. To work alongside peer mentors to develop peer support for emotional health issues
10. To help develop community awareness, through signposting, of the wide range of emotional health resources available locally and nationally to schools, GPs and communities
11. To create an emotional health toolkit for young people
12. To promote preventative and early intervention approaches in collaboration with other colleagues and communities
13. To promote, signpost and develop a range of online resources for young people to access
14. To design and deliver a robust evaluation of outcomes, involving stakeholders and children, young people and families
15. To review early intervention emotional health support, and the role of the Emotional Health Academy, in light of evaluations, and to participate in the continuous review of effectiveness and co-design.

Multi-agency management roles *(to include all stakeholders)*

1. To oversee the creation and design of the Academy; West Berkshire Council will work in close partnership with BHFT and CCG advisors in the design and development of the Academy.
2. To ensure safeguarding practices are robust

3. To recruit the psychology graduates who will be our emotional health workers
4. To deliver training to the emotional health workers on a range of psychological and mental health issues including ' *Emotional Health First Aid,' Mental Health First Aid'* programmes.
5. To coordinate training from other sources
6. To work alongside, as mentors and supervisors, the Emotional Health workers to extend the practical support and interventions available to schools
7. To develop and aid new opportunities for the Emotional Health workers to work in different settings e.g. GP surgeries, community centres and children centres
8. To offer regular 1:1 case work supervision and group reflective practice sessions
9. To teach the skills of working with children, young people, families and professional colleagues e.g. working with groups, presentation skills, communication, report writing, research and evaluation, project management, time management, working 1:1
10. To manage, with others, the daily organisation of the Emotional Health workers
11. To create and deliver a training package for the recruits, including full induction, opportunities for shadowing, visits and work alongside a wide range of colleagues, especially Help For Families, Children's Centres, schools, specialist settings, youth workers, YOT, voluntary groups, GP mental health practitioners, Family Resource service, Social workers, Behaviour Support team, Educational Welfare officers, SEN, college and university links.
12. To design and deliver a robust evaluation of outcomes, involving stakeholders and children, young people and families
13. To review early intervention emotional health support, and the role of the Emotional Health Academy, in light of evaluations, and to lead the continuous review of effectiveness and co-design.

What training will the emotional health workers receive?

As a minimum this will include:

- Restorative Practices
- Safeguarding and child protection
- Signs of Safety and reducing risks
- Psychological theories and evidence bases
- Mental Health First Aid
- Emotional Health First Aid
- Solution Focused thinking
- Cognitive Behaviour Therapy
- Video Interaction Guidance
- Mindfulness
- Attachment
- 5 ways to wellbeing approaches
- Awareness of SEND issues
- Specific training on working with young people with ASD and anxiety
- Basic counselling skills

- ‘dealing with difficult people’ and LA mandatory training
- Perinatal maternal mental health
- Communication, presentation and training skills
- Research and evaluation methods

a) ***Using existing skills and resources***

In order to make best use of limited and reducing existing resources the professional skills of Clinical and Educational Psychologists will be partially deployed, through the Emotional Health Academy, in each community to:

i) Provide training to universal staff and volunteers
ii) Professionally supervise staff and oversee the activity of volunteers
iii) Analyse school and community needs and develop group or peer-to-peer led care to respond to needs
iv) Providing 1 to 1 care
v) Maintain the rigour and robustness of evidence-based practice, solution-focused thinking and restorative approaches.

b) ***Creating a new more cost effective service – to resource the Emotional Health Academy***

West Berkshire currently invests £120,000 in PCAMHS and Help for Families therapeutic resources; which equates to 1.7 FTE staff. These resources could be reinvested in a multi-disciplinary team of psychology assistants, volunteers and FSWs under the supervision of the Educational Psychology service.

£120,000 investment would enable a realisation of at least 4 FTE Emotional Health workers. They could undertake the following functions:

a) Analysis of presenting need and undertaking non-statutory assessments
b) Leading or overseeing group or peer led support activities
c) Providing 1 to 1 support, where the level of need of the child, young person or family indicates that is appropriate for them to do so.
d) Providing training to staff and volunteers

All of these roles and functions would be fulfilled within the framework of the close supervision of Clinical and Educational Psychologists working alongside Senior Social Workers, other professional colleagues and the voluntary sector.

Berkshire Healthcare Foundation Trust are working with West Berkshire Council to ensure that Clinical Supervision support is offered to the Emotional Health Academy workers. BHFT and WBC are currently exploring both external supervisory support options and clinical staff secondment options.

c) ***Sufficiency within the national workforce***

There are a wealth of psychology graduates seeking employment and struggling to be successful, due to lack of sufficient experience. In a recent West Berkshire advertisement for an Assistant Psychologist, 70 suitable applicants applied for 1 post.

The Emotional Health Academy will learn from the established West Berkshire Social Work Academy model and ensure that learning is shared between the two professions.

This professional investment and opportunity to work in multi-professional team would increase West Berkshire's opportunity to attract high calibre graduates. Emotional Health Workers would be asked to commit to a minimum of a two-year employment period with West Berkshire.

d) <u>What is the potential for growth?</u>

With funding, new recruits could be added every year so increasing the emotional health worker resource available to all communities.

The Academy should aim to develop a core offer to settings, with additional traded options, enabling communities to create and access bespoke support, interventions and training.

Offering support to independent schools, other organisations and neighbouring Local Authorities would be realistic options for income generation.

Appendix 2 – Emotional Health Academy Costs

Expenditure	Cost per annum
Part-time Strategic Management	£20,000 - 24,000
Operational Manager	£35,000-45,000
Emotional Health Workers in communities x 7-8 FTE	£180,000 - 200,000
1 specialist emotional health worker FTE (clinically trained)	£35,000 - 45,000
Academic Tutor (part-time backfill)	£16,000
Professional & Clinical Supervision costs	£15,000 - 20,000
External Training	£5,000
ICT equipment	£8,000
Administrative support	£9,000
Travel	£1000
TOTAL	**£324,000 - 373,000**

Accommodation costs will be absorbed by West Berkshire Council.

It will only be possible to implement the Emotional Health Academy model if partner agencies are able to make an active contribution. The scale of the Academy will be directly proportionate to the funding income received. These estimations of income are cautious.

Contributor	2016/17	2017/18	2018/19
West Berkshire Council	£120,000	£100,000	£80,000
Philanthropic investment	£120,000	£100,000	£80,000
CCGs and Schools	£120,000	£100,000	£80,000
Income generation through marketing	£0	£60,000	£120,000
Additional philanthropic or alternative national investment	£0	£100,000	£200,000

Appendix 3 - Strategic Principles and Objectives

In order to achieve our mission we are committed to working in line with the following strategic principles.

Putting children and young people first	The child and family are at the centre of all service planning and delivery at a strategic and operational level, and are involved in shaping these services to ensure they best meet their needs.
Focusing on quality and innovation	There is one front door into services for children and their families, with expert staff available to ensure they are able to access the right professional at the right time. Commissioned services are clearly targeted to meet the needs of individual children and families based on a sound analysis and understanding of need and evidence of what works best. Families are supported by expert and highly skilled professionals who use evidence-based interventions to effect change and who evaluate the impact of the interventions and obtain on-going feedback from families on the outcomes of their work. That we all invest in the early years' of a child's life; given that research has highlighted the significance of a child's development in the first years of their life and that support in these years has greater impact and is more effective and efficient.
Valuing diversity and championing inclusion	There is a 'whole family' approach based on a family assessment of need, ensuring that each family member has their individual needs identified and a clear plan is put in place to address these. Families and local communities are supported to help themselves and solve their own problems
Being a listening and learning organisation	The voice of the child or young person is heard within the assessment and intervention process and that, wherever possible, the family owns the assessment and intervention plan.

Working in partnership to improve our services	Partners should commit, wherever possible, to investing resources and funding in early intervention and prevention to ensure that children's needs are identified and responded to as swiftly and effectively as possible and to prevent the escalation of need. Families' needs are best met by an integrated and joined-up approach from all the relevant agencies in a 'team around the family' and that interventions are coordinated by an accountable Lead Professional and are reviewed regularly. Families experience a seamless and integrated approach as service users which minimises disruption and inconsistency in their experience of professionals, interventions and services. There is a common process and language for integrated working across all partners and agencies who work with children and their carers, and this is supported by: i) the restorative practice approach to working with families and with each other ii) the Signs of Safety framework iii) the Outcomes Star

Appendix 4 – Working restoratively with families

What is a restorative approach?
A restorative practice is a 'high challenge' and 'high support' approach; we work 'with' families; we don't do 'to' them and we don't do 'for' them.
The approach is most successful when all of the professionals working with a family work in a restorative way. Families lead the development of their plans. That might be through:

i) a restorative Team Around the Family (TAF) arrangement;
ii) through a Family Group Conference (FGC);
iii) through one-to-one work e.g. targeted Youth Support;
iv) or through restorative conferencing.

Restorative working also involves identifying 'significant others' who could provide support, encouragement and a shared sense of accountability and responsibility with the family, with a particular focus on owning and naming areas of risk within the family. We know from national and local learning, that plans are much more successful when:
i) the design of a plan is led by a young person/family;

ii) the plan is supported by significant people in the family's life e.g. friends, extended family, neighbours;

iii) when a family/young person feels held to account and responsible for the implementation of a plan by people they respect and trust i.e. 'significant others' and workers that they have a strong relationship with.

What are the benefits that young people and families experience from a restorative way of working?

Young people and parents/carers describe the following experience of this way of working:
 Feeling listened to, as one young person put it, 'You asked me things no one had ever asked me. I'm doing things I didn't think I could do'

 Feeling able to achieve things, or manage situations, that previously felt too difficult; and more in control e.g. of both assessment and planning

 Not being constrained by existing services – being able to work creatively to access new services and new support that is uniquely defined for their needs and circumstances

 Feeling more accountable, not just to professionals, but also to friends and family members for their behaviour and their outcomes

 A sense of hope that change is possible

Almost all families represent that the 'high challenge' elements of the restorative way of working are difficult at the time, but most families identify those challenges are instrumental in making and sustaining change.

3) Seeking informed consent

Working 'with' families means seeking their informed consent from the outset to work in partnership with workers (i.e. staff and volunteers). To give informed consent parents/carers and young people need to understand:

 Who information will be shared with and for what purpose

 That information will be shared proportionately (e.g. what someone needs to know to fulfil their role) and used appropriately

 That they have a choice e.g. to give partial consent to share information with some organisations and not others; or not to give consent at all

 That there are statutory obligations that would place a duty on a worker to share information i.e. child protection concerns, to prevent or detect criminal activity, potential fraudulent activity.

Young people can give their own informed consent if they have sufficient emotional maturity and intellectual capacity[4] to understand: i) the options they have available, ii) the choice that they are making and iii) the consequences of those choices.

Seeking the informed consent of parents/carers or young people is an essential part of the 'first conversation;' but it's also an ongoing conversation with families that can be revisited whenever it needs to be i.e. when new information emerges that needs to be shared; if sensitive information emerges that might elicit partial consent.

4) 'First conversations'

Wherever possible first conversations will be led by a worker the family know and trust; if a lead professional arrangement is already in place, this person will ordinarily lead a first conversation. A 'first conversation' includes:

- an opportunity to understand the family/young person's perspective – their strengths, their needs, any risks that need to be managed and their aspirations and hope. You could use the Outcome Star or Eileen Munro's '3 Houses' to capture your discussion and clearly highlight any risks that need continual review and management
- a description of working in partnership 'with families' e.g. family led plans;
- seeking 'informed consent';
- The bottom line – what needs to change and what the consequences of not affecting change will be (e.g. many of these families are on the cusp of prosecution, eviction, exclusion, children being taken into care, etc).

[4] 2 Referred to as 'Fraser' or 'Gillick' Competence - see http://www.nspcc.org.uk/inform/research/questions/gillick_wda61289.html for a summary of these principles

How we work together with families is crucial to our ability to influence improvements in outcomes. What families and keyworkers tell us that works is:

a) ***Persistence*** –provide frequent reminders for appointments/meetings; keep trying, don't be put off by failed attempts; most Family First families circumstances and choices appear to deteriorate, before they improve

b) ***Honesty*** and ***trust***– be open and honest and keep revisiting the 'bottom-line' together, so that families know exactly where they stand. This is particularly essential where there are concerns about child protection or safeguarding of children.

c) ***High Challenge and High Support*** – uniquely tailored to a family's situation and their needs

d) ***A sense of hope/aspiration*** – frequent encouragement that change is possible is essential, incentives and rewards to recognise progress that families make is really helpful - plans are shaped around the family's potential and aspiration for change; they are informed by the active contribution of 'significant others' around the family, who all have a role to play in the plan.

These principles apply equally to adult service users.

Appendix 5 - Brilliant West Berkshire - Extending the thinking

National and regional research on the 'causal factors' that are most often prevalent in children and young people requiring specialist interventions in their childhood include:

1) Emotional ill-health or mental illness
2) Witnessing violence/abuse in the home of the community
3) Living with an offender
4) Lack of aspiration or hope
5) Living with someone with significant physical health needs
6) Living in over crowded housing
7) Material or social poverty or isolation

Longer term, Brilliant West Berkshire partners will explore together how finite resources could be reviewed to maximise outcome change for children and families. The following strategic principles (supported by the information in Appendix 3) could provide a framework for multi-professional teams in communities

- Children, young people and families receive the *services they need*, *when they need them* and *where they can access them*;

- Services work together to provide a *coordinated whole family approach*, reducing the likelihood of the development of more complex needs;

- Commissioners work together across sectors and services to meet need in the best possible way and achieve best *value for money*; and

- We know and can demonstrate through evidence and feedback that the *services provided have made a difference* to the lives of children, young people and families and local communities.

- We will work 'with' children, young people and families and 'with' each other; using the restorative values of 'high support' and high challenge'.

- We will ensure that 'significant others' are routinely involved in assessment and planning.

By doing this, children and young people will live safe, healthy and fulfilling lives, and develop into responsible adult citizens, thereby breaking intergenerational cycles of risk and vulnerability. Families will become more resilient and develop capabilities to prevent and resolve problems. This will in turn reduce demand for higher cost specialist services and achieve greater use of community based universal preventive services.

Even where there is abuse and / or neglect and a child is removed from the family, the ultimate goal is still to work with the family and to ensure that the child is living in a positive environment e.g. special guardianship with a kinship carer or an adoptive family, where universal services will be sufficient to meet their needs.

Title of Report:	**SEASONAL INFLUENZA CAMPAIGN 2015-16; NATIONAL AND LOCAL ACTIONS**
Report to be considered by:	The Health and Wellbeing Board
Date of Meeting:	26th November 2015

Purpose of Report: **To update the Health and Wellbeing Board on local implementation of national Flu plan for 2015-16.**

Recommended Action: **For information only.**

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 For the Board to note progress of local implementation and to consider their role in promoting uptake of flu vaccine among staff and residents of care homes, for example through Health Watch.

2. KEY POINTS:

- **The national Flu Plan was published in March 2015; immunisation of at-risk groups is a key component of the Flu Plan.**
- **Immunisation is commissioned by NHS England and delivered by a mix of providers.**
- **Following a Berkshire workshop in June 2015, local stakeholders have worked together to develop and implement flu plans**
- **Local authorities have a key role in promoting and increasing vaccine uptake among eligible groups and are responsible for provision of vaccine to frontline health and social care workers they employ**
- **Other employers of health and social care staff, (e.g. care home staff and other carers) have a responsibility to provide vaccine to frontline staff they employ**
- **NHS employers have a responsibility to provide vaccine to all frontline staff**
- **Flu vaccine is available from October to March 2015, eligible individuals are encouraged to get vaccinated as early as possible**
- **Uptake and flu diagnoses are monitored throughout flu season and fed back to local stakeholders to enable appropriate response**

3. BACKGROUND

3.1 Seasonal Flu

Flu is a key factor in NHS winter pressures. It impacts on both those who become ill, the NHS services that provide direct care, and on the wider health and social care system that supports people in at-risk groups. Flu occurs every winter in the UK. The National Flu Plan aims to reduce the impact of flu in the population through a series of complementary measures. These measures help to reduce illness in the community and unplanned hospital admissions, and therefore pressure on health services generally and A&E in particular. The plan is therefore a critical element of the system-wide approach for delivering robust and resilient health and care services throughout the year. Successful local implementation of the flu plan depends on partnership working; the roles and responsibilities of DH, NHS, PHE and Local Authorities in response to Flu are shown in

Figure 1.

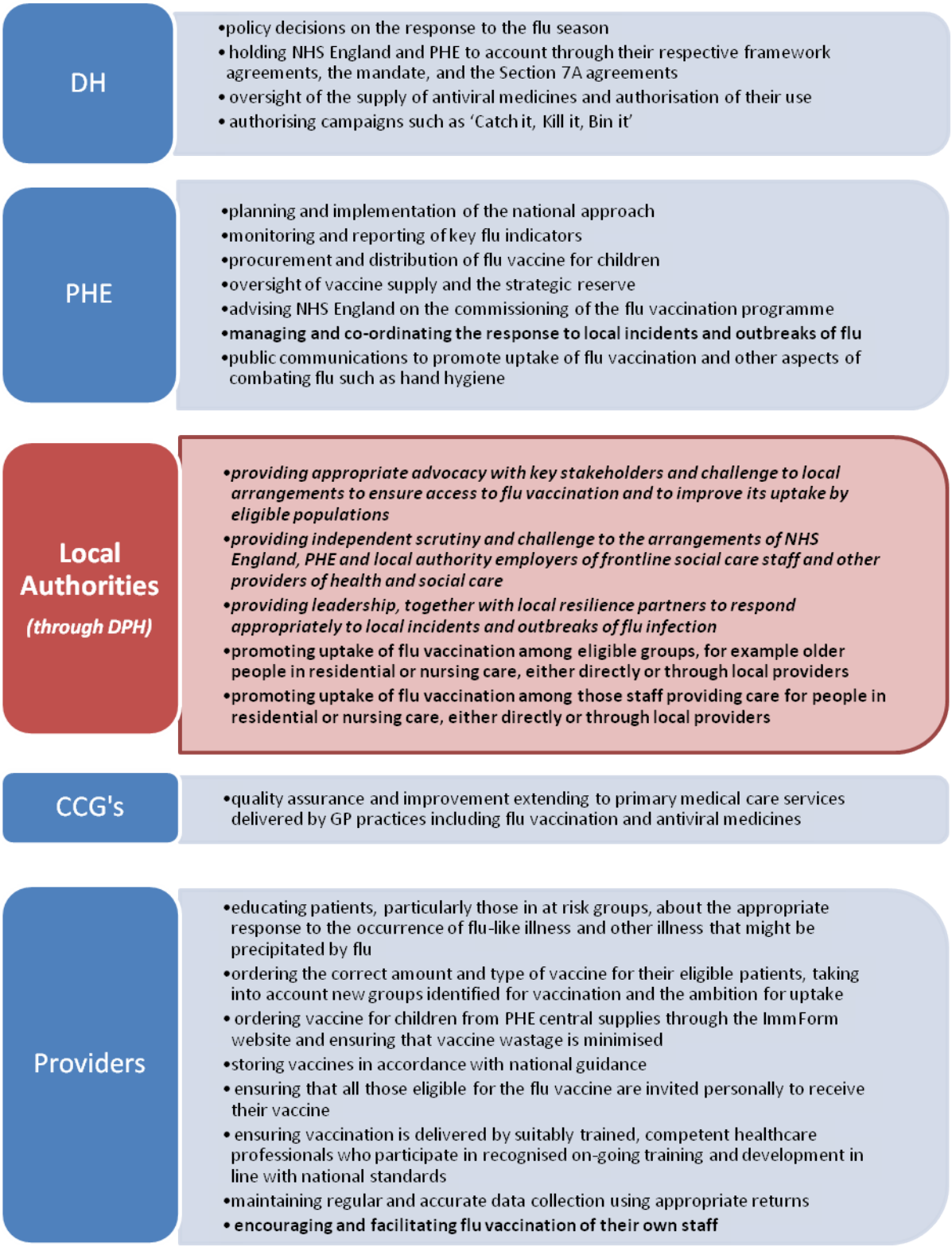
3.2 The national flu immunisation programme

Flu vaccination remains the best way to protect people from flu. People in certain groups are at increased risk of severe symptoms if they contract flu, these groups are eligible for free flu vaccine.

- Adults aged 65 or above
- Children aged 2 to 4 years or in school years 1 and 2
- Pregnant women
- Paid and unpaid carers
- Frontline health and social-care workers
- People living in long-stay residential care homes,
- Adults and children (6 months to 64 years) with one or more of the following conditions;
    - a heart problem
    - a chest complaint or breathing difficulties, including bronchitis, emphysema or severe asthma
    - kidney disease
    - lowered immunity due to disease or treatment (such as steroid medication or cancer treatment)
    - liver disease
    - stroke or a transient ischaemic attack (TIA)
    - diabetes
    - a neurological condition, e.g. multiple sclerosis (MS), cerebral palsy or learning disability

It is important to continue to communicate the benefits of the vaccine among all recommended groups and to make vaccination as easily accessible as possible, including for frontline health and social care workers, including those employed by private organisations.

Figure 1: Roles and responsibilities of local authorities and partner organisations in response to seasonal flu



3.3 Aims of the flu immunisation programme

The aims of the immunisation programme are to;

- Offer flu vaccine to 100% of people in eligible groups.
- Immunise 60% of children, with a minimum 40% uptake in each school
- Maintain and improve uptake in over 65s and 6 months to 64 years in clinical risk groups with at least 75% uptake for those aged 65 years and over and 75% uptake for health and social care workers
- Improve uptake over and above last season among those in clinical risk groups and prioritise those with immunosuppression, chronic liver and neurological disease, including people with learning disabilities

4. LOCAL ACTIONS

Across West Berkshire residents can access flu vaccine in a number of ways as set out in **Table 1**

Table 1: Access to flu vaccine for eligible groups

Group	Provider
Children aged 2 to 4	Primary Care
School years 1 and 2	School based programme, Berkshire Healthcare Trust
Special Schools	School based programme , Berkshire Healthcare Foundation Trust
Adults aged 65 or above	Primary Care or Pharmacy
Adults in clinical risk groups	Primary Care or Pharmacy
Children in clinical risk groups	Primary Care (or through special school programme)
Paid and unpaid carers	Primary Care or Pharmacy
Pregnant Women	Maternity Unit at Royal Berkshire Hospital or Primary Care
Health and social care workers	Via occupational health arrangements

Local Flu Timeline

March 2015: Annual Flu letter and National Flu Plan published
June 2015: Berkshire Flu Workshop (Berkshire stakeholders)
July 2015: Berkshire Local Authority Flu Plans Produced (Berkshire Shared PH Team)
June – August 2015: Commissioning (NHS England)
July 2015: Local Communications Plan available (NHS England)
July-October 2015: Local communications and promotion campaigns developed
September 2015; Schools poster competition (Oxford Academic Health Sciences Network)
October 2015: Vaccine available to order
October 2015: National communications materials available
October-2015-March 2015: Flu campaign in operation
March 2015: Local review planned

5. Equalities

5.1 This item is not relevant to equality.

Appendices

There are no Appendices to this report.

Consultees

Dr Lise Llewellyn, Strategic Director of Public Health
Lesley Wyman, Consultant in Public Health West Berkshire Council

Stakeholder workshop held in June 2015 including Dr Chris Cook and Harpal Aujla, Screening and Immunisation Team NHS England South - South Central and representatives from Berkshire West CCGs, GP practices, NHS provider organisations, Public Health England and public health teams across Berkshire.

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