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Notice of Meeting

Health and Wellbeing Board

Thursday, 28th January, 2016
at 9.00 am

in the Council Chamber Council Offices
Market Street Newbury

Date of despatch of Agenda: Wednesday, 20 January 2016

For further information about this Agenda, or to inspect any background documents referred to in Part I reports, please contact Jo Reeves on 01635 519486
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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), Andrew Sharp (Healthwatch) and Councillor Roger Croft (Executive Portfolio: Leader of Council, Strategy & Performance, Finance)

Also to: Jo Reeves (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).

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.

3 **Minutes** 5 - 16
To approve as a correct record the Minutes of the meeting of the Board held on 26th November 2015.

4 **Health and Wellbeing Board Forward Plan** 17 - 18
An opportunity for Board Members to suggest items to go on to the Forward Plan.

5 **Actions arising from previous meeting(s)** 19 - 20
To consider outstanding actions from previous meeting(s).

6 **Public Questions**
Members of the Executive to answer questions submitted by members of the public in accordance with the Executive Procedure Rules contained in the Council's Constitution.
(Note: There were no questions submitted relating to items not included on this Agenda.)

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.	21 - 24
9.20 am	9	**Primary Care Strategies (Cathy Winfield/Angus Tallini/Rupert Woolley)** Purpose: To present North and West Reading CCG's Primary Care Strategy to the Board and to provide an update on Newbury and District CCG's Primary Care Strategy.	25 - 70
9.35 am	10	**Urgent and Emergency Care Review 'Safer, Better, Faster' (Maureen McCartney)** Purpose: To provide an overview of the urgent and emergency care system in the Thames Valley.	71 - 82

Integration Programme

9.50 am	11	**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. Item to include: • An update on progress with the BCF Projects • The BCF for 2016/17 • Changes to the Hospital at Home Project • Update on the Connected Care Programme	83 - 116

Development Plan

10.05 am	12	**Governance for the Health and Wellbeing Board (Nick Carter)** Purpose: To present and agree governance proposals based on the development session that took place on 26th November 2015.	117 - 124

10.20 am	13	**New Health and Wellbeing Priorities (Tandra Forster/Lesley Wyman/Mac Heath/Shairoz Claridge)** Purpose: To present and agree the streamlined priorities for the Health and Wellbeing Strategy.	125 - 128

Other issues for discussion

10.35 am	14	**Local Safeguarding Children's Board Annual Report (Rachael Wardell)** Purpose: To present the annual report to the Board for information.	129 - 170

Other information not for discussion

	15	**Syrian Refugee Resettlement Programme** Purpose: For information.	171 - 206
	16	**Safeguarding Adult's Board Annual Report** Purpose: For information.	207 - 268
	17	**Members' Question(s)** Members of the Executive to answer questions submitted by Councillors in accordance with the Executive Procedure Rules contained in the Council's Constitution. *(Note: There were no questions submitted relating to items not included on this Agenda.)*	
	18	**Future meeting dates** 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

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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, 26 NOVEMBER 2015

Present: Dr Bal Bahia (Newbury and District 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) and Councillor Mollie Lock (Shadow Executive Portfolio: Education and Young People, Adult Social Care)

Also Present: Jessica Bailiss (WBC - Executive Support), Lesley Wyman (WBC - Public Health & Wellbeing), Tandra Forster (WBC - Adult Social Care), Shairoz Claridge (Newbury and District CCG), Mac Heath (Head of Children and Family Services) and Andrea King (Head of Prevention and Developing Community Resilience)

Apologies for inability to attend the meeting: Dr Barbara Barrie and Andrew Sharp

PART I

49 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.

50 Minutes

The Minutes of the meeting held on 26th September 2015 were approved as a true and correct record and signed by the Chairman.

51 Health and Wellbeing Board Forward Plan

The Health and Wellbeing Board noted the forward plan.

52 Actions arising from previous meeting(s)

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

53 Public Questions

There were no public questions received.

54 Petitions

There were no petitions presented to the Board.

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

Tandra Forster introduced agenda item eight to Members of the Health and Wellbeing Board with the purpose of highlighting any emerging issues. Tandra Forster drew the Board's attention to the Adult Social Care section and reported that some of the latest data reported was from quarter two due to the timing of submission deadlines.

ASC1: Proportion of older people who were still at home 91 days after discharge from hospital to reablement/rehabilitation service: The target was 92% and performance was 90% and therefore was highlighted red. Tandra Forster explained that the indicator referred to a small cohort of people. The Better Care Fund (BCF) Joint Care Provider (JCP) Project would help improve performance for this indicator.

Regarding Delayed Transfers of Care, performance was green with regards to all delays and performance in relation to those attributable to social care was amber. There was a good relationship with the Royal Berkshire Hospital (RBH) however, it was acknowledged that there were still areas that needed improving. Focus was being given to extending the JCP and increasing seven day working. Home care in rural areas was also a challenge and would be incorporated into the BCF for 2016/17.

Shairoz Claridge introduced the Acute section of the Dashboard.

AS1: 4 hour A&E target – total time spent in Accident and Emergency (A&E) department: The RBH were currently the only hospital trust achieving this target. It was expected that with the approach of winter the number of people using A&E would increase. Hampshire Hospitals and Great Western Hospital were struggling to meet the target. Shairoz Claridge highlighted that the Newbury and District Clinical Commissioning Group were not the commissioners for these two Foundation Trusts however, efforts were being made to obtain narrative around the target. Year to date information showed that 70% of those accessing urgent care from West Berkshire flowed towards the RBH, 14% go to Hampshire Hospitals and 8% to Great Western Hospital.

There was a great deal of work taking place regarding urgent care services. Vanguards were redesigning the Urgent Care system and details on this could be found within the document 'Safer, Better, Faster'. Urgent Care was being looked at locally on a Thames Valley basis. A paper was being brought to the next Board meeting on the 111 service, which formed part of the Urgent Care system.

Tandra Forster reported that Adult Social Care was currently developing its winter plan. Performance in West Berkshire was very good with only a few spikes throughout the year. Different ways to manage performance were being explored.

AS5: Ambulance Clinical Quality – Category A 8 Minute Response Time: Shairoz Claridge reported that the provider was the key to turning performance around on this target, which was currently red. There were currently challenges being faced in recruiting and retaining staff.

(Cathy Winfield joined the meeting at 9.15am)

Rachael Wardell introduced the Children's Social Care section of the Dashboard.

CSC1: the number of Looked After Children (LAC) per 10,000 population: the volume of LAC in West Berkshire was still above the national rate. Rachael Wardell explained that the figure of 48 did not mean than there were 48 LAC in West Berkshire but that there were 48 per 10 000 population.

CSC2: the number of child protection plans per 10 000 population: this remained stable in West Berkshire however, was above the national average. Rachael Wardell stated that recent data showed this number was starting to reduce slightly and this was as a result of the way cases were being managed.

CSC3: the number of Section 47 enquiries per 10 000 population: there had been a significant increase in the number of Section 47 enquiries according to the data for quarter two. As a result of this increased thresholds had been reviewed and conclusions made that the necessary Section 47 enquiries were being applied. It was not yet clear why an increase was being witnessed.

CSC4 and CSC5: to maintain a high percentage of (single) assessments being completed within 45 working days and LAC cases reviewed within required timescales: both of these indicators were green and performing within the target however, Rachael Wardell felt that all LAC should expect to be reviewed on time.

CSC6: Child Protection Cases which were reviewed within required timescales: although amber, performance against this target was very strong and only one percent away from being rated green.

CSC7: percentage of LAC with Health Assessment completed on time: Performance was currently red at 73% (target 90%) and Rachael Wardell had requested that the indicator be added to the Dashboard due to under performance in this area. All LAC received a Health Assessment when brought into care and therefore it was felt that the target for this should be 100%. 73% was a significant improvement and October data showed further improvement over 80%. It was hoped that at least 90% would be achieved by December.

Councillor Graham Jones stated that he was pleased to see the indicator on Health Checks incorporated as part of the Dashboard. He questioned the arrow symbol for those indicators showing volume, in particular the number of LAC. Rachael Wardell explained that numbers were compared to the normal range nationally. LAC within the system were those children who could not be safely protected at home. There was no right or wrong in terms of these figures however increased numbers, or a number of LAC higher than the normal range, indicated significant pressure on the system. Councillor Roger Croft queried what the 'normal range' referred to and Rachael Wardell confirmed that it was the 'England normal range' that was used. Given the prosperity of the District Councillor Croft queried if West Berkshire should expect to fall into the lower part of the 'normal range' and Rachael Wardell confirmed that this was correct.

Leila Ferguson was concerned that the number of LAC could rise significantly if money for Short Breaks was reduced or removed. It was hoped that the necessary conversations were taking place on this. Rachael Wardell explained to ensure all Board Members were clear, that Short Breaks provided respite care for families with children with disabilities. It was possible that some families might feel unable to care for their child at home if this service was removed.

RESOLVED that the Health and Wellbeing Board noted the Dashboard.

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

Tandra Forster introduced the report (Agenda Item 9) to Members of the Health and Wellbeing Board regarding the Better Care Fund (BCF) and wider integration programme. Tandra Forster reported Berkshire West would be showcasing its BCF projects in February and as part of this a Team from NHS England would be visiting. The team would not just be looking at the BCF projects but also wider integration work. They would also be attending and observing one of the Locality Group meetings.

Tandra Forster referred to Appendix C and explained that it was a performance report that showed how well the national conditions for the BCF were being met. The report had to be submitted to NHS England on a quarterly basis and quarter two had already been submitted. Shairoz Claridge reported that West Berkshire was progressing well in comparison to other areas particularly in relation to increasing seven day working provision.

The submission dates for the quarterly returns to NHS England did not align with meetings dates for the Board and therefore wording was being agreed with Democratic Services to enable delegated authority to the Corporate Director (Communities Directorate).

Dr Bal Bahia reported that the ACG tool had been used in Newbury to help identify patients. Regular meetings were taking place with the Primary Care Team to ensure pathways were agreed for patients with the most complex needs. Tandra Forster reported that good work was taking place with some GP Practices.

Tandra Forster reported that conversations were already taking place regarding what the BCF would look like in 2016/17. There would be a 1.9% increase in the total amount of funding available.

Tandra Forster drew Board Members' attention to the Hospital at Home Project, which had undergone a great amount of change including enhancement of the Rapid Response Team. The project would now be much more focused on care homes and enhanced support in these settings to avoid unnecessary admissions. The title of the project would be changing and the new name would be brought to the Board in January 2016. Shairoz Claridge reported that six to seven people had already used the Rapid Response Service.

Three voluntary organisations had shown a keen interest in the Personal Recovery Guide Project and performance was improving. This would help inform decision making in 2016/17. Shairoz Claridge added that the project was being viewed in a broader aspect rather than just urgent care services. It was important to obtain robust data around this.

Regarding seven day working the aim was to have a wider remit of skills available seven days per week. Shairoz Claridge referred to the frail elderly strand of work and reported that colleges within the Commissioning Support Unit were finalising a finance model. The output would be a new pathways for the frail elderly.

All Local Authorities and CCGs were required to evaluate their CF projects. Pricewater House Cooper was helping to support this process.

It was hoped that the approach to the BCF in 2016/17 would be improved as a result of lessons learnt in 2014/15. Tandra Forster reported that operational guidance had not yet been provided however, it was hoped that it would be available soon given that the Spending Review had taken place.

Regarding the Personal Recovery Guide Project, Dr Bal Bahia reported that Care Coordinators were now working with GP Practices to increase signposting, which should in turn increase uptake.

Councillor Hilary Cole queried when the showcasing event was taking place in West Berkshire and the date of 3rd February 2016 was confirmed.

Councillor Cole queried the cost of the internal audit being carried out at the CCG by Price Waterhouse Cooper. Shairoz Claridge reported that this formed part of the CCGs routine internal audit work.

RESOLVED that the cost information would be reported back to Councillor Cole outside of the meeting.

Regarding wording going to Democratic Services in relation to the Scheme of Delegation, Councillor Graham Jones suggested that both himself and Dr Bahia needed to be part of the sign off process.

RESOLVED that the Board noted the BCF report and approved the quarter two data return.

57 Feedback on the Health and Wellbeing Strategy Hot Focus: Looked After Children (Mac Heath)

Mac Heath drew the Board's attention to his report (Agenda Item 10), which provided an update on the progress of Health Assessments for Looked After Children, subsequent to the Health and Wellbeing 'Hot Focus Session' that took place on 11 June 2015.

Mac Heath reported that there were 164 LAC in June 2015 and only 51% had their Health Assessment completed on time. The rate had recently increased to about 81% and the commitment was to raise this to at least 90% by Christmas. Conversations had been taking place with foster parents to help understand the health needs of children. There had also been huge efforts to drive recruitment of foster parents. A huge challenge was when children where placed with a family 20 miles or so outside of the West Berkshire borders. Mac Heath stated that there was still much work to do however, things were improving.

Councillor Lynne Doherty felt that the 90% Health Assessment target should be 100%. Mac Heath recognised why Councillor Doherty felt the target should be 100%. In his previous authority 98% had been achieved however, there had been a couple of children who had refused to take part in Health Assessments which is why 100% was not reached and signified why a 100% target was not always realistic. Mac Heath was meeting with other Heads of Children's Social Care the following day where this would be discussed.

RESOLVED that the Board noted the report.

58 Joint Strategic Needs Assessment and the District Needs Assessment (Lesley Wyman)

The Board considered a report (Agenda Item 11) concerning the process of merging the Joint Strategic Needs Assessment (JSNA) with the District Profile and to share some of the latest data on JSNA chapters.

The JSNA used data and evidence about the current health and wellbeing of residents in West Berkshire and highlighted the health needs of the whole district. Councils and Clinical Commissioning Groups (CCGs) had an equal and joint duty to prepare JSNAs as part of the NHS reforms outlined in the Health and Social Care Act 2012. In West Berkshire this process was overseen by the Health and Wellbeing Board. The JSNA was the key source of information which was used by the Health and Wellbeing Board to agree the priorities within the Health and Wellbeing Strategy.

The structure of the JSNA took a life course approach and focused on the demographics of the West Berkshire population and information about different groups of people throughout their life. The main sections including demography were **starting well**, which was about giving children a healthy start in life and laying the groundwork for good health and wellbeing throughout life; **developing well**, which focused on children and young people aged between 5 and 19 years, detailing what affected their health; **living well**, which looked 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 were available for West Berkshire in the form of a District Profile. This had been produced locally for a number of years and had provided a wealth of facts and figures that could also be used to guide commissioning of services within the district. There were considerable overlaps between the JSNA and the District Profile resulting in the decision to bring together these two key documents into a District Needs Assessment (DNA).

A strict version control process would be employed whereby each section of the DNA would be allocated to a designated data provider who would be responsible for the updating of information/data when it became available. The Research, Consultation and Performance team within West Berkshire Council would oversee this process, with updates being released on a quarterly basis and version control documentation logging the changes made and the version reference number.

A solution would be explored for presenting the key findings as part of a high level summary (e.g. info graphics). This would be accessible for a wider audience and would enable them to get an effective overview of the District, the needs of communities and gaps in services.

Cathy Winfield advised that it would be of benefit to CCGs to receive headline data in September as they began to prepare their budgets for the following financial year in the autumn. Lesley Wyman agreed that data could be provided to all partners in September.

Rachael Wardell posited that a key issue was that it was difficult to make visible the positive impact of public health programmes. For example, the quality of the delivery within schools of these programmes was clear however those Not in Employment, Education, or Training (NEET) were difficult to engage. The district had an advantaged population on the whole however, there was a need to 'close the gap' between the advantaged population and the less advantaged.

Lise Llewellyn commented that a disadvantage of the JSNA was that the data presented a negative slant on the population, whereas the DNA might be more positive.

Councillor Lynne Doherty questioned the timeliness of the data available, for example some figures cited that they referred to 2012/13 and others 2013/14. She asked that a note be included with data to advise whether it was the most current data available.

Lesley Wyman referred to the Public Health outcomes framework which did have a 'time-lag'. She advised that an advantage of the DNA would be that updated information would be immediately published. Information on what action was being taken by health partners to rectify concerning data trends could also be included.

Rachael Wardell commented that in the current financial climate there needed to be clear evidence of the ways in which public money affected outcomes. However the positive impact of some services might not be known until the funding and the programme was withdrawn.

Cathy Winfield drew attention to the information in the report that the rate of young people who smoked was increasing. She also noted the information on cancer trends, which indicated that West Berkshire was an outlier. Lesley Wyman added that the under 75 mortality rate was consistent and being monitored. Dr Lise Llewellyn commented that Public Health Berkshire had produced a cancer profile which was specific to each CCG area.

Councillor Graham Jones drew attention to the statistic on page 70 of the agenda which reported that two thirds of West Berkshire residents were overweight or obese. He identified a link between this figure and the information that 10% of NHS spending was for diabetes related illnesses. Councillor Jones was alarmed that such a proportion of the resource was targeted at treating this area of illness rather than preventative measures. Lesley Wyman agreed that obesity was the biggest challenge in public health and the Health and Wellbeing Board's next hot focus session would be on the topic.

Rachael Wardell stated that she would like to see a clearer distinction between obesity and being overweight, arguing that West Berkshire's rates of obesity were better than the national average. It was felt that focussing on those who were overweight might be counterproductive. Dr Lise Llewellyn agreed that the overall health of those who were overweight and active was better than those who were of a normal weight and inactive, however people with obesity would find it very hard to be active. Councillor Roger Croft remarked that if using Body Mass Index as an indicator, most rugby players (who were very active) would be considered to be technically obese.

Councillor Jones summarised that there was an increase in health issues associated with lifestyle issues.

59 Draft Strategy for Community Engagement (Dr Bal Bahia)

The Board considered a report (Agenda Item 12) concerning the Draft Strategy for Community Engagement. 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 strategy identified a vision, acknowledged the challenges faced by the HWB partners and a path towards working in partnership to achieve the strategic aims. There would be a joint meeting on 10 December 2015 to network and promote the strategy.

Rachael Wardell offered the view that the capacity and knowledge and skills of key individuals and organisations was core to achieving the outcomes in the strategy. The key challenge would be the financial pressures experienced by all healthcare partners as they absorbed the local proportion of the £30billion reduction in spending on healthcare. Public finance would be the main challenge to public health.

Lise Llewellyn, referring to a point about health inequalities on page 87 of the agenda, stated that as West Berkshire was affluent it could be easy to overlook deprived groups, however overcoming the health inequality which existing between those who were more and less affluent would be a focus of the engagement strategy.

Councillor Doherty commented that she was pleased with the aspiration of the strategy and that my identifying the differences between partner agencies, action could be taken to overcome these differences.

Councillor Croft commended the report and expressed that it was at risk of being process-led rather than outcome-led. Dr Bahia responded that the first steps would be to link in with partner agencies and then more focus could be applied to outcomes.

Lise Llewellyn noted the point regarding using technology to engage with communities. She agreed that social media was a resource that was not being utilised effectively by Public Health and there was still a level of expectation that people would attend a public meeting. Further consideration ought to be given to how technology could be utilised.

Jo Kransinski hoped that Healthwatch could become more involved in the engagement process once it was more established.

Councillor Jones summarised that the Board were satisfied to adopt the draft strategy.

RESOLVED that the Board noted the report.

60 Update from Healthwatch West Berkshire (Jo Karasinski)

Jo Karsinski introduced her report (Agenda Item 13), which aimed to inform the Health and Wellbeing Board on Healthwatch West Berkshire's activities and plans for the coming year.

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. No staff had been retained from the previous Healthwatch provider and therefore a transitional period of three months was agreed to establish a new Healthwatch West Berkshire. An interim manager was appointed to maintain a service and aid in recruiting a new team.

Two interim board meetings had 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 Healthwatch West Berkshire.

The Champions' Advisory Board had been appointed and was responsible for the elderly, homeless and children. The membership of this group currently stood at 12 active members and might expand if additional members were thought to improve the wider representation of the population.

Andrew Sharp was attending other Healthwatch meetings (Reading, Wokingham and Swindon) to help identify areas for joint working.

Jo Karasinski referred to the table of activities on page 97, which showed the various groups Healthwatch West Berkshire was visiting.

There was still work to take place around marketing Healthwatch West Berkshire and further work on this would be taking place imminently

Regarding the work plan and reporting a new custom built Healthwatch England CRM (Customer Relationship Management) system was being used and would aid reporting across a range of metrics.

Jo Karasinski concluded that activity was happening rapidly and a lot of work was taking place around recruiting volunteers and developing projects such as Healthwatch Youth.

Councillor Graham Jones asked if Healthwatch linked to the Patient Participation Panel and it was confirmed that it did. Jo Karasinski attended all panel meetings.

Cathy Winfield welcomed the joint working opportunities that were being sought particularly as many areas had providers in common. Jo Karasinski reported that they were learning a great deal from their peers in other areas.

RESOLVED that the Board noted the report.

61 Delivery Plan Performance Report (Lesley Wyman)

The Board considered the report (Agenda Item 14) 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 eleven priorities in the Health and Wellbeing Strategy.

The Health and Wellbeing Strategy had eleven 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.

Terms of reference for the Delivery Groups were sent out alongside a Delivery Plan template for each of the priorities and 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

Progress was varied across the priorities and where groups had already been in existence this had usually been beneficial. This had certainly been the case for the following:

- **Carers Strategy Group**
- **Mental Health Collaborative**
- **Healthy Lifestyles Network**
- **Newbury Dementia Action Alliance**

The Children and Young People's Group was being set up initially by the Head of Prevention and Community Resilience, West Berkshire Council. The first meeting was on 24 November 2015. The group would link into the existing School's Health and Wellbeing group. It was agreed by the Health and Wellbeing Board at an earlier meeting that the Children and Young People Delivery Group would address the three 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 had been discussions about the possibility of addressing children and young people's mental and emotional wellbeing through the Mental Health Collaborative, however this had not been completely agreed and was still under consideration.

Since there had been such a diverse response to the setting up of Delivery Groups and the development of Delivery Plans it was 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.

Cathy Winfield stated that there was not the organisational capacity to support lots of new groups and recommended that existing groups were captured.

Lesley Wyman posed to the Board how these groups should be required to feedback progress.

Jo Karsinsksi advised that she had asked to join the Dementia Group in her capacity as the Healthwatch representative and enquired upon how effective this group was.

Leila Ferguson requested that Empowering West Berkshire be involved in these groups as there was huge variety in their voluntary sector prospectus.

Rachael Wardell, in her capacity as Director of Children's Services and of Adult Social Services observed that there was not sufficient visibility of children's issues. She was pleased to see the creation of a children and young people group as she did not think that children's' issues should be sidelined. It was however the intention that the Delivery Groups would supply only exception reports to the Board. Councillor Mollie Lock agreed that children's issues should be prioritised.

62 Emotional Health Tier 2 design proposals (Andrea King/Sally Murray)

Andrea King introduced her report (Agenda Item 15) to the Health and Wellbeing Board which aimed to update them on the Building Community Together emotional health re-design proposals for children and young people's emotional health services. It also aimed to inform the Board that the West Berkshire Transformation Plan for emotional health services submitted to the Department of Health (DH) on Friday 16th October, included explicit commitment to the creating of the Emotional Health Academy in West Berkshire.

Andrea King highlighted that approval was being sought from the Board retrospectively for the strategic commitments to improving child and adolescent mental health support in the West Berkshire Transformation Plan.

Andrea King reported that the local Transformation Plan ensured that children and young people with emotional needs were reached earlier. The provision of a Transformation Plan was a requirement by the DH and there had been a very tight timescale provided.

An away day had taken place in July, which had brought together partner agencies to do the design work. A local design had been based on the Brilliant West Berkshire initiative and incorporated an Emotional Health Academy, which would poses the role of delivering sustainable changes to improve the emotional health and wellbeing of children and young people in West Berkshire.

The Academy would be unique to West Berkshire and would focus on Tier Two Child and Adolescent Mental Health Services (CAMHS). Many children were waiting half a year for services to the aim was to get services to these children more efficiently.

Tier Three CAMHS would also be increased an a recruitment drive was planned for January 2016.

The Academy model would be launched in April 2016 and Andrea King gave thanks to headteachers who had provided funding for the initiative. Rachael Wardell expressed her support for the Academy and investment in CAMHS Tier Two and Three services. She commended the Transformation Plan, which had been well received.

Dr Lise Llewellyn was unclear about some of the content within the appendices and queried if the cost of the Academy would be covered by the Transformation Fund. Andrea King reported that the Academy would be funded by the Local Authority and partner contributions. £120k would be provided by West Berkshire Council, then headteachers would match fund this amount approximately. CCG colleagues had advised that a bid should be submitted for £100k. The scale of the Academy would depend on how much funding was received. It was confirmed that whichever model was adopted, it had to be sustainable.

Councillor Mollie Lock queried if all schools had to comply with the initiative or if they could opt in or out. Andrea King confirmed that schools could opt in or out and that there was sliding scale from small schools.

RESOLVED that the Health and Wellbeing Board approved in retrospect, the strategic commitments to improving child and adolescent mental health support in the West Berkshire Transformation Plan, subject to further funding information being provided.

63 Members' Question(s)

64 Question submitted by Councillor Adrian Edwards

A question standing in the name of Councillor Adrian Edwards on the subject of whether the West Berkshire Health and Wellbeing Board would consider appointing a senior executive from the Berkshire Healthcare NHS Foundation Trust, was answered by the Chairman of the Health and Wellbeing Board.

A supplementary question standing in the name of Councillor Adrian Edwards on the subject on whether the Health and Wellbeing Board would accept a presentation in the future from Berkshire Healthcare NHS Foundation, was answered by the Chairman of the Health and Wellbeing Board.

65 Seasonal Influenza Campaign 2015-16

The report was noted by the Health and Wellbeing Board.

66 Future meeting dates

It was confirmed that the next meeting of the Health and Wellbeing Board would take place on the 28th January 2016.

(The meeting commenced at 9.00 am and closed at 10.50 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?
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)						
1st - 4th March - Berkshire West Health and Wellbeing Peer Challenge						
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	24th 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	24th 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	24th February	Tandra Forster/Shairoz Claridge	Health and Wellbeing Management Group	Part I
Better Care Guidance for 2016 and the process for 2016/17	To inform the Board of the new guidance for 2016.	For information and discussion	24th February	Cathy Winfield/Shairoz Claridge)	Health and Wellbeing Management Group	Part I
Health and Wellbeing Strategy / Joint Strategic Needs Assessment						
Joint Strategic Needs Assessment and the District Needs Assessment	To present a snapshot of the JSNA, which includes any changes the Board needs to be aware of.	For information and discussion	24th February	Lesley Wyman	Health and Wellbeing Management Group	Part I
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	24th February	Lesley Wyman/TBC	Health and Wellbeing Management Group	Part I
Other Issues for discussion						
Recruitment and workforce issues	To inform the Board about recruitment/workforce issues being faced by Health and Social Care.	For information and discussion	24th February	Tandra Forster /Shairoz Claridge	Health and Wellbeing Management Group	Part I
Community Engagement Event and Engagement Strategy	To update the Board on the community engagement event with the voluntary sector that took place in December; to present the Community Engagement Strategy and inform the Board about plans for joined up communications with the voluntary sector	For information and discussion	24th February	Dr Bal Bahia	Health and Wellbeing Management Group	Part I
End of Life Care	tbc	For information and discussion	24th February	Dr Jane Baywater	Health and Wellbeing Management Group	Part I
Beat the Street Programme	To inform the Board on outcomes as a reusl tof the programme,	For information and discussion	24th February	Maureen McCartney	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	24th February	Tandra Forster	Health and Wellbeing Management Group	Part I
Other information not for discussion						
Learning Disabilities	To inform the Board on work taking place in this area.	For information and discussion	24th February	Patrick Leavey	Health and Wellbeing Management Group	Part I
28th April 2016 - half day hot focus session - Obesity (Shaw House)						
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	27th April	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	27th April	Tandra Forster/Shairoz Claridge	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	27th April	Lesley Wyman	Health and Wellbeing Management Group	Part I
23rd June 2016 - half day hot focus session, topic tbc (Shaw House)						
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	8th 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	8th June	Tandra Forster/Shairoz Claridge	Health and Wellbeing Management Group	Part I
Health and Wellbeing Strategy / Joint Strategic Needs Assessment						

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?
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/four months.	For information and discussion	8th June	Mac Heath/Sally Murray/Andrea King	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	8th June	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	8th June	Nick Carter/Graham Jones	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	31st August	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	31st August	Tandra Forster/Shairoz Claridge	Health and Wellbeing Management Group	Part I
Health and Wellbeing Strategy / Joint Strategic Needs Assessment						
Feedback on the Health and Wellbeing Strategy Hot Focus : Obesity	To feedback on activity that has taken place over the last three months.	For information and discussion	31st August	TBC	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	31st August	Lesley Wyman	Health and Wellbeing Management Group	Part I
20th October - half day hot focus session, topic tbc (Council Chamber)						
24th November 2016						
Items for Discussion						
System Resilience						
Health and Social Care Dashboard	To present the Dashboard and highlight any emerging issues	For information and discussion	26th October	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	26th October	Tandra Forster/Shairoz Claridge	Health and Wellbeing Management Group	Part I
Health and Wellbeing Strategy / Joint Strategic Needs Assessment						
Feedback on the Health and Wellbeing Strategy Hot Focus: TBC	To feedback on activity that has taken place over the last three /fourmonths.	For information and discussion	26th October	TBC	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	26th October	Lesley Wyman	Health and Wellbeing Management Group	Part I

RefNo	Meeting	Action	Action Lead	Agency	Agenda item	Comment
70	26-Nov-15	Councillor Hilary Cole queried the cost of the internal audit being carried out at the CCG by Price Waterhouse Cooper. This would be reported back to Councillor Cole.	Shairoz Clardige	CCG	BCF Update	Shairoz Claridge to contact Councillor Cole.
71		It was requested that the next Hot Focus Session be on Obesity.	Lesley Wyman	WBC	JSNA and DNA	Placed on forward plan for the 28th April 2016.
72		The Health & Well-Being Board approved in retrospect, the strategic commitments to improving child and adolescent mental health support in the West Berkshire Transformation Plan subject to further funding information being provided.	Andrea King	WBC	Emotional Health Tier 2 design proposals	This information has been sent to Board Members.

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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%	↓	**88% November**	Small cohort - prone to fluctuations *Awaiting further narrative from ASC*
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	↓	**395 November**	*Awaiting narrative from ASC*
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	↑	**71% November**	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. Although we are seeing an improved position we are planning on some additional capacity so that we meet the March 16 deadline.

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 remained 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 significantly 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 against 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 against 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	2014/15 Benchmark	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%	↓	**95% October**	Throughout Q2, 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 throughout quarter 3.
		Hampshire Hospitals NHS Foundation Trust				↓	**89% October**	The lead commissioners for these contracts are working with providers to improve the position through their system resilience programmes. HHFT A&E Remedial Action Plan not yet finalised. CCGs continue to work with the Trust to agree plan and trajectories to sustain performance at 95%. In line with the contractual process, CCGs are to withhold 2% of the contract value (from Dec 15 onwards).
		Great Western Hospitals NHS Foundation Trust				↓	**93.3% October**	The lead commissioners for these contracts are working with providers to improve the position through their system resilience programmes. The CCG has piloted a project to support urgent "on the day" demand and after successful pilot in 2014/15, the project has been extended to a larger scale in 2015/2016 to support on the day demand across primary care and divert activity away from A&E. The service is an extension to the OOHs provision and Standard operating procedures have developed links between both services. There will be three additional urgent care centres started running in November 2015. This includes provision for two children's urgent appointment clinics. There will also be a pilot extension offered for GP surgeries to be funded for collaborative geographic clinics across Swindon to have weekend appointments. Urgent home visiting capacity to see patients who can not attend the surgery (but without which hospital attendance would be necessary) has double the capacity, an additional potential 12 visits across Swindon per day.
AS2	Average number of Delayed Transfers of Care (all delays) per 100,000 population (18+)	Berkshire Healthcare NHS Foundation Trust	Monthly			↑	**0.6 Q2**	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. Implementation of the Joint Care Provider and 7 day working means that we are getting in earlier and no delays are as a result of a social care assessment. Performance with the RBH remains strong and we have seen improvements with the Community Hospital. The main challenges remain with our other hospitals, in particular North Hants, and the primary reasons are lack of capacity in both homecare and nursing/residential. We are working with both the Contracts and re-ablement team to look at other options but there are no quick solutions. We are also setting up a meeting with North Hants to look at the discharge process.
		Great Western Hospitals NHS Foundation Trust				↑	**3.1 Q2**	
		Hampshire Hospitals NHS Foundation Trust				↓	**3.1 Q2**	
		Oxford University Hospitals NHS Trust				↔	**0.3 Q2**	
		Royal Berks NHS Foundation Trust				↑	**2.4 Q2**	
		Total West Berkshire		14.7 (2012/2013 data)		↑	**9.4 Q2**	

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			↑	**0.6 Q2**	(As above)
		Great Western Hospitals NHS Foundation Trust				↑	**0.8 Q2**	
		Hampshire Hospitals NHS Foundation Trust				↓	**2.5 Q2**	
		Oxford University Hospitals NHS Trust				↔	**0.0 Q2**	
		Royal Berks NHS Foundation Trust				↑	**0.7 Q2**	
		Total West Berkshire			4	↑	**4.6 Q2**	
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 October**	The urgent care operational team and locally with the local authority are working to improve the systems flow and therefore resilience, including the introduction of the integrated discharge team at Royal Berkshire Hospital and care coordinators in the community wards at West Berkshire Community Hospital (WBCH) to focus on admissions and discharge arrangements. A weekly review of the community hospital delays has been introduced as part of the systems resilience calls in October, and the joint care provider pathway was implemented in November 2015 for WBCH
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%	↑	**75% October**	The ambulance service contract requires the national performance standards for ambulance response times to be achieved on a Thames Valley basis annually. The 2015/16 contract also includes performance standards for each of the CCGs to improve the variation from CCG to CCG. The national standard for the Red 1 and Red 2 8 minute response time is 75% and the Newbury & District CCG standard for these standards is 70%. During September neither the Thames Valley wide nor CCG level standards were achieved. Performance in September at Thames Valley level deteriorated in Red 1 calls, and improved for Red 2 and Red 19 calls. The remedial action plan has been agreed with SCAS as a result of the contract performance notice and this forecasts recovery in performance from March onwards. The Trust has started the National Ambulance Response Programme (NARP) pilot in October which allows SCAS more time to assess Red 2 calls before dispatching an ambulance which should result in emergency ambulances only being dispatched to the most appropriate calls. Following a month of the pilot, SCAS will review the impact on performance and re-profile the trajectory as necessary.
AS6	A&E Attendances	Royal Berkshire Foundation Trust for Berkshire West	Monthly	1256 average monthly figure from 13/14		↓	**1262 October**	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		↑	**375 October**	
		Great Western Hospital for Berkshire West	Monthly	168 average monthly figure from 13/14		↑	**182 October**	
AS7	Number of non elective admissions	Royal Berkshire Foundation Trust for West Berkshire	Monthly	547 average monthly figure from 13/14		↓	**695 October**	Q2 activity has shown an increase in NELs. Some of the QIPPs were not delivering or have been reconfigured (e.g. H@H). There has been a change in recording of NELs at RBFT (especially due to new observation ward), potentially an increase in acuity and patient need
		Hampshire Hospital Foundation Trust for West Berkshire		157 average monthly figure from 13/14		↑	**164 October**	
		Great Western Hospital for West Berkshire		84 average monthly figure from 13/14		↓	**104 October**	
AS8	Total number of 111 calls (Answered in 60 seconds)	Berkshire wide	Monthly		No Target	↑	**16,765 October**	Please note: There has been a change in the way this data is reported in that a monthly report is now received rather than on a weekly basis. Data has been back dated accordingly. During October, 93.5% of 111 calls were answered within 60 seconds across Berkshire against a target of 95%. The YTD performance remains above standard at 95.9%. SCAS has reported that the performance dip was due to scheduling/ rota challenges as they were realigning the service to meet the latest demand profiles. In addition, SCAS plan their schedules to be responsive to the hour change, (as the 'call surge' times change) however this year the surges did not match the pattern expected and therefore SCAS realised a dip in performance. The analytical and rostering team continue to review the demand patterns on a daily basis to correct the deficit.

Primary Care								
Ref.	**Indicator**	**Basis**	**Frequency**	**Baseline data**	**2015/16 Target**	**Positive or negative trend (see key)**	**Latest data**	**Narrative**
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**	**Baseline data**	**2015/16 Target**	**Positive or negative trend (see key)**	**Latest data**	**Narrative**
CS1	Mental Health - Crisis response % of responses with 4 hours	Berkshire West	Quarterly		90%	↔	**100% Q2**	Q1 and Q2 data has shown a consistently high achievement of this indicator

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. Please note: There has been a change in the way this data is reported in that a montly report is now recieved rather than on a weekly basis. Data has been back dated accordingly.

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:	**Primary Care Strategy**
Report to be considered by:	The Health and Wellbeing Board
Date of Meeting:	28th January 2016

Purpose of Report: **The Health and Wellbeing Board is asked to note and endorse the Berkshire West Primary Care Strategy.**

Recommended Action: **To note**

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

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

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

Health and Wellbeing Board Chairman details	
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Executive Report

1.1 This report follows previous Health and Wellbeing Board reports on the development of the Berkshire West Primary Care Strategy. Following further engagement with the public, this strategy has now been signed off by the Joint Primary Care Co-Commissioning Committee on which the Health and Wellbeing Board is represented. The wider Health and Wellbeing Board are now asked to endorse the principles set out in the strategy, a copy of which is included with this paper.

1.2 We will also be publishing an engagement report which will describe how the strategy has been informed by extensive discussion with patients through public meetings, dissemination of information about our vision and online consultation. It is intended that this initial engagement now develops into an ongoing dialogue with the public regarding specific projects and initiatives as we move towards implementation. Should specific changes to individual practices be proposed the CCGs will ensure that practices fulfil their responsibility to consult with their registered patients.

1.3 The CCGs would also like to highlight that we have applied to move to a fully-delegated co-commissioning arrangement with effect from 1st April 2016. We believe that this will have a positive impact on the development of local primary care services, putting us in a stronger position to implement the vision described in the strategy.

Equalities

2.1 Equality Impact Assessments will be carried out as appropriate for all decisions made under co-commissioning arrangements and in respect of any service changes proposed as a result of the implementation of the Primary Care Strategy.

Appendices

Appendix A - See attached Primary Care Strategy

NHS Wokingham Clinical Commissioning Group

NHS South Reading Clinical Commissioning Group

NHS North and West Reading Clinical Commissioning Group

NHS Newbury and District Clinical Commissioning Group

Berkshire West Primary Care Strategy

2015 – 2019

1. Introduction

The Berkshire West CCGs' 5 Year Strategic Plan describes how, by 2019, enhanced primary, community and social care services in Berkshire West will work together to prevent ill-health within our local populations and support patients with complex needs to receive the care they need in the community, only being admitted to hospital where this is absolutely necessary.

The overriding aims of our overarching Berkshire West CCGs plan which underpin this strategy are:

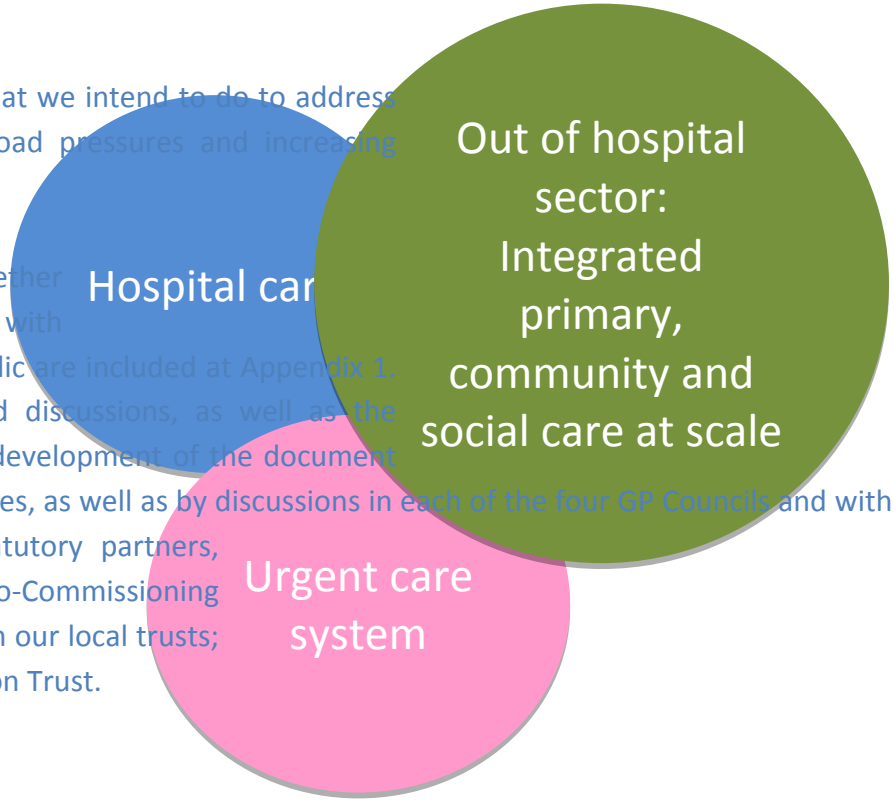
- Placing a greater emphasis on prevention and putting patients in control of their own care planning.
- Moving away from disease specific services to the commissioning of person centred care.
- Implementation of new models of care which support better integration, and which expand and strengthen primary and out of hospital care.
- Development of new payments mechanisms which incentivise the delivery of outcome focused care and which support the future sustainability of the local system.
- Commissioning highly responsive services urgent care services which ensure patients get the right care at the time in the right place.
- Better use of technology and innovation to achieve better outcomes for patients and improved demand management.
- Achieving parity of esteem for people with mental health problems and learning disabilities.

The Berkshire West local health economy is innovative and high performing, benchmarking well on key measures such as non-elective admission rates and prescribing. However it is recognised that the system faces significant operational, clinical and financial challenges to sustainability going forward. The CCGs are therefore working with partners to define a new model of care reflecting the triple aims of the *NHS Five Year Forward View* which are to increase the emphasis on primary prevention, health and wellbeing, to improve the quality of care by improving outcomes and experience for patients and achieving constitutional standards, and to deliver best value for the taxpayer by operating a financially sustainable system. There is an emerging consensus locally that a clinically and financially sustainable health economy can best be delivered through the creation of an Accountable Care System (ACS), bringing together commissioners and providers to assess population need, determine priorities,

redesign services, agree and measure outcomes and allocate resources along care pathways and in such a way as to incentivise all organisations to work towards the same goals. Such a system would ultimately function on the basis of a place-based capitated budget incorporating all aspects of healthcare including primary medical services with providers and commissioners jointly incentivised to deliver specified outcomes in a cost-effective way.

This Strategy builds upon the CCGs' overarching Strategic Plan to describe a detailed vision for primary care services in Berkshire West; anticipating that primary care will play a pivotal role in delivering new models of care and in ensuring the sustainability of the broader health and social care system in the light of increasing demand and financial pressures.

To ensure primary care is able to function in this way, this Strategy also describes what we intend to do to address the current challenges facing the sector including financial issues, growing workload pressures and increasing challenges in recruiting and retaining GPs and other key healthcare professionals.



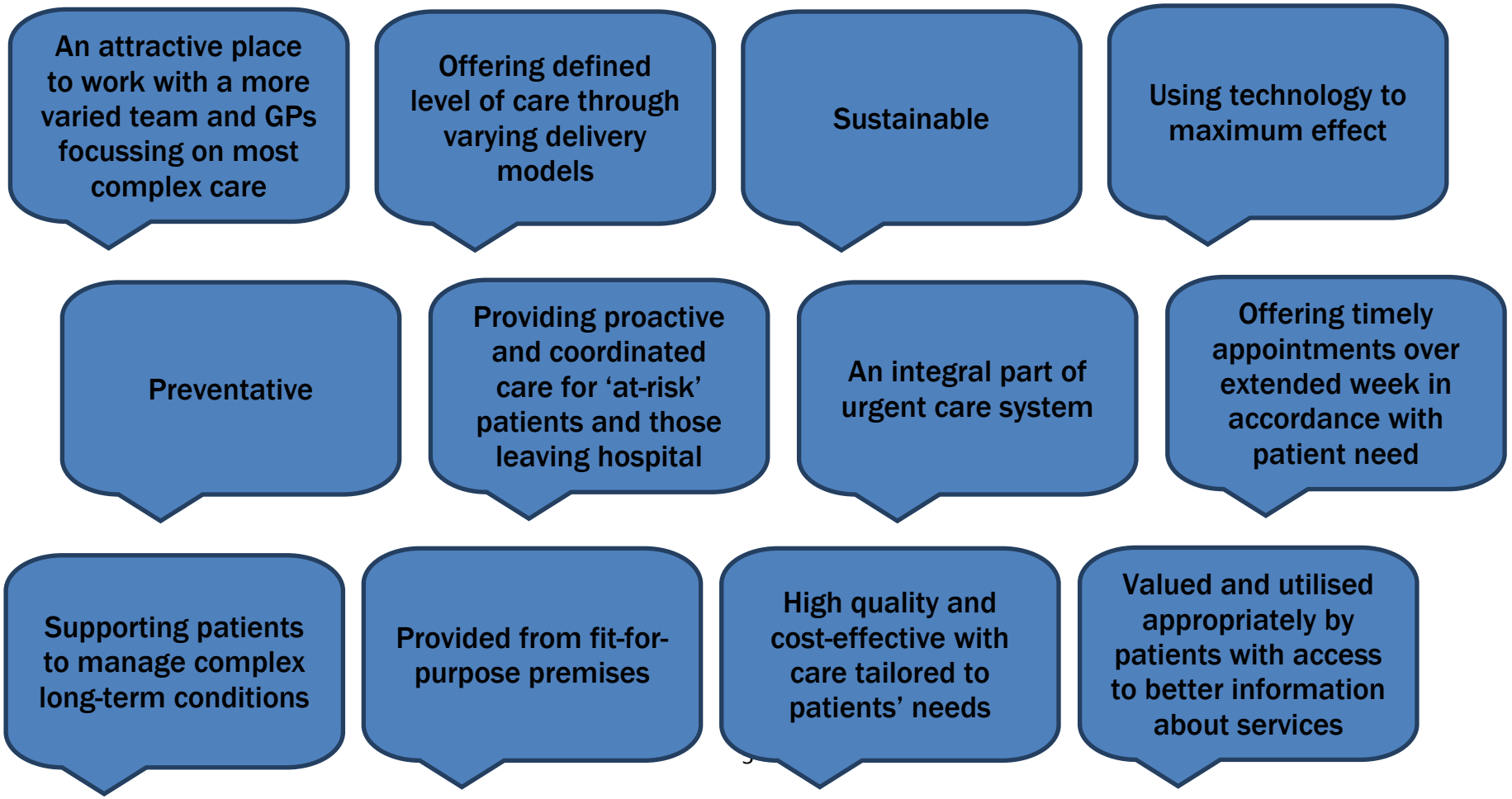
The Strategy has been jointly developed by the four Berkshire West CCGs, working together with NHS England as the statutory commissioners of primary care services, and with patients and members of the public. Further details of our engagement with the public are included at Appendix 1. This has included a combination of online surveys, public meetings and targeted discussions, as well as the publication of a summary version of this strategy aimed at a patient audience. The development of the document was also guided by a Task and Finish Group including GPs, Practice Managers and Nurses, as well as by discussions in each of the four GP Councils and with the four Governing Bodies. We have also discussed the Strategy with our statutory partners, Healthwatch and the Local Medical Committee through our Joint Primary Care Co-Commissioning Committee (JPCCC) and Health and Wellbeing Board meetings, and have shared it with our local trusts; the Royal Berkshire NHS Foundation Trust and the Berkshire Healthcare NHS Foundation Trust.

At this stage the Strategy focuses on primary medical services, and to a lesser extent on community pharmacy, but the opportunities and importance of integrated working with other community services is also a key theme.

Implementation of the Strategy will be overseen by the Joint Primary Care Co-Commissioning Committee (JPCCC), linking with the CCGs' other Programme Boards as appropriate. The Terms of Reference for the Joint Primary Care Co-Commissioning Committee are available at http://www.wokinghamccg.nhs.uk/joint-primary-care-co-commissioning-committee.

2. Our Vision for Primary Care

By 2019, primary care in Berkshire West will be:



3. The Case for Change

There are currently 53 GP practices in Berkshire West, providing care to approximately 520,000 patients from 75 surgeries. For 2015-16, the total budget for general practice services in Berkshire West was £66.9m, made up of £61.2m NHS England funding for contractual payments including QOF and enhanced services, and £5.7mm invested by the CCGs in community enhanced services including Admissions Avoidance (care planning for Over 75s), support to care homes, early identification of diabetes and extended hours.

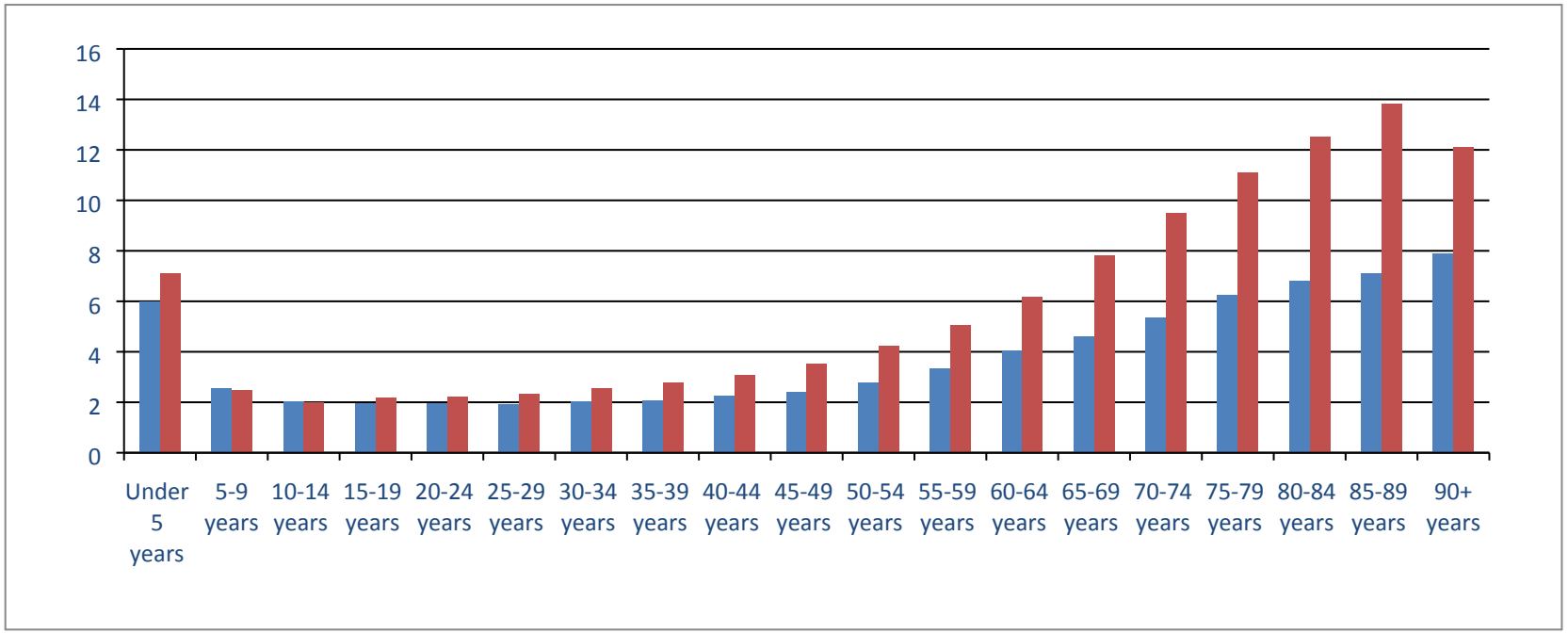
All practices in Wokingham CCG and all but one in Newbury and District CCG hold GMS contracts. In North and West Reading and South Reading CCGs, the majority of practices hold PMS contracts. There are currently four APMS contracts in place in Berkshire West, one of which includes a Walk-in Centre component and two of which are one-year interim contracts held by Berkshire Healthcare NHS Foundation Trust (BHFT). The Walk-in Centre contract will be re-procured during 2016-17 whilst the other three APMS contracts are currently being re-procured with the intention of new contracts commencing from July 2016.

The quality of primary care provision in Berkshire West is generally high. Average QOF achievement exceeded the England average for three of the four CCGs and was also above average in 11 practices in the remaining CCG. The Primary Care Web Tool collates key primary care quality data such as QOF achievement and prevalence, prescribing, screening and immunisation uptake rates, A&E attendances, non-elective admissions for patients with long-term conditions and National Patient Survey results. Practices that are outliers on more than six indicators are identified as requiring further investigation to understand the reasons behind this. No Berkshire West practices are in this group although some are outliers on a smaller number of indicators. There is also some local variation between practices serving similar populations which needs to be understood and addressed as appropriate. 25 practices have so far been visited by the Care Quality Commission (CQC) of which 61% have been rated as good or outstanding. Where practices have been rated as 'Requires Improvement' many of the issues identified have been procedural matters which have been relatively easy to address. A small number of local practices have been placed in special measures in recent months and the CCGs and NHS England have worked closely with the practices on Quality

Improvement Plans which are proving successful in addressing the issues identified. Going forward the CCGs are now working to support all practices to better understand the CQC requirements and inspection process.

Out-of-Hours services are provided by Westcall (part of the Berkshire Healthcare NHS Foundation Trust). Westcall is recognised as being a high quality provider of out-of-hours care and is staffed to a large extent by local GPs. This knowledge of local services and care pathways, together with access to patient records through the Medical Interoperability Gateway and to care plans via Adastra, ensures that the service is able to work effectively to meet urgent care needs and avoid unnecessary admissions to hospital during the out-of-hours period.

It is becoming increasingly evident that pressures affecting the wider UK primary care system are starting to impact upon Berkshire West practices. The national increase in consultation rates, reflecting an ageing population increasingly suffering from one or more long-term conditions (see Figure 1, below), is being replicated in Berkshire West where over the 2014-15 Winter period, practices reported a 25% increase in consultation rates when compared with the previous year. We are undertaking further work locally to understand levels of capacity and demand in primary care which will inform our future commissioning decisions.



Changes in consultation rates 1995-2008 (HSCIC)

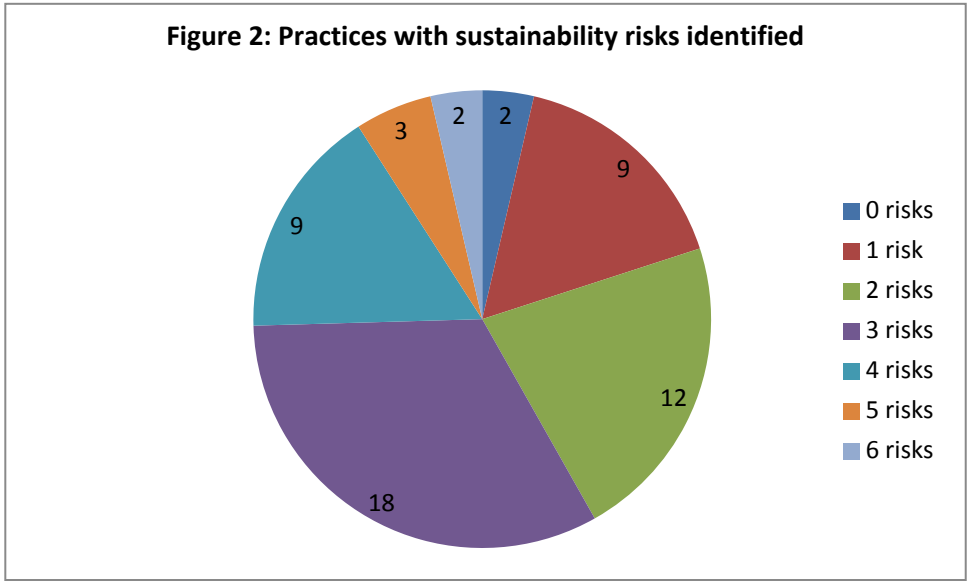
A further pressure relates to GP recruitment and retention. The Royal College of General Practitioners (RCGP) reports that the number of unfilled GP posts has quadrupled in the last three years and that applications to undertake GP training have dropped by 15%.[1] The Nuffield Trust reports that a third of GPs aged under 50 are considering leaving the profession in the next five years due to workload pressures.[2] There is an increasing trend towards part-time posts with 12% of general practice trainees now working in this way, and towards salaried employment with just 66% of GPs now working as partners compared to 79% in 2006.[i] 27 of the 55 Berkshire West practices have indicated that they are currently experiencing issues with recruiting GPs and other

[1] http://www.rcgp.org.uk/news/2014/october/over-500-surgeries-at-risk-of-closure-as-gp-workforce-crisis-deepens.aspx
[2] *Is Primary Care in Crisis?,* The Nuffield Trust, November 2014

clinical staff and with a high proportion of Berkshire West GPs and Practice Nurses aged over 50 these issues are expected to become more acute over time.

Patients have told us that they are generally happy with the standard of care provided but would like services to be better co-ordinated so that they only have to 'tell their story once'. Around 60% of patients say that current surgery opening times meet their needs. Where weekend access is provided the preference is for Saturdays mornings. Waiting times for appointments and continuity of care are frequent concerns but people are increasingly willing to consider alternative access models such as speaking to GPs over the telephone or seeing different members of the practice team such as pharmacists or physicians' associates. There is also consistent across all age groups feedback that people want to interact with their surgery online although some indicate that they would need help to register for online services. Patients would welcome being supported to take a greater role in their care and also believe that primary care could work more effectively with other organisations including in the voluntary sector to promote health and wellbeing. Further information about the priorities identified through patient engagement, together with details of how these are reflected in the Strategy are included in Appendix 1.

The CCGs recently undertook a 'risk mapping' exercise aiming to assess the stability of the CCGs' GP practices in order to work with them proactively to address risks and avoid potential contract failures. In addition to recruitment and retention and workload pressures associated with serving a deprived or growing population, this took into account CQC risk ratings, practice size, condition of premises and the potential financial impact of contractual changes. Eight measures were considered in total and Figure 2 summarises the level of 'sustainability risks' identified. This data is now being triangulated with quantitative data from other sources such as the national Primary Care Web tool, other CCG reporting tools and demographic information to establish a dashboard of quality and risk relating to primary care contracts.



The remainder of this document describes the strategic objectives and key workstreams which will enable us to realise our vision for primary care.

4. Strategic objectives

In order to deliver our vision, we have set the following five strategic objectives for primary care:

- Addressing current pressures and creating a sustainable primary care sector.
- Interfacing in new ways with specialisms historically provided in secondary care to manage increasingly complex chronic disease in a community setting.
- Managing the health of a population by working in partnership with others to prevent ill-health. Acting as accountable clinicians for the Over 75s and other high risk patients and co-ordinating an increasingly complex team of people working in primary, community and social care to support patients at home.
- Using new approaches and technologies to improve access and patient experience, ensuring that the needs of patients requiring urgent primary care are met appropriately and appointments are available in the evenings and at weekends.
- Making effective referrals to other services when patients will most benefit.

The following sections describe in more detail the models of care that we intend to develop in relation to each of these strategic objectives or 'asks' of primary care. In delivering these models, we will also address other aspects of our vision, such as ensuring that primary care in Berkshire West is sustainable, cost-effective and an attractive place to work, and that patients value the services provided and are supported to access them appropriately.

- **Strategic Objective 1: Addressing current pressures and creating a sustainable primary care sector.**

Innovative solutions will be employed to address the challenges currently facing the primary care sector. We will work to address the current workforce crisis at all levels; improving pre-registration training provision, building job satisfaction through more rewarding continuing professional development processes and working to improve retention of mid-career GPs and others by working with practices to offer more varied and flexible employment opportunities. We will also look to maximise the potential of new roles in primary care including Physicians' Associates, practice-based pharmacists and enhanced administrative and care co-ordination roles. Alongside this we will work to enable practices to respond to demand in new ways (see Strategic Objective 3) and to ensure that the expansion of the role of primary care is accompanied by an increase in primary care investment (see Strategic Objective 2).

Digital systems are the foundation upon which we will build a modern, efficient and responsive primary care sector. Enabling information to flow between care providers within and beyond organisational boundaries, and between care providers and patients, is a key means by which we will achieve a sustainable primary care sector. GP IT systems sit at the heart of primary care technology facilitating and recording thousands of interactions with patients every week. GP practices have led the way in the move from paper to digital record-keeping and recently begun offering online transactions, such as appointment bookings, repeat prescriptions, and online access for patient to their GP- held records.

In a challenging financial environment, IT services must not only improve the quality of care through enhancing the patients' experience of services, but also enable the practice to realise efficiency benefits and reduce administrative burden. Building on the solid foundations which are already in place in primary care, our vision is to support practices to develop IT functionality which responds to the evolving needs of patients and underpins integration across care pathways.

It is our view that addressing workforce challenges, capitalising on IT developments and providing the models of care set out under the following strategic objectives will require primary care providers to operate at scale. Single-handed and small practices are unlikely to be able to provide the range and breadth of services described, or to manage the communication and relationships required to operate as part of a truly integrated system. Similarly, investment in IT and premises infrastructure is only likely to be cost effective where it serves a large patient population. There is evidence that encouraging the emergence of larger providers is likely to result in sustainable provision and improved outcomes for patients going forward.[3] Our intention is therefore to make commissioning and investment decisions that support the development of providers with at least 6,000 registered patients, and ideally 10,000 or more and to support collaborative working between practices through federations, networks and joint provider organisations.

- **Strategic Objective 2: Interfacing in new ways with specialisms historically provided in secondary care to manage increasingly complex chronic disease in a community setting**

Existing community-based care pathways, such as that developed for diabetes, will form the starting point for expanding similar models to other specialties. Virtual outpatient clinics and community-based consultants will become the norm and technology will be used to maximum effect to support self-care and timely liaison between clinicians working in primary and secondary care. Where additional services are commissioned from primary care, the associated investment must follow.

The implications of providing a greater range of services in primary care must be fully factored in to all levels of workforce and premises planning. Larger primary care providers will be better placed to take on expanded roles, and in any case collaboration will be required so that specialists can interface across practices.

[3] *Securing the future of general practice: new models of primary care,* Nuffield Trust and the King's Fund (2013)
Primary Care: Today and tomorrow – Improving general practice by working differently, Deloitte Centre for Health Solutions (2012)
Breaking Boundaries – a manifesto for primary care, NHS Alliance (2013)
Primary Care for the 21st Century, Nuffield Trust (2012)
Does GP practice size matter?, Institute of Fiscal Studies (2014)

- **Strategic Objective 3: Managing the health of a population by working in partnership with others to prevent ill-health. Acting as accountable clinicians for the Over 75s and other high risk patients and co-ordinating an increasingly complex team of people working in primary, community and social care to support patients at home.**

Primary care will take a more active role in working to improve the health of the population it serves. Practices will provide more primary and secondary prevention services, linking extensively with public health, the voluntary sector and other community organisations to prevent ill-health and promote wellbeing.

Primary care should work as part of the broader health and social care system to avoid patients going into crisis and requiring emergency admission and to support effective discharge from hospital. Proactive care planning for patients with complex needs who may be at risk of admission, including those in care homes, will be further developed to become a core element of primary care provision. A multidisciplinary approach will be taken, with technological solutions supporting the sharing of care plans so that patients only have to 'tell their story' once and different organisations can work together in a co-ordinated way to meet their needs.

Supporting the broader health and social care system will be our programme for information sharing and connecting the health and social care system - "Connected Care". This has already commenced with the introduction of static interoperability, between practices and Out of Hours primary care, and through a proof of concept testing process connecting GP practices with secondary care. Over the next 18 months all practices will join a wider dynamic programme connecting, practice systems with acute, community and social care systems.

- **Strategic Objective 4: Using new approaches and technologies to improve access and patient experience, ensuring that the needs of patients requiring urgent primary care are met appropriately and appointments are available in the evenings and at weekends.**

New technology will enable practices to respond to demand in different ways such as through greater use of the telephone, online consultations and email advice systems (with safeguards in place to ensure these systems are used appropriately), as well as technology enhanced mobile working. Patients

will be supported to self-care where appropriate and to access the right services at the right time. Community pharmacy may also play a greater role in providing advice, guidance and treatment to patients.

The CCGs will encourage practices, especially smaller ones, to work together to respond to same day requests for appointments in a different way, thereby freeing up time for staff to focus on planning care for at-risk patients and on managing long-term conditions. The potential for NHS 111 to take an enhanced role in managing same day demand will be explored through the forthcoming Thames Valley procurement of an Integrated Urgent Care Service. . This service will work with GP practices, out-of-hours, the Walk-in Centre, A&E and other services to meet the needs of people with urgent care needs in accordance with the *Safer, Faster, Better* guidance.[4]

We will continue to commission extended hours primary care provision, reflecting NHS England planning guidance. Currently we are focussing on improving patient experience through bookable appointments to be provided across an extended weekday and at weekends by single providers or through collaborative models. Additional capacity will also continue to be commissioned at peak times in-hours over the Winter period thereby working to reduce demand on other services, particularly A&E.

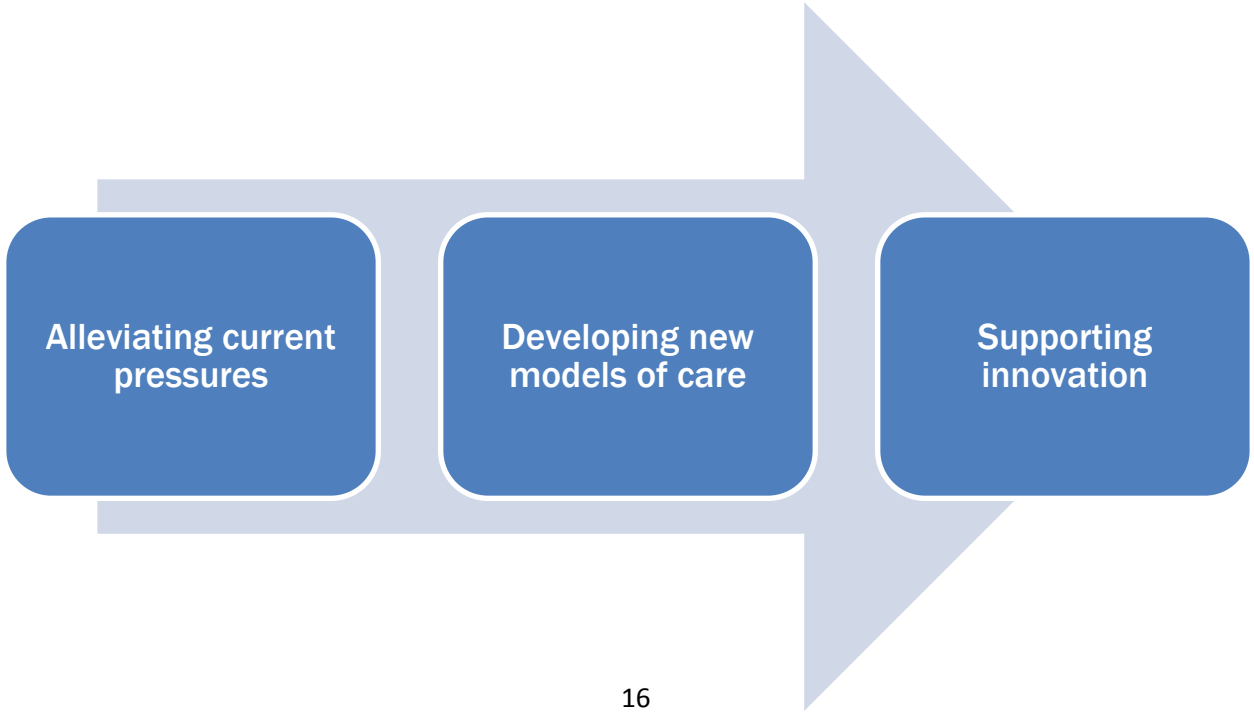
- **Strategic Objective 5: Making effective referrals to other services when patients will most benefit**

The CCGs will work with practices through peer review and closer liaison with secondary care colleagues to reduce unexplained variation in levels of referral between practices and individual clinicians, thereby ensuring that patients are referred to the services that will most benefit them and at the most appropriate stage of their treatment. Support to referrals will be strengthened through the further development of the DXS system which works as an integral part of practice clinical IT systems, providing a directory of services and detailed information on agreed care pathways and local referral criteria.

[4] *Safer, Faster, Better: good practice in delivering urgent and emergency care,* NHS England, 2015, www.england.nhs.uk/wp-content/uploads/2015/06/trans-uec.pdf

5. Our Strategic Approach

The previous sections have highlighted that there is a real opportunity to build upon the high standards of provision in Berkshire West to create an expanded primary care sector as described in our Strategic Plan, but also a risk that this may be stifled by the pressures currently facing general practice. This strategy therefore takes a maturation approach whereby we will first look to support primary care providers to address the very real challenges they are facing, moving on to develop the new models of care described above, with a view to the primary care sector as a whole then being in a position to take a lead role in the new integrated model of care we envisage operating in Berkshire West by 2019. The outline workstreams and investment plan set out below span these three areas and will inform the development of a more detailed Implementation Plan. The following section also describes how co-commissioning arrangements agreed with NHS England will underpin the delivery of this Strategy.



a) Workstreams to deliver our Strategic Objectives

Strategic objective for primary care	Anticipated workstreams
1: Addressing current pressures and creating a sustainable primary care sector.	Four sets of inter-related workstreams will aim to achieve sustainability for the local primary care sector: Workforce: • Supporting new roles in primary care, e.g. Physicians' Associates, prescribing pharmacists, AHPs. • Development of generic primary care nurse role allowing greater flexibility around where care can be delivered. • Expansion of training provision and development of network of multi-professional training practices or training hubs. • Offering student nurse placements in primary care • Shared training programmes for existing staff including clearer career structures for e.g. practice nurses and administrative staff. Greater sharing of training with other providers / across disciplines. • Development of new roles around care planning and signposting e.g. care navigators, voluntary sector co-ordinators and enhanced case co-ordinator roles • Supporting collaborative approaches to recruitment and development of shared posts and portfolio careers. Shared locum arrangements. • More effective linking with HETV and other appropriate organisations around workforce planning and training provision. • More co-ordinated appraisal system and CPD arrangements including a structured programme to support nursing revalidation and care certification for HCAs. • Further development of specialist nursing and medical roles working across networks of practices. IT (see also other objectives, below): • Maximising potential of self-care/triage apps • Installation of new servers, single domain and Wi-Fi in every practice. This is the biggest upgrade to GP Practice IT in 20 years and will mean Berkshire West has one of the most advanced infrastructures in the country.

	Premises: • Systematic planning for population growth • Maximising investment from housing developments • Maximising investment from national funding streams such as Primary Care Infrastructure Fund • Planned investment in premises which will enable delivery of the models of care described in this document, including underpinning the 'upscaling' of provision as described above. Organisational form: • Developing commissioning approaches that support upscaling and collaborative working between practices e.g. through federations, networks and joint provider organisations as a means of sustaining primary care by achieving economies of scale and efficiencies. This work will also put providers in a better position to take up opportunities to develop an extended role for primary care as part of the broader new model of care we are looking to develop in Berkshire West.
2: Interfacing in new ways with specialisms historically provided in secondary care to manage increasingly complex chronic disease in a community setting	• Roll out of existing community-based pathways to other specialties e.g. respiratory medicine. • Development of virtual outpatient clinic model and more community-based clinics • Expansion of community-based consultant roles, building on community geriatrician and community diabetologist models • Improving interface between primary and secondary care clinicians, e.g. greater provision of advice via Choose and Book, E-referral and telephone , using technology to share information between clinicians electronically, psychiatrists to visit practices to jointly review patients with complex mental health needs. • Further developing GP specialist roles working across clusters of practices, including in mental health in order to support effective management of mental health conditions within primary care. • Risk stratification of patients with long-term conditions • Supporting self-care for patients with long-term conditions including through technological means, remote monitoring and wearable devices.

3: Managing the health of a population by working in partnership with others to prevent ill-health. Acting as accountable clinicians for the Over 75s and other high risk patients and co-ordinating an increasingly complex team of people working in primary, community and social care to support patients at home	• Systematic development and implementation of risk profiling and multi-disciplinary care planning for Over 75s and patients with complex health needs, including improved sharing of information and using technology to further develop the role of patient in managing their care. Anticipatory Care CES to support face-to-face care planning, medications review and sharing of information through Adastra. Improving care planning and systematic annual reviews for patients with chronic mental health needs and improved processes to review the health needs of patients with a learning disability. GP job plans to include care planning as a core component of their regular workload. • Improving interface between primary care, community services, social care and the voluntary sector through the development of neighbourhood clusters based around groups of GP practices. • Building on existing preventative work e.g. targeted screening for diabetes and exercise schemes to focus more strongly on promoting health and wellbeing amongst the practice population and ensure such work is appropriately reflected in contractual arrangements. • Supporting practices to better meet the needs of carers, including through provision of Directory of Services enabling improved signposting to voluntary sector support. • Supporting information sharing between practices and the wider health and social care system through the Berkshire West Connected Care Programme.
4: Using new approaches and technologies to improve access and patient experience, ensuring that the needs of patients requiring urgent primary care are met appropriately and routine appointments are available in the evenings and at weekends.	• Practices to be commissioned to offer more bookable appointments in the evenings/early mornings and at weekends , reflecting NHS England planning guidance. Additional capacity to be commissioned at peak times in-hours to support system resilience. Smaller practices to be encouraged to work collaboratively to increase appointment availability, sharing patient records as appropriate. Empowering patients to self-care where possible and to access services appropriately. • Enabling practices to utilise technology to maximum effect to offer patients different options for accessing services e.g. via telephone or online consultations or through email advice portals. • Supporting practices to work together to respond to same-day demand in new ways thereby meeting urgent needs more efficiently and freeing up capacity for other aspects of primary care. To include considering shared call handling / urgent clinic models and potential role of NHS 111 in triaging in-hours calls. • Further exploration of potential role of community pharmacy as part of urgent care response. • Establishing clearer standards and expectations of practices with regard to capacity based on review of current local practice and patient feedback.

	• Supporting practices to deliver care through mobile working • Ensuring availability of a same day primary care response to patients in mental health crisis as part of the implementation of the local action plan linked to the Mental Health Crisis Care Concordat.
5: Making effective referrals to other services when patients will most benefit	• Roll-out of the DXS system and the associated service directory to be available to all practices and to include information on voluntary sector provision and carer support. • QIPP scheme to reduce variation in referrals and non-elective admissions where there is no clinical rationale behind this. To be delivered through peer review, CCG support and education sessions.

b) Co-commissioning

Co-commissioning will be a key enabler for the delivery of this Strategy. The CCGs were approved to jointly commission primary medical services with NHS England with effect from 1st May 2015. Responsibilities are discharged through the Joint Primary Care Co-Commissioning Committee (JPCCC) which follows national guidance with regard to the scope of joint commissioning, governance requirements and arrangements for managing conflicts of interest. We are now considering taking on fully delegated responsibility for commissioning primary medical services from 1st April 2016.

Co-commissioning will enable CCGs to influence the content and management of core and enhanced primary care contracts (within national parameters) and to align the commissioning of primary care with the organisations' broader commissioning intentions, thereby enabling care to be commissioned across the full extent of the patient pathway, and supporting the move towards place-based budgeting as set out above.

The following opportunities and priorities have been identified:

- Through co-commissioning we will work to further develop our local definition of what high quality primary care looks like, what level of service patients can expect and our anticipated outcomes, linking back to the strategic objectives set out in this document. We will then work to reflect this in contractual arrangements including our APMS service specifications and an associated 'contract plus' offer for GMS and PMS practices. This will ensure that providers are paid the same rate where they provide the same level of service irrespective of the type of contract that they hold and that

patients have access to a defined level of service even though delivery models may vary. This 'contract plus' offer will be funded initially through re-invested PMS premium funding but we are committed to working towards aligning funding levels for all practices by also commissioning it from practices that do not have access to this source of investment.

- We will take every opportunity to ensure that the commissioning decisions we make support delivery of strategic objectives for primary care, for example with regard to future practice changes. This will include encouraging 'upscaling' and collaboration between practices as we have recognised that this will best support delivery of the models of care described in this Strategy.

- Linked to this, the CCGs will look to develop a framework for further improving quality and addressing unwarranted variation in primary care. This will be based upon CCG-led peer support and sharing of best practice but will also incorporate arrangements to identify and address any ongoing performance issues. By risk mapping practices on an ongoing basis we will also be able to ensure that we offer targeted support to practices experiencing particular issues and work with those most under pressure to develop plans for the future. We will also support practices to prepare for CQC inspections and to make improvements to services where these are identified as a result of visits.

- Over time we will explore the potential to re-design QOF and directed enhanced services to better reflect local needs. We will look to consolidate enhanced services commissioning to reduce the bureaucracy associated with managing multiple contracts.

- We will work to develop a strategic plan for primary care premises, ensuring that investment is targeted towards premises developments which will underpin delivery of the new models of primary care described in this strategy and that the system is able to respond proactively when national funding streams are made available

c) CCG-level planning

The four GP Councils have engaged with the development of this strategy through a series of workshops and the strategic objectives set out in this document reflect the collective output of these sessions. However whilst the associated workstreams (see above) will span the four CCGs, it is envisaged

that implementation arrangements will vary between them, reflecting their differing population needs and the nature of their existing models of primary care provision.

The following table shows how the emerging local vision of each CCG aligns with the broader strategic objectives for primary care identified in this document by identifying key priorities identified for each CCG area. .

	Newbury & District	North and West Reading	South Reading	Wokingham
1: Addressing current pressures and creating a sustainable primary care sector.	• Supported self-care and automating QOF. Using technology to support self-care for long-term conditions; enabling patients to enter their own data and reminding them to attend for appointments. • New 'GP Personal Assistant' admin role • Freeing up GP time to focus on most complex patients and work that can only be done by them personally, thereby ensuring they are working 'at the top of their licence'. • Multidisciplinary training environment; learning environment enabling everyone in the team to	• Increase use of pharmacists • Shared approach to multi-disciplinary training, appraisal and CPD, utilising where possible existing programmes run by local trusts • Maintain and develop Nurse and HCA training programme • Explore the potential of the voluntary sector in supporting the needs of patients • Continue to explore the potential of collaborative working arrangements across practices and proactively plan for future provision of services for patients in North	• Discussions have focussed on potential for practices to work more closely together through hub and spoke model thereby creating efficiencies. These 'clusters' would share back office functions and provide services jointly where appropriate, thereby creating efficiencies and improving choice for patients. • Part of PMS premium funding to be used to establish Transformation Fund to support service developments aimed at achieving sustainability. Plan for use of this funding being developed across	• Discussions have focussed on how practices can work together to deliver efficiencies. Federated and networked models have been considered but progress to date has been focussed on the neighbourhood cluster model. This would enable practices to work together to create back office and other efficiencies, to jointly address workforce issues and to improve the interface with other services. There will be three clusters, each serving a population of 40-60,000 people. • Key priority is planning for population growth – it is estimated Wokingham will

	benefit from shared expertise, to keep up to date and to develop their skills. • Development of pharmacist roles. • Consideration to be given to collaborative recruitment approaches. • Fostering collaboration between practices as providers to achieve economies of scale and support sustainability.	Caversham. • Work with BHFT to pilot new ways of working across Community Nursing and Practice Nurse services • Support GP manpower by encouraging retiring GPs to join 'bank' arrangements	three key areas of IM&T infrastructure, workforce and premises. • Premises strategy being developed in line with clustering approach.	have an additional 32,000 residents by 2022.
2: Interfacing in new ways with specialisms historically provided in secondary care to manage increasingly complex chronic disease in a community setting	• Direct access diagnostics and new ways of working with consultants to reduce the need for referrals. • Geriatrician to support GPs in looking after care homes • Care closer to home using West Berkshire Community Hospital as a hub. Outpatient appointments provided in community by community-based consultants. Aspiration to develop West Berkshire Community Hospital as a Diagnostic and Treatment Centre, avoiding the need for travel to acute hospitals.	• As lead commissioner of urgent care across Berkshire West we will review patient pathways to identify potential improvements in a community setting.	• Hubs (likely to service around 25,000 patients) would have critical mass to offer new services and interface with consultants and others in new ways.	• Clusters would have critical mass to offer new services and interface with consultant and others in new ways. There will be opportunities to further develop GP specialist roles working across practices and linking in new ways with secondary care clinicians.

	• Supporting collaboration between practices as providers to expand the range of services offered by primary care.			
3: Managing the health of a population by working in partnership with others to prevent ill-health. Acting as accountable clinicians for the Over 75s and other high risk patients and co-ordinating an increasingly complex team of people working in primary, community and social care to support patients at home	• Continuity when it matters – implemented by an extended team(see above) led by an accountable clinician such as a GP or community matron, focussing on patients from whom continuity is important and could affect clinical outcomes (e.g. those with complex multi-morbidity, enduring mental illness or requiring end-of-life care). • Further development of anticipatory care planning • Personal recovery guide jointly with social care and the voluntary sector.	• Explore potential of care planning for other long-term conditions • Work with Public Health to increase preventive work, including increasing physical activity rates through Beat the Street . • Ensure that all practices utilise the Living Well pilot and evaluate its benefits • Consider the benefits of introducing a specialist GP role for care home patients and the frail/elderly • Instigate/participate in coproduction opportunities as they arise	• Hubs would act as point of interface with other organisations, thereby supporting cluster working as set out in BCF plan. •	• Cluster Care planning working with Care Navigators • Social workers, housing officers etc. would be aligned to clusters enabling services to work together more effectively to meet people's needs in the community. • Voluntary Sector Co-ordinator role being piloted. This role supports practices to signpost patients to the range of voluntary sector services available to them, with a particular focus on reducing social isolation amongst older people and supporting new families moving into Wokingham.
4: Using new approaches and technologies to improve access and patient experience, ensuring that the needs of patients requiring	• Different length appointments according to patient need • Extended Hours capacity commissioned in accordance with patient need and linked	• Ensure that 80% of practices provide extended access • Discuss and agree how an integrated urgent care system could best support practices to manage patient	• Hub and spoke model would offer flexible approaches to extended hours provision and potentially in-hours requests for same day appointments.	• Considering collaborative approach to call handling and meeting on the day demand through cluster-based urgent care centres. Over time this should ensure GPs have the

urgent primary care are met appropriately and routine appointments are available in the evenings and at weekends.	to the Out of Hours provision • Exploring triage to prioritise appointments using a combination of the most experienced clinician and enhanced reception roles • Develop collaborative working to deliver improved access across the 11 practices, including exploring potential of shared call handling through hubs (involving GPs, minor illness nurses and Nurse Practitioners) and/or a locally-agreed protocol and thresholds for on-the-day appointments. This would give GPs in practices more control over their day and enable them to focus on most complex or those needing continuity (see above). • Exploring utilising technology to obtain succinct patient history prior to appointments and more use of Skype and telephone consultations.	demand for urgent care	• Practices could collaborate to meet on the day demand thereby freeing up time for care planning for patients with the highest needs.	capacity to focus on providing proactive, community-based care for patients with higher levels of need.

5: Making effective referrals to other services when patients will most benefit	• Directory of Services likely to be delivered as part of DXS system. To facilitate direct access to other professionals (e.g. IAPT, Social Services, Physiotherapy) and to incorporate a service navigation function which will support patients and practices to access the services they need.	• Ensure practices are aware of voluntary sector services available to support their patients and that these are included on DXS • Continue to provide practices with referral benchmarking information at practice visits and as routine every quarter • Through regular reporting of referral benchmarking information reduce levels of variation between practices.		• DXS information will improve co-ordination of care and links with voluntary sector. • Considering how to reduce variation in referral rates for some time and now working with other CCGs on BW QIPP scheme.

6. Investment plan

Core primary care services are funded through NHS England's GP commissioning budgets. A high-level summary of 2015-16 budgets is provided below. Further enhanced services are commissioned by unitary authority Public Health departments.

CCG	GP Contract Payment £0	QOF and Aspiration £0	PCO Admin £0	GP Drugs Payments £0	GP Premises £0	Misc. Items £0	Enhanced Services £000s	Total Area Team £0
Newbury and District	8,624	1,141	448	914	1,143	339	850	13,459
North and West Reading	8,997	1,170	427	386	1,109	315	669	13,073
South Reading	12,750	1,101	418	74	1,781	300	849	17,273
Wokingham	11,191	1,549	596	442	1,954	438	1,108	17,278
Total	**41,562**	**4,961**	**1,889**	**1,816**	**5,987**	**1,392**	**3,476**	**61,083**

CCG budgets relating to primary care in 2015-16 are set out below. In addition to GPIT funding of £1.3m and established enhanced services funding of £0.5m, we have used the £5 per head funding to support the care of the Over 75s (as per the 2014-15 planning guidance) to invest in an Anticipatory Care CES designed to significantly advance our third Strategic Objective (Managing the health of a population in partnership with others). In addition, we have invested £2.5m to extend GP access into the evenings and weekends as well as at peak times in-hours over the Winter period, following a £1m pilot scheme in 2014-15. These two schemes combined equate to an 8.4% increase in investment in primary care. Further information about current IT investment plans are included in Appendix 3, below.

	CCG Budgets				
CCG	£5 per head "anticipatory care" £000	Enhanced Access £000	Other Enhanced Services £000	GPIT £000	Total CCG £000
Newbury and District	576	576	101	299	1,552
North and West Reading	560	560	116	279	1,515
South Reading	643	643	94	352	1,732
Wokingham	722	722	187	406	2,037
Total	**2,500**	**2,500**	**498**	**1,336**	**6,836**

In addition, the CCG is responsible for commissioning the Westcall Out-of-Hours service provided by the Berkshire Healthcare NHS Foundation Trust. For 2015-16, £5.02m was spent on commissioning this service.

Further investment in primary care may follow where it is identified that this will result in overall cost savings in other parts of the CCGs' commissioning budgets. It is also intended however that the strategy will be delivered through the re-alignment of existing commissioning budgets to better reflect the strategic objectives described. As set out in the above co-commissioning section, key priorities will include:

- Development of an APMS offer that reflects our strategic objectives with KPIs aligned to local patient need.
- Redesign of QOF to reflect local priorities.
- Ensuring infrastructure investment furthers our strategic aims.

- Re-investment of released PMS premium funding in service models which reflect this strategy, and with the intention of aligning GMS and PMS funding levels in the future. The mechanisms for doing this require further discussion.

7. Delivering the Strategy

The following table summarises the types of outcomes that would result from successful delivery of our strategic objectives for primary. More specific outcomes will be developed as we move towards implementation and progress against these will be monitored by the Joint Primary Care Co-Commissioning Committee. The Committee will also take oversight of the delivery of the Strategy as a whole and will assess progress and review this document periodically in the light of developments in co-commissioning and the broader health and social care economy's approach to integration and sustainability.

Strategic objectives	High-level outcome measures
1: Addressing current pressures and creating a sustainable primary care sector.	• Decreased number of vacancies within practices, application rates improved as primary care is seen as a more attractive place to work. • Staff satisfaction improved • Smaller practices working in federation or other collaborative forms from fewer/better premises serving populations of at least 6,000 but ideally 10,000 patients • No new contracts awarded to single-handed practitioners or practices that would have a list size of less than 6,000 • All primary care premises are fit-for-purpose • Primary care workforce diversified to include pharmacy, nursing, therapists and physicians associates. • Multidisciplinary and joined up arrangements in place for pre-registration training and continuing professional development • Practices receive a consistent level of funding for a defined level of service so that patients in Berkshire West have access to a consistent level of provision. PMS premium funded reinvested to support delivery of models of care set out in this Strategy. • Services provided outside of core contracts are resourced appropriately. • Contractual arrangements simplified and bureaucracy reduced. • Quality standards are maintained or improved and unexplained variation between practices is addressed.

	• Patients supported to access practices online. • Patients are supported to use self-care apps • Opportunities to interface with patients in different ways e.g. through telephone and Skype consultations, patient history-taking apps etc. are utilised to full effect thereby enabling practices to manage growing demand.
2: Interfacing in new ways with specialisms historically provided in secondary care to manage increasingly complex chronic disease in a community setting	• New care pathways in place between primary and secondary care resulting in fewer visits to hospital. • Improved control of long-term conditions e.g. reduced HbA1C level etc. • Positive feedback from patients with long-term conditions
3: Managing the health of a population by working in partnership with others to prevent ill-health. Acting as accountable clinicians for the Over 75s and other high risk patients and co-ordinating an increasingly complex team of people working in primary, community and social care to support patients at home	• Directory of Services in place supporting improved links with the voluntary sector and increased signposting to voluntary services. • Risk stratification actively used to identify and develop care plans for at-risk individuals thereby reducing avoidable hospital admissions • Preventative work in place with lower risk groups. • Improved patient feedback regarding co-ordination of care • Interoperability achieved and services therefore able to share information with patient consent
4: Using new approaches and technologies to improve access and patient experience, ensuring that the needs of patients requiring urgent primary care are met appropriately and routine appointments are available in the evenings and at weekends.	• Bookable GP appointments available from 8am-8pm in the week and at weekends, reflecting NHS England planning guidance • Improved patient survey results / Friends and Family test responses • Practices utilising shared call handling and/or on-the-day provision where appropriate to create efficiencies which free up time for GPs to focus on more complex patients.

5: Making effective referrals to other services when patients will most benefit	• Unwarranted variation in referral and non-elective admission rates reduced for specialties where this has been identified. • DXS utilised to maximum effect to support delivery of agreed care pathways and signposting to other services as appropriate.

8. Next steps

Delivery of the strategy will be overseen by the Joint Primary Care Co-Commissioning Committee. The Committee will develop an implementation plan which will form the basis of a strategic programme for primary care for which it will take lead responsibility, identifying and working to mitigate risks as appropriate. It will also link extensively with the CCGs' other Programme Boards around specific workstreams.

Further engagement with patients around the workstreams set out in this Strategy will be undertaken as part of the CCGs' broader Communications and Engagement Strategy. A communications plan will be developed for each workstream which will aim to build upon the useful information already obtained with regard to many of the themes covered in this Strategy document.

Appendices

Appendix 1: Patient Engagement

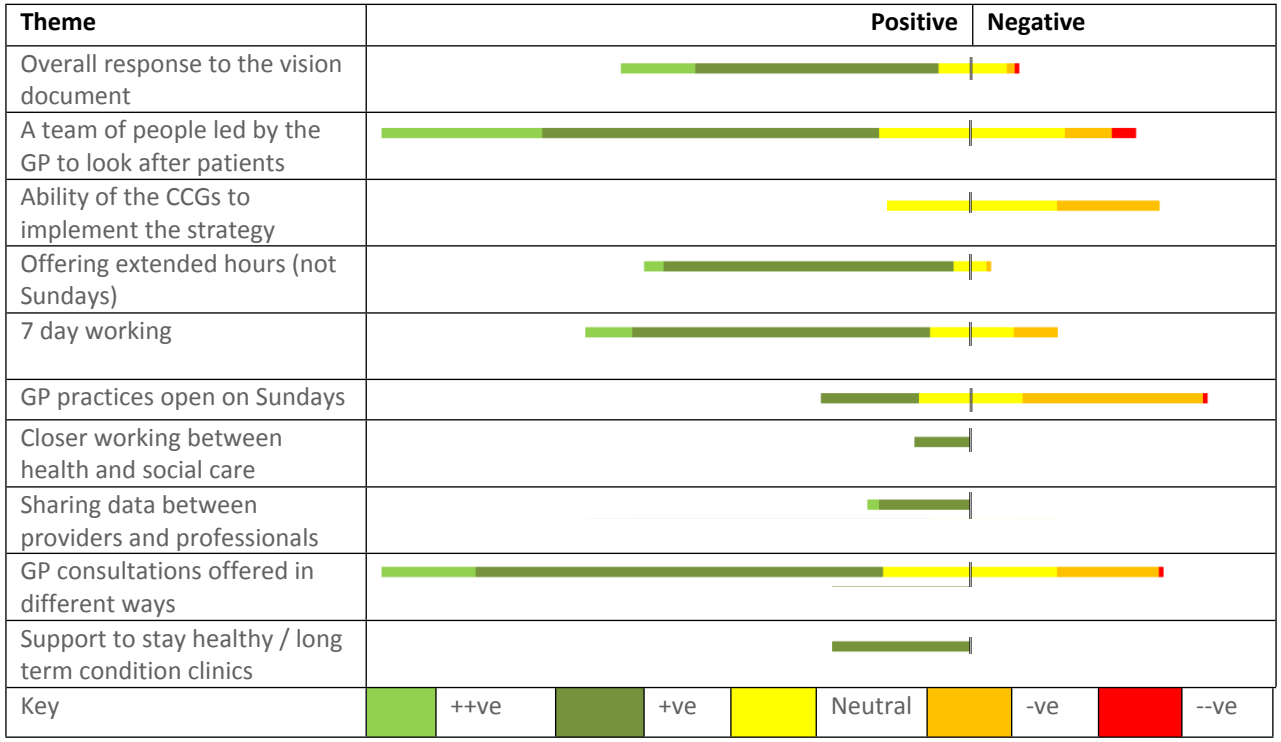
The CCGs' engagement with the public regarding primary care began with the Call to Action events held in 2014. Since this time we have developed an ongoing dialogue with individual Patient Voice Groups and have raised primary care through broader engagement work undertaken as part of the CCGs' overall Communications and Engagement Strategy.

Following production of the draft of this Strategy, a patient-facing version was produced which has formed the basis of an intensive programme of engagement over the last few months, as well as an online survey. Specific engagement has also been undertaken in relation to the three APMS contracts we are procuring in 2015-16 which has elicited useful feedback in terms of our overall direction of travel for primary care commissioning. The following table summarises key recent engagement events and activities which have had a primary care focus:

Date	Event
November 2014	Reading 'GP Question Time' event
March 2015	Wokingham 'Have your say'
March 2015	Newbury Primary Care Event
July 2015	North and West Reading CCG annual meeting and engagement event
August to December 2015	Primary Care Strategy survey live on Berkshire Health Network.
September 2015	South Reading CCG annual meeting and engagement event
July – August 2015	NHS111 engagement
September 2015	APMS engagement: Circuit Lane
September 2015	APMS engagement: Priory Avenue
October 2015	APMS engagement: Shinfield Medical Practice
October 2015	Woosehill Surgery PPG survey
October 2015	Wokingham PCS engagement event
November 2015	South Reading Patient Voice PCS engagement
November 2015	Trinity School, Newbury – sixth form
November 2015	Mailout to more than 70 residential care homes across Berkshire West to promote feedback on the strategy

The heat map below demonstrates the key areas of interest for patients reading the vision document and responding to the online survey. The length of line indicates the volume of responses and the bar colour the sentiment of respondents. The heat map below represents 988 statements (83% of total). The map tells us that respondents were overwhelmingly positive towards the ideas set out in the vision document, welcome a wider range of professionals offering care and are enthusiastic for new styles of GP consultation – including Skype video consultations.

Some online respondents were concerned about our how we will implement the vision. We intend to address this concern through the implementation plans that we put in place to support delivery of the Strategy which will include mechanisms for identifying and addressing risks to delivery. Seven day working was seen as beneficial overall, though many of those in favour felt that Sundays should not be used for routine appointments.



The following table summarises the key themes identified through all of the engagement activities we have undertaken as part of the development of this Strategy (including the online consultation above), and how these are reflected in the final document. A full report is available on the CCG websites.

Key themes identified through patient engagement	How these are reflected in Strategy
People want better co-ordination of care between organisations so that they only have to tell their story once and they are supported to navigate the care system. There is a view that this should be achieved through shared IT system, and should include working to avoid admissions from care homes. Patients with the most complex needs should be prioritised and plans should be in place to ensure they do not have to explain their illness at every consultation. These patients most value continuity of care. IT systems should ensure confidentiality of data. Technological solutions should not be a substitute for good face-to-face care but respondents did recognise the potential of wearable technology.	• Integration with social care and other services through neighbourhood clusters will improve communication between organisations • Patients identified as being most at risk of admission will have care plans in place which can be accessed by other organisations through Adastra. This will incorporate specific care planning processes for care home residents. • Berkshire West Connected Care Programme currently allows the out-of-hours GP service to access patients' records with their consent. Over time this will be expanded to cover A&E and other organisations. Data confidentiality and information governance are key considerations in all initiatives being progressed under this programme. The programme aims to ensure that technology is used to maximum effect to support patient consultations and enhance patients' overall experience of care. Other elements of our IT programme will ensure we maximise the potential of self-care and monitoring apps and gathering data from wearable devices. • Wokingham and NWR CCGs are piloting voluntary sector co-ordinator roles which will support patients to navigate the system. Learning from these pilots will be shared across Berkshire West.

Whilst satisfaction with opening hours is generally high, a significant proportion of patients would like their GP practice to be open more in the evenings and at weekends, or would be willing to access another surgery at these time. Others felt that good access in-hours with an ability to see their own GP was as important as extended opening. There is limited appetite for Sunday opening. Appointments could also be different lengths according to patient need. People are generally positive about accessing their GP surgery in new ways (email, Skype etc) although some said they would need support to do this and others expressed concerns that it must be voluntary and shouldn't substitute face-to-face care.	• We will commission practices to provide extended hours opening across weekday evenings and on Saturday mornings, in some cases working together to maximise access for patients. Maintaining and expanding capacity in-hours, particularly at peak times, will also be a focus. • Under the 2015-15 GP contract, practices are required to offer patients a named GP responsible for co-ordinating their care. This now applies to all patients; addressing the concerns expressed by some around this previously being limited to Over 75s. • GP practices will make best use of technology such as email, texting, online services such as repeat prescriptions and consultations. Information and support will be available for patients from practices to enable then to get started. • NHS 111 will play an integral role for patients to be able to access the NHS locally out of hours.
People recognise that there is a need to promote self-care and to ensure that patients access services appropriately. There is general support for the concept of the NHS 111 service.	• We will use new technology to support self-care as a component of care for patients with long-term conditions. • Our Communications plan will provide more information about self-care for minor ailments and appropriate usage of A&E and other services. • As part of implementing the Strategy the JPCCC will work with the Urgent Care Programme Board to consider the future potential of NHS 111 to respond to on-the-day demand for primary care services.

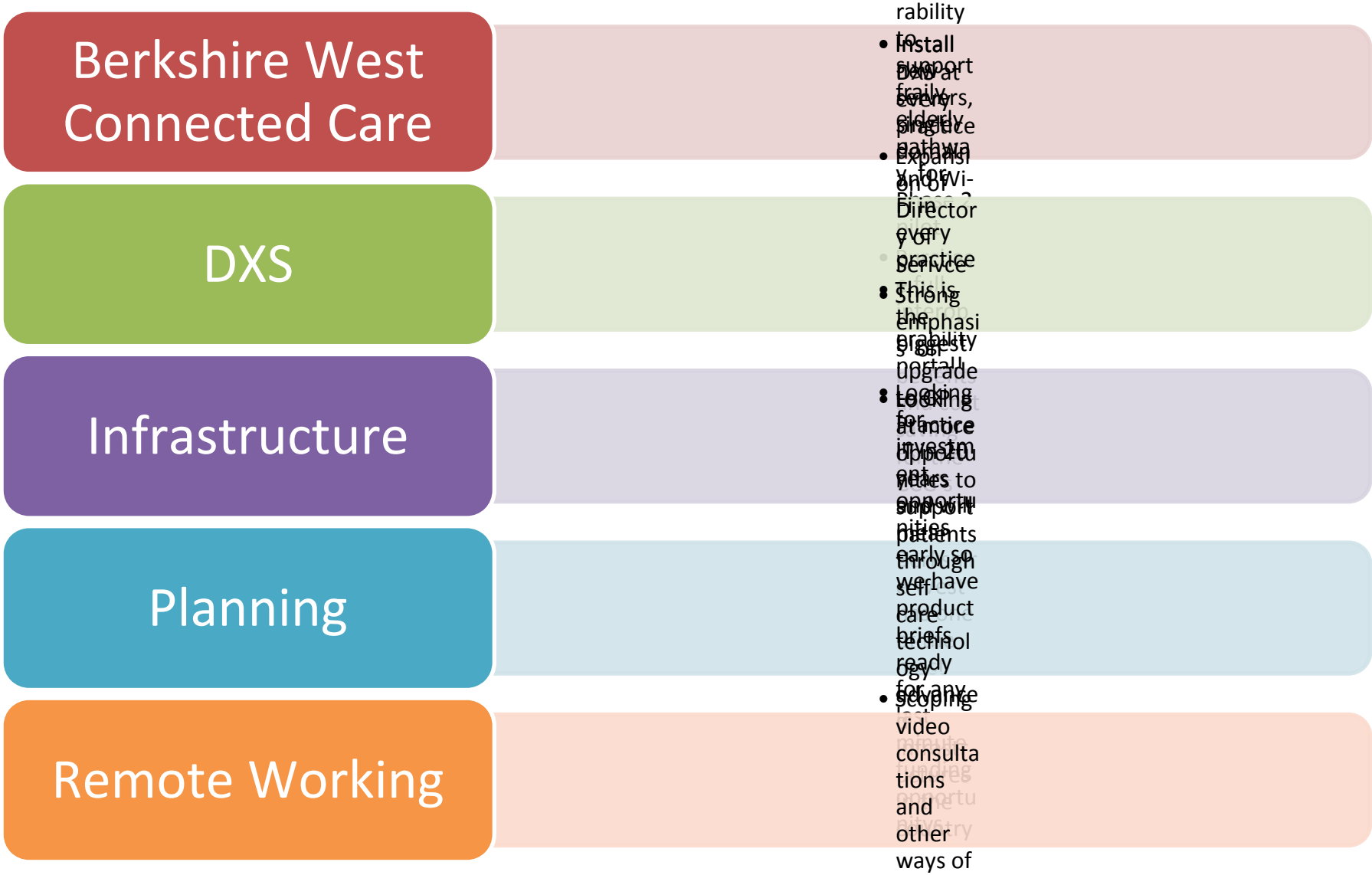
People believe that the voluntary sector could play a greater role in meeting peoples' needs, although there it is important to assure the quality of the services offered and to fund these organisations appropriately. GPs need to be more aware of voluntary sector provision.	• Wokingham CCG are piloting a Voluntary Sector Co-ordinator role as part of their cluster working project. • We are working to improve signposting to voluntary sector provision for example through the Directory of Services linked to the new DXS system and through pilot roles such as the Voluntary Sector Co-ordinator in Wokingham. The provision of information about support to carers through this system is also being explored.
People identified the need for primary care to work with other agencies to support wellbeing and help prevent mental health issues. A particular focus should be ensuring that young families have access to the support they need. Young people were also identified as a priority group. Staff should be supported to understand the needs of particular groups attending practices such as those with learning disabilities. GP practices should work with and support carers; signposting them to other services where appropriate.	• Our vision for primary care involves practices working at the heart of the communities they serve and with other agencies to prevent both physical and mental ill health and to work as proactively as possible to minimise the impact of illness. • Wokingham's pilot Voluntary Sector Co-ordinator role will have a particular focus on the needs of young families moving to the area. • Information on support services and organisations will be better available to practices through the DXS system (see above). Specific action will be taken to ensure GP practices support carers effectively. • We intend to continue to work closely with practices around continued professional development. This could include providing training around the needs of particular groups.
There is also a view that GP practices should routinely offer more information on the benefits of exercise and how to prevent diabetes and that young families need more support. It was recognised that practices should work in partnership with	• NWR and Wokingham GPs are promoting physical exercise through the 'Beat the Street' initiative. We have also commissioned practices to provide support to patients identified as being at risk of diabetes or in the early

other organisations to enable early intervention and prevention of more complex health issues. Some patients also indicated that they would welcome more general health advice and health checks.	stages of diabetes. Through this Strategy we will work with Public Health to further build the role of primary care in preventing ill health (see above).
It is recognised that practices will increasingly involve teams of different healthcare professionals, thereby widening the workforce. Patients feel that this is appropriate as they recognise that they do not always need to see their GP but do want to be assured that appropriate leadership arrangements are in place and there is clarity of roles. Most people were positive nurses and pharmacists in particular taking on enhanced roles. Generally people welcomed the idea of more services being available in their GP surgery from a mixed skill-set team and it was felt that this would also make primary care careers more attractive.	• The workforce sections of this Strategy describe how different professionals such as Physicians' Associates, pharmacists and emergency care practitioners may increasingly become involved in the delivery of primary care, with a wider practice team working to support the specific needs of different groups of patients. We will support practices to diversify their teams with clear lines of accountability and information for patients about different professional groups. • The Strategy describes how practices will in future work differently with secondary care consultants and other professionals to provide a much broader range of services in primary care.
People want more planned care for long-term conditions, including continuity of care where possible. Having substantive staff in post supports this.	• The CCGs recognise that continuity of care is important to patients with complex needs and where this improves outcomes practices should endeavour to provide this. Where different professionals are involved in a patient's care, care planning and better sharing of information will improve communication between them (see above). GPs are also now required under their contracts to identify a named GP for all patients. • The Strategy sets out a range of actions that will be taken to support practices to address difficulties in recruiting to substantive posts. We recognise that recruitment is a key challenge for the primary care system and that we need to work as proactively as possible to address this.

People want to understand how the Strategy will play out in rural areas and for smaller GP surgeries which may not be able to host multidisciplinary teams.	• The CCG elements of the Strategy above starts to set out how the vision might be implemented at a local level. This may include smaller practices working together to provide some services, thereby ensuring that patients in all areas have access to the same range of services and supporting practice sustainability. Practical considerations such as a rurality would be taken into account in any such approaches.

We recognise that engagement with the public should be an ongoing process. Going forward we intend to undertake specific engagement around key workstreams resulting from the implementation of this Strategy. This will be in addition to any formal consultation required with regard to service changes. We will build upon our successful approach of combining public meetings, focussed discussions with key groups and online publications and surveys to engage with as broad a range of patients as possible; also working through established mechanisms such as our Patient Voice and PPG Forum groups, the Berkshire Health Network and practice-based participation groups. If you would like to know more please contact the CCGs Patient and Public Involvement Team on 0118 9822709 (8.30am-4.30pm, Monday-Friday) or on ppiteam.berkshirewest@nhs.net. Information about how to register with the Berkshire Health Network is also available at https://www.healthnetwork-berkshire.nhs.uk/consult.ti/system/register.

Appendix 2: IM&T investment plans



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Title of Report:	**Urgent & Emergency Care Review - Progress Report**
Report to be considered by:	The Health and Wellbeing Board
Date of Meeting:	28th January 2016

Purpose of Report:

This report is to inform the Health & Wellbeing Board about the "Urgent and Emergency Care Review" and the action being taken at national and local level in implementing this.

Recommended Action:

1) That the Health and Wellbeing Board notes the report and the action being taken nationally and locally to deliver the objectives of the "Urgent and Emergency Care Review".

2) The Board is also asked to note how the local health and social care system currently works in partnership to support good patient flow around the system, which is critical is to the success of our local urgent and emergency care system. Maintaining patient flow through hospitals relies on a dynamic equilibrium between admissions and discharges. it is therefore imperative that the Royal Berkshire Hospital, Berkshire Healthcare Foundation Trust and West Berkshire Social Services work closely together to prioritise activities aimed at achieving the earliest possible discharge of patients from hospital.

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

Urgent and emergency care is one of the new models of care set out in the NHS Five Year Forward View (FYFV). "*The Urgent and Emergency Care Review*" (referred to as the *Review)* proposes a fundamental shift in the way urgent and emergency care services are provided, and will be the first major practical demonstration of these new models of care.

"…. the NHS will begin joining up the often confusing array of A&E, GP out of hours, minor injuries clinics, ambulance services and 111 so that patients know where they can get urgent help easily and effectively, 7 days a week…" . Simon Stevens, Chief Executive of NHS England.

The patient offer for 2020 will be:

i. A single number – NHS 111 – for all your urgent health needs
ii. Be able to speak to a clinician if needed
iii. That your health records are always available to clinicians treating you wherever you are (111, 999, community, hospital)
iv. To be booked into right service for you when convenient to you
v. Care close to home (at home) unless need a specialist service
vi. Provide specialist decision support and care through a network

2. Background

Urgent and emergency care is one of the new models of care set out in the Five Year Forward View. The Urgent and Emergency Care Review proposes a fundamental shift in the way urgent and emergency care services are provided, and will be the first major practical demonstration of these new models of care.

In November 2013 the NHS set out its vision for a future system which is safer, sustainable and capable of delivering care closer to home, helping to avoid unnecessary journeys to, or stays in hospital unless clinically appropriate. The *Review* is harnessing an approach of developing urgent and emergency care networks which rely on different parts of the system working together to create a completely new approach to delivering urgent care for physical and mental health.

The vision is simple:

- Firstly, for those people with urgent care needs we should provide a highly responsive service that delivers care as close to home as possible, minimising disruption and inconvenience for patients and their families;
- Secondly, for those people with more serious or life threatening emergency care needs, we should ensure they are treated in centres with the very best expertise and facilities in order to maximise the chances of survival and a good recovery.

To do this requires change across the urgent and emergency care system by:

- Providing better support for people to self-care
- Helping people with urgent care needs to get the right advice in the right place, first time
- Providing highly responsive urgent care services outside of hospital

- Ensuring that those people with more serious or life threatening emergency care needs receive treatment in centres with the right facilities and expertise in order to maximise chances of survival and a good recovery; and
- Connecting all urgent and emergency care services together so the overall system becomes more than just the sum of its parts.

3. Implementation of the Review

Since November 2013 NHSE has been working with stakeholders from across the urgent and emergency care system to translate the *Review* vision into practical pieces which, when combined, will deliver the objectives of the Review. This is being done through a Delivery Group (which includes NHS England, Monitor, Trust Development Agency, Public Health England and CCGs), the majority of the work being led directly by NHS England, and the rest by system partners such as Monitor and Health Education England.

Implementing this vision is not a 'quick fix' but will instead be a transformational change that will take several years to effect. Delivering safe and effective urgent and emergency care cannot be done from within organisational or commissioning silos. It requires cooperation between and within numerous organisations and services, and collaboration between clinicians and supporting staff who place patient care at the centre of all they do. It is also recognised that this transformation will be occurring in the face of significant demand pressure in general practice, primary care and across the wider health and social care system.

Urgent and Emergency Care Networks: The establishment of Networks, which give strategic oversight of urgent and emergency care and connect all services within the urgent care system, is a key enabler for delivering the objectives of the *Review*. Nationally twenty-four networks have been agreed and are now meeting, bringing together representatives of their constituent system resilience groups (which locally we call the Berkshire West Urgent Care Programme Board), CCGs, acute receiving hospitals, ambulance services, NHS 111, mental health, community healthcare, local authorities, community pharmacy, Local Education and Training Boards and other key stakeholders.

Urgent and Emergency Care Route Map: NHSE has developed a route map that outlines high-level expectations to support networks and System Resilience Groups in prioritising their delivery of the Review. This route map (attached as **Appendix A**) signals the supporting products on offer from NHS England and partners alongside the expectations on networks and SRGs. This route map will be supported by a detailed implementation plan.

As an initial step in the route map, a stocktake of urgency and emergency care services has been undertaken by NHSE to understand:

- all urgent and emergency care services that are available in the network;
- the commissioning and service arrangements for these services; and
- Operational hours, case mix and facilities.

New commissioning standards for integrated urgent care: Published in October 2015 these support commissioners in delivering a fundamental redesign of the NHS urgent care 'front door'. The standards are built on evidence and what is known to be best practice.

Currently around the country, commissioners have adopted a range of models for the provision of NHS 111, OOH and urgent care services in the community. In most cases, however, there are separate working arrangements between NHS 111 and OOH services, and a lack of interconnectivity with community, emergency departments and ambulance services. This no longer fully meets the needs of patients or health professionals. The new commissioning standards required commissioners to take necessary steps to ensure that functionally integrated 24/7 urgent care access, treatment and clinical advice services are commissioned.

Urgent and Emergency Care Vanguards: Nationally eight urgent and emergency care (UEC) vanguards have been selected to accelerate delivery of the objectives of the *Review,* acting as test beds for new urgent and emergency care initiatives including clinical decision support hubs, a focus on liaison psychiatry, implementing a new payment model and testing new systemic outcome indicators.

Potential New Payment Model: NHS England and Monitor have published "*Urgent and emergency care: a potential new payment model"*, which sets out potential payment options and provides detailed guidance on how a new payment approach might be implemented in practice. This will be tested in Vanguard sites.

Workforce: NHSE is also working with Health Education England to review the UEC workforce and make sure that it is fit for purpose and there is a clear supply of staff to meet future demands. This includes describing and ensuring the supply of a trained alternative workforce out of hospital and on the interface with emergency departments to support the urgent and emergency care agenda. This involves the development and promotion of roles such as: physician associates, paramedics, pharmacists, and advanced clinical practitioners. They are working to enhance the role of paramedics to support the ambulance service as a treatment service, in line with the paramedic evidence-based education project (PEEP) report. A new single accredited curriculum for paramedics is in development., which academic institutions will begin to deliver from 2016 and will markedly enhance skills for paramedics to 'hear and treat', 'see and treat', as well as to work independently and in wider urgent care, such as primary care, as an alternative to A&E and ambulance conveyance.

Support Products: To support Networks and SRGs, a range of enablers have been, or are being, developed. These include:

- *Safer, Faster, Better: good practice in delivering urgent and emergency care* (published September 2015).
- *Guidance for Commissioners regarding Urgent Care Centres, Emergency Centres and Emergency Centres with specialist services*.
- *Integrated Urgent Care Commissioning Standards* (published October 2015)
- *Ambulance service: new clinical models*.
- *Improving referral pathways between urgent and emergency services in England*.
- New system-wide indicators and measures.
- *Urgent and emergency care: a potential new payment model* (published August 2015).
- Standards for commissioning of 24/7 mental health crisis services
- Information technology that supports patients and clinicians to access the right care.
- *Urgent and emergency care: financial modelling methodology*.
- Local capacity planning tool.
- Self-care initiatives.

"'Safer, Faster, Better': good practice in delivering urgent and emergency care: a guide for local health and social care communities":
https://www.england.nhs.uk/wp-content/uploads/2015/06/trans-uec.pdf
This important document was published on 1st September. It is one of a suite of documents and tools being produced to support local health systems to implement the recommendations of the Review. It sets out design principles drawn from good practice which have been tried, tested and successfully delivered by the NHS in local areas across England. It's clear that the guide should not be taken as a list of instructions or new mandatory requirements and that implementation should be prioritised taking into account financial implications and local context.

Current position in relation implementation of the *Review* at a local level

Thames Valley Urgent and Emergency Care Network: The Network which is chaired by Dr Annet Gamell, Chief Officer of Chiltern CCG had its inaugural meeting on 21st October 2015. Berkshire West CCGS are represented by Dr Andy Ciecierski, Cathy Winfield and Maureen McCartney. There is also Director of Adult Social Services representation. It meets on a monthly basis and is responsible for delivering key elements of the Urgent and Emergency Care Route Map at **Appendix A**.

Procurement of a Thames Valley wide Integrated NHS 111/ Urgent Care Service: In 2014 CCGs in Thames Valley agreed to work together to commission the NHS 111 service. Following publication of the new commissioning standards for integrated urgent care in Oct 2015 it was agreed that this work should move to the commissioning of an integrated NHS 111/Urgent Care Service for Thames Valley. This will offer patients who require it immediate access to a wide range of clinicians, both experienced generalists and specialists. This model will also offer advice to health professionals in our local communities, such as paramedics and emergency technicians, so that no decision needs to be taken in isolation. Within Thames Valley this new integrated service will have access to a wider range of dispositions including, but not limited to, ambulances, 24/7 primary care, pharmacists, mental health professionals and midwives. Clinicians will be supported by the availability of clinical records through IT system interoperability which will support robust clinical decision making and the direct booking of appointments into other services. This work is being led by the Berkshire West CCGs and it is expected that the new service will be in place by April 2017.

How the local Health and Social Care System works in partnership to support implementation of the Review and the earliest possible discharge of patients from hospital : The Berkshire West Urgent Care Programme Board which has senior level representation from health and social care is responsible for ensuring whole system resilience, the planning and delivery of urgent and emergency care improvement at a local level and delivering the NHS constitutional target that 95% of patient should be admitted, transferred or discharged within 4 hours of their arrival at A&E. There is a system wide strong focus on partnership working to achieve joint discharge planning and timeliness of post-acute transfer with the principle of a "pull" system of discharge.

The Board is supported in its work by an Urgent Care Operational Group made up of key operational managers which meets monthly. Its purpose is to deliver operational improvements and tackle blocks and issues along the urgent care pathway.

Both the Board and the Operational Group have been successful in helping establish and maintain very good working relationships between partner organisations.

The Board has begun the process of assessing where we are as an urgent care system against the best practice listed in “Safer Faster Better” and this was the subject of an Urgent Care Programme Board workshop on 17th December. The outputs of this will also help inform the further development of our local strategy for urgent care services.

Good patient flow around the system is critical to the success of our local urgent and emergency care system. The general principles of good patient flow are described in the document. Maintaining patient flow through hospitals relies on a dynamic equilibrium between admissions and discharges so it is really important that our local health and social care communities prioritise activities aimed to achieve the earliest possible discharge of patients. Numbers of patients on the *“Fit List”*, i.e. those clinically fit to leave the hospital who are awaiting onward health and/or social care are reviewed on a daily basis and are currently the subject of a daily system wide telephone conference call chaired by the CCG Urgent Care Lead/On call Director. The Berkshire West Health and Social Care system has set itself a target that each Local Authority and the Community Health Trust should have no more than 5 patients on the list with each having an average length of stay on the list of no more than 5 days.

The Joint Care Provider project which is funded by the Better Care Fund is an important enabler in helping our local system achieve this target. There is now consistent seven day social worker presence at the Royal Berkshire Hospital and patients are being pro-actively identified in advance of being added to the *“Fit List”*. West Berkshire is also leading the way in arranging weekend discharges for patients.

Appendices

Appendix A - Key elements of the Urgent and Emergency Care Route Map

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Urgent and Emergency Care Route Map (1)

Appendix A

NHS England

1 System Architecture	Deliverable	Supporting product publication	Timescale for implementation
Establishing U&EC Networks	• Principles of governance to support membership structure and ToRs • Stocktake of U&EC services by networks. • Support for overarching network U&EC plan agreed with regions; Networks to develop plans. • Networks to define consistent pathways for urgent care with equitable access	• Safer Faster Better published	• August 2015 • Nov 2015 • Jan 2016 • Dec 2016
Identifying and piloting system wide outcome metrics	• Development of a single framework for measuring and reporting on system outcomes (nationally, with local trial) • Toolkit to support measurement	• 2016 • 2016	• 2017
Develop a new payment system	• Local payment model for pilot sites, taking into account mental health outcomes (Monitor) • Roll-out of shadow testing model in pilot areas / vanguards • Implementation nationally	• August 2015 – Local payment example produced by Monitor • Sites to be confirmed as part of vanguards	• April 2016 • April 2018
Enhanced summary care record	• Urgent and emergency care services to have greater electronic access to records including summary care record, end of life care records, special patient notes and mental health crisis plans (including patient held plans)		• June 2016
Workforce	• Underpinning work programme with Health Education England		• Ongoing
2 Accessing the UEC system			
Accessing the UEC System	• Align or novate existing NHS111 and OOH contracts to deliver a more functionally integrated Urgent Care Access, Treatment and Clinical Advice Service model **or** plan for migration to full integration when contracts allow • New NHS 111 commissioning standards published nationally • Guidance on the establishment of clinical hubs (within standards) • Guidance on specialist advice (within standards) • Clinical triage of green ambulance calls established (within standards) • Development of Access to Service Information (next generation of the DoS) for timely access to service information and the technical links with ERS to support booking across the urgent care system.. • Deliver the Clinical Triage Platform (next generation of clinical decision support) to reflect an integrated urgent care system • NHS 111 online platform integrated into NHS Choices, with a clear expectation of digital first	• Oct 2015 • Oct 2015 • Oct 2015 • Oct 2015 • OBC March 2016 • OBC March 2016 • OBC March 2016	• Nov 2015 • TBD in local plans • TBD in local plans • TBD in local plans • June 2018 • June 2018 • December 2016

Urgent and Emergency Care Route Map (2)

3	UEC Centres	Deliverable	Supporting product publication	Timescale for delivery
	Direct booking from 111 to urgent care centres	• SRG to drive adoption of and greater provision of direct appointment booking into UCC, ED and primary care. National support, local delivery		• Ongoing
	Local Directory of Services (DoS)	• Networks / SRGs to ensure maintenance of local DoS	• N/A	• Ongoing
	Ensure **UCCs provide a consistent service**	• Specification to support move to ensure local care centres are consistently called Urgent Care Centres and offer consistent service	• Q4 2015/16 – Spec for UCC and Emergency Centres	• 2016 – 2020 in line with local plans
4	**Paramedic at Home**			
	More patients more appropriately dealt with at **home by paramedics**	• Clinical models to support increase in proportion of calls to 999 dealt with via 'see and treat' • Referral pathways set between paramedics and other providers	• Guidance on clinical models – Q3 2015 /16 • Guidance on referral pathways –Q3 2015 /16	• In line with local implementation plans
	Ensure a **clinically appropriate response by ambulance services to 999**	• Ambulance dispatch on disposition evaluated and national standards reviewed • Implementation of recommendations	• Final recommendations by Autumn 2016	• Autumn 16 – Spring 17
5	**Emergency Centres and Specialist Services**			
	Analytical activity	• Analysis of non-elective activity and capacity	• Capacity and demand tool Aug-Dec 2015	• Aug- Dec 2015
	Hospitals providing 7 day services across ten identified specialties	• Compliant with 7DS clinical standards as per NHS Standard Contract • All urgent network specialist services compliant with four mortality clinical standards on every day of the week	• Standard Contract	• Ongoing
	Discharge from hospital	• DTOC plans submitted • Support packages for CCGs and SRGs	• 7DS standards to include discharge planning and consultant review of patients.	• 2017
	Ensure patients are treated in the right networked facilities	• Facility specifications and advice to support designation of network facilities and definition of consistent care pathways	• Q4 2015/16 – Spec for UCC and Emergency Centres	• 2017

Urgent and Emergency Care Route Map (3)

6 Mental Health Crisis	Deliverable	Supporting product publication	Timescale for delivery
An access and waiting time standard will be introduced for 24/7 crisis assessment	• Access and waiting time standard for 24/7 crisis assessment response (community based) • Improving access to health-based places of safety following Section 136	• Introduced 16/17 • Prepared in 15/16	• 2017/18 implementation • 16/17 introduction
An access/ waiting time standard will be introduced for liaison mental health services in A&E	• Access and waiting time standard for assessment by liaison mental health services in A&E (as per 7DS standard)	• Introduced 16/17	• 2017/18 implementation
An assessment standard for those with Mental Health needs	• A next generation clinical assessment system specifically designed to support mental health needs and crisis. This will cover Multi – channel access; i.e. voice, face to face/ telephone and online.	• Prepared in 16/17	• 2017/18 implementation
7 Supporting Self Care			
Personalised care and support planning	• People who are most at risk of needing emergency care, including mental health crisis care, will have the option of a person centred care and support plan	• Guidance published January 2015	• 2017
Support for self-management	• Supported self-management guide published with Age UK based on 11 principal risk factors associated with functional decline in older people living at home • Consensus statement and practical guidance to support commissioners and Fire and Rescue Services to use the 670k home visits carried our annually by the FRS to keep people 'safe and well' • Tools to support implementation of key approaches, including self-management education and peer support e.g. commissioning tool / economic model underpinned by a clear evidence base • A series of innovative tools / training packages to support culture change for health and care professionals • An overview and assessment of the levers, barriers and enablers of person-centred care – and a set of recommendations for the future	• Published January 2015. Revision in October 2015 • October 2015 • Beta versions from Spring 2016 • Final products to be developed nationally Autumn 2016	• 2015/16 publication. 2016/17 integration within frailty pathway approach • Implementation support from 2015/16 • Implementation in line with local plans 2016 / 2017
Personalised Health Budgets	• CCGs are developing their local personal health budgets offer and will be introducing PHBs beyond NHS continuing healthcare in line with the 2015/16 planning guidance.	• National roll out from April 2015	• Implementation in line with local plans 2017

Urgent and Emergency Care Route Map (4)

8 Independent Care Sector	Deliverable	Supporting product publication	Timescale for delivery
Local Commissioning Practice	• Guidance to CCGs and LAs on working with the ICS, including encouraging joint winter and future capacity planning • Clarification guidance to be made available on Continuing Healthcare processes – within Quick Guide: Improving Hospital Discharge • Guidance for acute trusts on how to support self-funders (choice protocols)	• Guidance published Q3 2015/16 • Guidance published Q3 2015/16 • Guidance published Q3 2015/16	• Q3 – Q4 2015/16 • Q3 – Q4 2015/16 • Q3 – Q4 2015/16

Better use of care homes	• Guidance for best practice clinical input required for care homes:
	  • Quick Guide: Clinical input into care homes
	  • Phase II – long term models including cost benefit analysis
	• Quick Guide: Identifying local care home placements
	• Quick Guide: Technology in care homes
		Guidance published:
		• Q3 2015/16
		• 2016/17
		• Guidance published Q3 2015/16
			• Q3 2015/16 – Q4 2016/17
			• Q3 – 2015/16

Improving Hospital Discharge	• Quick Guide: Improving Hospital Discharge to the care sector • Quick Guide: Sharing Patient Information	• Q3 2015/16	• Q3 2015/16
Better use of care at home	• Quick Guide: Better use of care at home	• Guidance published Q3 2015/16	• Q3 – Q4 2015/16
9 Primary Care			
Improved access to primary care	• 18 million people will have access to weekend and weekday appointments, and/or different modes of accessing general practice • Routine access to GP appointments at evenings and weekends	• Phase 2 PMCF • Primary Care Infrastructure Fund	• March 2016 • 2020
Increased role for pharmacy in urgent care	• Pharmacy access to Summary Care Record • Seasonal Influenza Vaccination Advanced Service for community pharmacy • Quick Guide: Extending the role of Community Pharmacy in UEC	• Refreshed guidance Autumn 2015 • Q3 2015/16	• Autumn 2015-17 • Autumn 2015 • Q3 – 2015/16
Improving oral and dental health	• Quick Guide: Best use of unscheduled dental care services	• Guidance published Q3 2015/16	• Q3 – 2015/16

Title of Report:	**Better Care Fund – Progress Report**
Report to be considered by:	The Health and Wellbeing Board
Date of Meeting:	28th January 2016

Purpose of Report: **To update the Health and Wellbeing Board about progress on West Berkshire Locality Better Care Fund Programme**

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.		

Health and Wellbeing Board Chairman details	
Name & Telephone No.:	Councillor Graham Jones (01235) 762744
E-mail Address:	Graham.Jones@westberks.gov.uk

Contact Officer Details	
Name:	Tandra Forster
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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 Quarter 2 template has been submitted. Quarter 3 data will be submitted in February 2016.

2.2 In order to smooth the submission process delegated authority to the Head of Service, Adult Social Care, West Berkshire Council in consultation with the Chair and Vice Chair of the Health and Wellbeing Board has been sought.This will be incorporated as part of changes to the Council's constitution.

3. **'Showcasing' West Berkshire.** The visit is scheduled for the 3 February 2016, an agenda has been developed and will involve as many system representatives as possible.

4. **Better Care Fund from 1st April 2016.** The Department of Health has confirmed that the will be a BCF for 16/17. Operational guidance will be published in January 2016. The timetable will be very challenging with the outline financial planning needing to be submitted by the 8th February 2016. Initial discussions between the Council and the CCG are underway.

5. BCF Projects progress

(1) **Hospital At Home**
The resources for this project have been redirected 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; the option of re-running this leadership course is being explored to ensure that the full range of care homes in west Berkshire can benefit.

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

The project will simplify access to and reduces 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 was 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 this has now been established as a new service standard, however, funding is only 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. The pilot was expected to lead to an ongoing contract through competitive tender from April 2016, however, the take up of the service during this short pilot phase has been gradual as it is taking time for it to become known about and by April 2016 there will be insufficient data on which to confidently design a service going forward; for this reason the Integrated Steering Board has taken a decision in principle to extend the pilot for a further 3 months, subject to successful negotiations with the providers regarding the terms of the extension. .

(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. The workforce Project will be developing a Business Case for this project which will set out the overall cost

benefits to the BW10 Partnership system, as well as potential cost pressure changes that may result from Councils taking over some Health tasks or vice versa.

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.

Appendices

Appendix A – Highlight Report
Appendix B – Integration Portfolio Status Report and Risk Register
Appendix C -

Consultees

Officers Consulted: Steve Duffin, Shairoz Claridge, Patrick Leavey

Other: Not applicable

Connected Care - Phase 2

Project	West Berkshire Connected Care Project (Ref: IMT8002)	Project Manager	John Devine		Period Ending	20-Nov-15
Project Objectives		Project Budget:	£713k (FY2015-16)	Green	Planned Completion date:	31-Mar-16

The aim of the overall programme is to improve clinical effectiveness and patient experience by providing clinicians and carers with a comprehensive view of patient medical history irrespective of source, moving away from separated information systems and data silos to a multi-system cross care setting landscape.

Phase 2 of the Connected Care Programme will:
- Facilitate multiple organisations to share sub-sets of their data via a single integrated proof of concept portal with view-only functionality.
- Enable the partner organisations to procure a full portal solution.

Summary Status - Comments Overall Project (Incl Key Achievements)

Phase 2 Key Overview

Pilot Release 0.1 (MIG and RBH inpatient and emergency admissions/discharges)

• Now LIVE. Being utilised by 1st tranche of users (31) since 17th Nov -15.
• System is performing well as expected.

Pilot Release 0.2 (RBH outpatient encounters, allergies, labs and BHFT RiO)

• Go-live delayed due to BHFT internal project commitments. Orion awaits the finalised RiO database specification document from BHFT before any further progress can be made.
• Testing of RBH Labs is expected to be complete before RiO data integration is completed (not holding up progress)
• Outpatient appointments re-configuration and testing to start as soon as RBH resources are available.
• Release 0.2 go-live date scheduled for 22nd Dec -15, subject to delivery of external dependency - BHFT D.B build. Please see dependencies for further info.

Data Providers

• GP and RBFT phase 2 data-sets defined and signed-off. BHFT require some minor clarifications before sign-off. CSU is trying to coordinate a meeting with Mark Davison and Bill Johnston.

Vendors

• Orion handed over portal for testing 2 weeks late. It was evident that there was a lack of Orion system testing prior to handover to the CSU.
• Orion Time and Management hours allocated to the delivery of the Connected Care project are now exhausted. Orion has agreed to complete all required work regardless.
• Service delivery has been good this week.

Phase 3 Key Overview

IG

• Steering Group: Dr Rawlinson (LMC) appointed as Chair. 14 partner organisations represented.
• Patient Information Programme Requirements, Consent Model and Patient Opt-Out Strategy now approved by the group and all individual organisations.

Finance

• Phase 3 funding streams confirmed.

Procurement

OBC

• Outline Business Case version 0.14 approved by board on 22nd Sept - 15.

ITT

• Issued to the market 29th Oct -15.
• 4 Supplier bids submitted; **Orion, Graphnet, Kainos and Bramble.**
• Stakeholder scoring of supplier submissions due to commence 26th Nov - 15.

FBC

Project Overview - Summary RAG Status *(see guide)*

Overall Project Status	Red
Time	Red
Project Spend YTD:	Green
Quality	Green
Resource	Green

Activities due to start and /or finish on a two month rolling period.

Major Deliverables / Milestones	Baseline Start	Forecast Start	Baseline Finish	Forecast Finish		Reason for delays, impacts etc. (Red/Amber-Red only)
Infrastructure in place, build complete	05-Jun-15	05-Jun-15	13-Jul-15	21-Jul-15	Blue	
Data sharing Phase 2 Schedule D sign-off	13-Feb-14	21-Jan-14	13-Mar-15	22-Jun-15	Blue	
Orion interfaces build	17-Jun-15	31-Jul-15	10-Aug-15	24-Aug-15	Blue	
Business Case signed-off by all partners	15-Jun-15	15-Jun-15	21-Sep-15	30-Sep-15	Blue	OBC approved during Connected Care board meeting in Sept - 15.
Pilot Release 0.1 (MIG and RBH ADTs)	25-Sep-15	10-Nov-15	25-Sep-15	11-Nov-15	Blue	
BHFT D.B build	30-Sep-15	30-Sep-15	02-Nov-15	TBC	Red	Please dependencies
Pilot Release 0.2 (RBH Labs and RiO)	09-Nov-15	22-Dec-15	09-Nov-15	22-Dec-15	Red	Please dependencies
ITT bids received Initial review PASS/FAIL	23-Nov-15	23-Nov-15	23-Nov-15	23-Nov-15	Green	
Stakeholder supplier submissions - scoring and moderation complete	26-Nov-15	26-Nov-15	17-Dec-15	17-Dec-15	Green	
Suppliers down-selected for demonstrations	23-Dec-15	23-Dec-15	23-Dec-15	23-Dec-15	Green	
Supplier demonstrations complete	07-Jan-16	07-Jan-16	08-Jan-16	08-Jan-16	Green	
FBC submitted for partner sign-off	15-Jan-16	15-Jan-16	15-Jan-16	15-Jan-16	Green	
Scores calculated/ successful bidder identified and informed	14-Jan-16	14-Jan-16	21-Jan-16	21-Jan-16	Green	
Supplier contract agreed	18-Mar-16	18-Mar-16	18-Mar-16	18-Mar-16	Green	

Dependencies

Plan Ref	Major Deliverables / Milestones	Date Needed	Supplying Project		Comments (e.g. impact on project/work stream)
1.4.1.9.4	Infrastructure in place, build complete	17-Jul-15	RBFT	Blue	COMPLETE
1.4.1.8.5	Orion build	10-Aug-15	ORION	Blue	COMPLETE
1.4.2.3.4.5.9.1.1	BHFT D.B build	02-Nov-15	BHFT	Red	**20th Nov:** BHFT D.B build delayed due to BHFT internal project commitments. Orion awaits the finalised RiO database specification document from BHFT before any further progress can be made. BHFT agreed to provide the document w/s 16th Nov -15. **Revised time-scales agreed with BHFT transformation lead 16th Nov -15;** • **17th Nov -15 (DELIVERY DATE MISSED):** Server available with IP address and RFC's to BHFT network and RBH Network submitted to enable connectivity • **20th Nov -15 (DELIVERY DATE MISSED):** BHFT finalisation of DB specification • **24th Nov -15:** Kick-off meeting with Orion to discuss the spec to enable Orion to write the SQL queries. • **1st Dec -15**: Establish connectivity between BHFT D.B and Orion portal / establish VPN tunnel / encryption • **2nd Dec to 21st Dec -15:** Testing • **22nd Dec -15:** Release 2 go-live

Connected Care - Phase 2

Project	West Berkshire Connected Care Project (Ref: IMT8002)	**Project Manager**	John Devine	**Period Ending**	20-Nov-15

Risks (Top 3 Red and Amber-Red)

Risk ID	Risk Description including Cause	Consequences / Impact		Mitigating Actions	Action Owner
10 - risks	**Capital funding in Berkshire East.** Potential risk of reduced funding due to lack of engagement from FHFT.	Reduced funding for Berkshire East. We need to consider the timing of FHFT's involvement in the procurement. Potential mitigation will require a separate Berkshire East and Berkshire West procurement phase. Berkshire East will need to carefully consider the timing of FHFT's involvement in the procurement.	Amber	**20 Nov -15:** FHFT will not be directly involved in the evaluation of supplier submissions or demos as it currently stands. CSU continues to engage with Sharon Boundy to ensure FHFT are aware of progress and key dates.	John Macdonald
11 - risks	**Non-attendance/participation** of nominated stakeholder review panel members in vendor requirements scoring and vendor demonstration workshops.	Incomplete/delayed vendor scoring could delay the procurement phase. Potential loss of stakeholder confidence as a result of an incomplete review panel.	Amber	**20 Nov:** • CSU PMO requested review panel partner nominations on 2nd Nov. PMO are chasing those partners who have not provided the requested information. • Appointment placeholders for moderation meetings and supplier demos have been sent out to all partner leads. PMO has requested that these are forwarded to the relevant evaluation panel members within their organisations. • Evaluation panel guidance / introduction drop-in sessions and 1 to 1 sessions have been offered to all partner leads. • Partner evaluation panel nominations will be reviewed by CC board on 26th Nov -15.	John Devine

Issues (Top 3 Red and Amber-Red)

Issue ID	Product / Milestone Impacted	Issue Description		Resolution Actions	Action Owner
17- issues	• Pilot Release 0.1 (MIG and RBH ADTs)	**RBH Cerner messaging formats** • Outpatient appointment cancellations are not being processed by the portal. This is attributed to unexpected formats of RBH Cerner messaging. • Patient "un-merge" messages are not being sent from Cerner as expected. This will require a manual RBH business process in order to ensure the portal reflects the patient merges that are being completed within Cerner. **IMPACT** • Delay to the availability of outpatient encounters via the Portal. This data will not be available until release 2 in December -15.	Amber	**20 Nov:** • RBH is currently unable to allocate the required resources to resolve the messaging format issues due to internal project demands. RBH are working to make these resources available as soon as possible. • RBH outpatient appointment encounters will be made available in release 0.2 of the portal in Dec -15 along with Labs.	John Devine

Phase 2

Pilot Release 0.1 (MIG and RBH inpatient and emergency admissions/discharges)

• Distribute baseline survey to first tranche of users (31)

• Coordinate further rollout of user accounts to RBH (40) and BHFT (40) users.

Pilot Release 0.2 (RBH Labs and RiO)

• Complete Orion / BHFT database specification “lockdown “meeting. Objective: enable Orion to write the SQL queries that will call RiO data from BHFT.

• BHFT to confirm IP address of the server that will host the RiO data and to submit required firewall change requests to RBH.

• RBH to allocate required resources to; a) modify Cerner messaging formats to enable the portal to process the cancellation of "un-checked-in" outpatient appointments and b) complete testing of Labs results.

Vendors

• Orion to support in the implementation and testing of the RBH message format fix (to enable the portal to process outpatient appointment cancellations)

• Attend the BHFT database specification “lockdown “meeting and commence development of RiO interface.

Phase 3

IG

• Steering Group: Next meeting 2nd Dec. Confirm individual representatives’ local governance arrangements required to formally sign-off of supporting collateral (where the individual group member may not have authority to do so)

• CSU IG Lead to commence development of Subject Access Request and Incident Management Reporting processes for submission to the group for review next month. Orion pilot portal auditing procedures to be reviewed also.

Comms / Benefits

• Establish a comprehensive ‘go to’ patient group where we can test messages / materials and encourage engagement. West Berks patient forums / groups are already engaged, and a group is being formalised.

• Continue to develop stakeholder analysis.

• Focus on the identification of Benefits for Social Care.

Procurement

ITT supplier submission/demo scoring

• CSU procurement to complete scoring of the x4 supplier submissions against the PASS/FAIL questions.

• CSU project team to commence delivery of the evaluator briefing and drop in sessions to ensure partner organisations are prepared to effectively score supplier submissions.

FBC

KEY			
Blue	Completed	Amber	Some slippage, seen as recoverable. Finish date still seen as achievable. Manageable within project
Green	On Track / Under Control	Amber- Red	Finish date very likely to slip, Management support required to resolve
		Red	Finish date has / will definitely slip. Can't be managed within the project

PROGRAMME	Integrated Carers Commissioning	**PROGRAMME MANAGER**	Janette Searle	**OVERALL RAG**	**amber**
REPORT MONTH END		**REPORT ISSUE DATE**	04.12.2015	**REPORT STATUS**	Final

is

PROJECTS/ SCHEMES STATUS		
A Berkshire West Carers Commissioning Forum (BWCCF) has been established under the chairmanship of the CCGs Director of Joint Commissioning to oversee the future commissioning and development of carer support across Berkshire West. This is one of the enabling work streams within the BW10 Integration Programme, The BWCCF leads on the development of strategic plans and commissioning arrangements for supporting carers across Berkshire West, and also informs the development of other plans and arrangements which have the potential to improve outcomes for carers. The aim is to move towards single pot funding for all carer support across the West of Berkshire and to offer a consistent range of services, particularly to improve the experience of carers supporting others across local authority boundaries.		**Project Status** **Financial Status** **Activity Status** **Milestone Status**

KEY ACHIEVEMENTS	
Carer Information Advice & Support Contract	Reading and West Berkshire: 17 bids across 5 lots received by the deadline against the Reading and West Berkshire commissioning prospectus. Initial scoring completed. Wokingham: Carers Prevention Services model completed
Carers breaks provision and support	West Berkshire Council will re-commission carers breaks provision from April 2016 through its Voluntary Sector Prospectus. Reading BC will re-commission carers breaks provision from June 2016 through its Narrowing the Gap Bidding Framework. Short Breaks for Disabled Children will be re-commissioned through a separate process. BW CCGs have launched a Partnership Development Fund round through which additional carers breaks support may be commissioned. Wokingham BC will re-commission against its Carers Prevention Services model.
BW Carers Commissioning Strategy	Surveys issued at Carers Rights Day events. Outline structure and timeline approved by a majority of the BW Carers Commissioning Forum, although Wokingham BC has not yet commented or shared their local draft carers strategy with the Forum
NEXT STEPS / PLANNED ACTIVITIES	
Carer Information Advice & Support contract	Reading & West Berkshire: Hold clarification meetings as required, and award funding agreements. Plan transition to new arrangements. Wokingham: develop commissioning plans based on the Carers Prevention Services model
Carers breaks provision and support	WB Council: receive and appraise bids into Voluntary Sector Prospectus Reading BC: receive and appraise bids into Narrowing the Gap Bidding Framework CCGs: receive and appraise bids into Partnership Development Fund Wokingham BC: re-commission against Carers Prevention Services model
BW Carers Commissioning Strategy	Review progress and allocation of tasks between BWCCF embers at 14.12.2015 meeting.
NEW ISSUES RAISED THIS PERIOD	

NEW RISKS IDENTIFIED THIS PERIOD

PROJECT MILESTONES, DELIVERABLES					
Project Milestones (Include all milestones from last month onwards)	*Task Owner*	*Original Delivery Date*	*Planned delivery Date*	*Conf H/M/L*	*Explanation for slippage, impact on workstream and actions being taken. Has any re-planning been approved by appropriate Board?*

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

BCF/ Programme Name Highlight Report

Project Budget / Cost Summary (£000s) as at DATE

Funded From:	s256				CTA			Council Funding				Explanation – please use box below if further space is required
Cost Type	Original budget (in Business Case)	Actual spend to date	Forecast to 31st March 2015	Forecast To Completion of scheme	Original budget (in Business Case)	Actual spend to date	Forecast to 31st March 2015	Original budget (in Business Case)	Actual spend to date	Forecast to 31st March 2015	Forecast To Completion of scheme	
Programme and Project Management costs												
Programme Manager												
Sub Total	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**0**	
Pump Priming for Go Live												
Sub Total	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**0**	
Totals	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**0**	

FINANCE *Explanation for slippage, impact on workstream and actions being taken. Has any re-planning been approved by appropriate Board?*

Full description of any areas of concern/ to highlight from costs table above

PROGRAMME	BW10 Market Management	PROGRAMME MANAGER	Stuart Rowbotham (SRO)	OVERALL RAG	A
REPORT MONTH END*	November	REPORT ISSUE DATE	December 2015	REPORT STATUS	Draft

PROJECTS/ SCHEMES STATUS		
To date the project has failed to gain any real traction or buy in for current work streams (placement/market date hub, fee setting protocols, shared provider failure processes/protocols). If the project is to continue, there is a requirement to re-affirm project aims to ensure they match Integration agenda aspirations and to ensure commitment from stakeholders. Depending on the agreed new aims of the project, it may be consumed into other existing integration work programmes, e.g. Joint Commissioning or Care Homes. Alternatively, the project may focus on options for joint functions between partners to deliver efficiencies e.g. process of residential/nursing care placements that may achieve original project aspirations of data sharing and fair fees. Any future project initiatives need to identify and realise a tangible benefit of joint working/collaboration and enhance or replace commissioning/market management activity already taking place locally. *If the project is to continue PM resource will need to be allocated/recruited as current role, provided via PMO, ended in October 15.*	A	Project Status
	G	Financial Status
	A	Activity Status
	A	Milestone Status

KEY ACHIEVEMENTS	To Date
Market Management Information System **Previously** - Feasibility Study for an Information Market Management System (IMSS)	**Market Intelligence** – software solution identified that provides on-demand area wide current/historic fee information for individual services plus recommended local 'fair fee' guides. Base data hub cost of £15k per partner with additional 'add-on' modules available (such as care directory, direct purchasing and real time vacancy management) at additional cost. West Berks LA have declared early that they didn't have a need (and in fact it felt it could be a threat to current pricing) and after failure to secure a 3rd partner (the original agreed critical mass) this initiative had effectively been discounted. However, alternative proposal has recently been put forward by the service provider for a system across Wokingham and Reading that meets the original remit and may present opportunity as part of a 'joint care home placement' function. This option will also assist with fair fee pricing and constancy across partners. Decision required as to whether to progress as potential pilot, possibly as part of joint functions/commissioning considerations.
Market/Provider Failure Management	Each authority has a draft or final policy to suit its own circumstances. Group agreed to include a uniform 'mutual aid' clause to provide support to any authority that suffers a provider failure.
Fair Pricing – Residential and Nursing Care	Group unable to reach a consensus on tools to agree a fair pricing mechanism; acknowledged that West Berks LA don't have the same n/h cost and availability problem that Wokingham/Reading have. However, information system and 'joint placement function' detailed above could deliver

	consistent pricing mechanism and usual cost across Reading and Wokingham.

NEXT STEPS / PLANNED ACTIVITIES	
	As per key achievement section above (MM Information system) – decision on joint functions/placement system required by Wokingham and Reading. As per Project status above – wider Project future/remit to be agreed via Delivery Group

NEW ISSUES RAISED THIS PERIOD
Project Support, via PMO, only in place until end of October 15

NEW RISKS IDENTIFIED THIS PERIOD
None

PROJECT MILESTONES, DELIVERABLES

Project Milestones (Include all milestones from last month onwards)	*Task Owner*	*Original Delivery Date*	*Planned delivery Date*	*Conf H/M/L*	*Explanation for slippage, impact on work stream and actions being taken. Has any re-planning been approved by appropriate Board?*
Reaffirm project aims and focus	SRO/PM		Dec 15	M	
Decision on progress of Management Information system	SRO/PM		Dec 15	M	

RESOURCE SUMMARY

Number of Main (FTE) Resources Required	*Number Now In Post*	*Explanation for variance, impact on work stream and actions being taken.*
0.4 Project Manager/Support	0	PT support via PMO ended October 15

2015/16 Project Budget / Cost Summary (£000s) as at 30 November 15				
Cost Type	***Original budget (in Business Case)***	***Actual spend to date***	***Forecast to 31st March 2016***	***Explanation/notes– please use box below if further space is required***
List Programme/Project Costs				
Project Manager	52,000	28,346	*28,346*	Previous PM role covered 2 programmes until the end of July – Market Management and Enhanced Support to Care Homes. 50% of costs apportion to Market Management and included in actual spend. From 01 August role reverted back to 2 days per week (delivered via BW10 PMO). Support via PMO finished end of October hence forecast underspend
Totals	52,000	28,346	*28,346*	

2015/16 Project Savings (£000) – If Applicable		
Planned Project Savings £000	***Forecast Savings To 31 Mar 16 £000***	***Explanation/notes for variance or slippage from target or last reporting period***

FINANCE *Explanation for slippage, impact on workstream and actions being taken. Has any re-planning been approved by appropriate Board?*
Full description of any areas of concern/ to highlight from costs table above

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PROGRAMME	Hospital @ Home Project	PROGRAMME MANAGER	**Fiona Slevin-Brown, SRO** **Rhian Warner, PM**	OVERALL RAG	Red
REPORT MONTH END	30th November 2015	REPORT ISSUE DATE	**4th December 2015**	REPORT STATUS	

PROJECTS/ SCHEMES STATUS

Project Status

- The H@H project has formally been paused: due to a lack of activity going onto the agreed pathway. Interim staff work plan proposals were shared with the 3 LA DAs 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.
- The proposals agreed were:
  - Rapid Response and Treatment to Care Homes and
  - Enhanced Medical support to the Older Peoples Mental Health Inpatients at Prospect Park Hospital.
- Approval has now been gained from the BW integration board and delivery groups
- RRAT has been presented to West Berkshire Integrated Care Steering Group, Wokingham Integration Strategic Partnership (WISP), Wokingham CCG GP Council and Wokingham Care Governance Board meeting
- Letters to Healthwatch on 2nd November to inform them of the changes to H@H project and to ask for a patient volunteer.
- Paper presented to the Delivery Group on the 18th November for the Health and Well-being Boards.
- The retrospective PID was completed and was circulated to the UCPB and the LA Integration Boards on the 16th November
- BHFT sent change of contract letter on the 4th November for the in year contractual changes
- Operational responsibility was handed over to BHFT on the 13th November 2015
- The Project Group monitoring this project was agreed and the first meeting will be held in December 2015.
- The potential phasing for Phase 2, 3 and 4 Care Homes has been circulated to the project group and LA Integration Board leads. Appendix 2

Current status

- Both projects have been live since the 19th October
- RRAT became fully operational from 26th October
- RRAT have received 15 referrals up to the 27th November 2015 with a target of 16 referrals in this time period for phase 1. See Appendix 1 for a brief overview.
- The community geriatrician is carrying out an average of 6-8 reviews per session for the OPMH Inpatients.

	Project Status
	Financial status
	Activity Status
	Milestone Status
	Project status: RAG scored amber as project has now been reframed and operationalized and aims and objectives not measurable at this point. *Financial status*: RAG scored red as no savings have been seen to date with the project and expenditure already committed. *Activity status:* RAG scored amber as 15 patients have been through the service against a target of 16 but data report not available to review until 5th working day of the following month. *Milestone status*: Green; no outstanding milestones for November

KEY ACHIEVEMENTS FOR NOVEMBER

Operational	Working with Project Group, ANPs and Community Geriatrician to develop further information for Care homes to reduce the risk of Care Homes calling RRAT when it should be 999 and vice versa. Liaison with NRS and Trish Guest to resolve the Telehealth equipment ordering issues
Communication	On-going Communications to all stakeholders on arrangements have continued throughout November. Communications to care homes and GPs have been delivered face to face by the ANPs, nurses and

	community geriatrician. PM has attended some GP Council meetings, LA integration boards and LA Quality Meetings as required updating GPs and LAs about project status and plans.

NEXT STEPS / PLANNED ACTIVITIES FOR DECEMBER	
	Presentations RBC Care Home Quality Board and Reading Integration Board 1st Project Group monitoring for the project moving forwards Agree activity modelling for 2016/17 with BHFT in order to inform workforce planning for 2016/17 and investment required from H@H funding Complete information required for Care Homes Project RRAT work stream for PID for QIPP and Finance RRAT Service to be added to 111 DOS, this is an on-going plan as the pathway is complex as it is a small group and geographically restricted.

NEW ISSUES RAISED
Telehealth equipment is time consuming to order as have to order each individual component. There is a risk that an item could be forgotten
NEW RISKS IDENTIFIED
There is a risk that care homes could call RRAT when they should be calling 999 for a resident which could incorporate a delay to treatment.

PROJECT MILESTONES, DELIVERABLES

Project Milestones (Include all milestones from last month onwards)	*Task Owner*	*Original delivery Date*	*Planned delivery Date*	*Conf H/M/L*	*Explanation for slippage, impact on work stream and actions being taken. Has any re-planning been approved by appropriate Board?*
Revised proposal for QIPP and Finance and Health and Well-being Boards	PM	31st Oct	31st Oct	High	Interim work plan proposals presented to QIPP and finance 22nd September. No agreement for 16/17 to date.
Write and Agree addendums to service specifications and pathway model	PM	9th Oct	9th Oct	High	Written and completed on 23rd October
Comms for all partners to be written and disseminated.	PM	13th Nov	13th Nov	High	Comms all written by 19th October and dissemination started on 19th October
Referrals to rapid response to commence	Care Homes GPs, A&E, SCAS	19th Oct	19th Oct	Med	2 referrals received to date
Agree phase 2, 3 and 4 care homes	PM	15th Nov	15th Nov	High	Agreed in principle for sign off at December Project Group meeting
Complete PID for presentation at QIPP and Finance Committee	PM	15th Nov	15th Nov	High	Retrospective PID completed and sent on 16th November
Agree Project Monitoring Board	All providers and partners	5th Nov	5th Nov	High	Project Board Agreed 5th November
Complete all information for RRAT work stream for Care	PM and BHFT	15th Dec	15th Dec	Med	

Homes PID including activity, capacity, and Workforce models for RRAT					
Review of Enhanced Support for OPMH and update business case for internal BHFT resubmission	PM and BHFT	15th Jan 2016	15th Jan 2016	Med	
Complete review of Phase 1	PM	18th Jan	18th Jan 2016	High	
Launch Phase 2	BHFT	1st Feb 2016	1st Feb 2016	Med	

Appendix 1

Action Date Time	Care Home Name	Patients reported condition	Locality
19/10/2015 09:53	Hungerford	Ref CareHome Concerns with pt having difficulties in breathing, having Ventolin inhaler not helping, Bloods taken a week ago, CRP raised, has chest infection has been on antibiotics. 02 sats around 90-92.	Newbury
26/10/2015 08:30	Riverview	RRAT Care Home River View Nursing Home Pt has history of falls.	Reading
27/10/2015 09:23	Woodbury House	Rapid Response and Treatment for Care Homes Wok - Lady EOL with dark coloured foot and midcalf - poor circulation	Wokingam
30/10/2015 09:33	Donnington	Ref for RRAT To avoid admission, Suspected UTI not eating or drinking and not able to swallow meds, Pt also had large seizure this morning as not able to take meds. Needs IV fluids and Antibiotics. Paramedic still on scene .	Newbury
03/11/2015 11:04	St Lukes	Ref RRAT RDG Was seen by Dr yesterday, Pt severely dehydrated with possible UTI	Reading
04/11/2015 15:53	Lakeside	Ref RRAT READING	Reading
06/11/2015 10:20	Suffolk Lodge	Rapid Response and Treatment for Care Homes (Wok) Patient may have a chest infection as patient has been coughing a lot. Suffolk Lodge rang the GP but they asked them to call the Hub. Pt has been out of hospital for 2 days now. Pt seems frail and mobilises with a Zimmer Frame plus one.	Wokingam
09/11/2015 09:20	St Lukes	Rapid Response and Treatment for Care Homes Rdg. patient is suffering with SOB and has some tingling in his fingers, have contacted the GP, but the GP is due a home visit. The RRAT Team has requested that the referral to be made to them. Pt does not look his normal self and suffers with dementia. Pt is normally independent with his mobility and walks with a walking frame. Pt needs prompting with all his ADLS.	Reading
19/11/2015 10:52	Suffolk Lodge	RRAT new referral	Wokingam
20/11/2015 09:56	Lakeside	RAPID RESPONSE AND TREATMENT FOR CARE HOMES (RDG) Pt came in with a fall and UTI and had a blocked catheter. The catheter has been taken out but not re inserted. Has been sent home with 5 days of Trimethoprim.	Reading
20/11/2015 10:23	Lord Harris	RRAT WOK REF GP summary requested	Wokingam
23/11/2015 14:12	Suffolk Lodge	RRAT REF WOK Received by the HUB Pt has dementia-unable to consent. Nursing home has with best interest.	Wokingam
25/11/2015 11:33	Alexandra Grange	Referral for RRAT Came in with diarrhoea and vomiting and needs to return home iv fluids and monitoring - Keep hydrated and avoid further admittance. - the referrer stated that they have spoken to the team and the Pt has been accepted. Pt summary has been requested from the surgery.	Wokingam
25/11/2015 12:01	Abbeyfield	Ref for RATT RDG Pt back to care home - needs IV AB - RATT team are present and need this referral opened up their team.	Reading
27/11/2015 07:59	Lord Harris	HUB Services RRAT Care Homes- Wokingham	Wokingam

Appendix 2

Phase 1 - 15 Care Homes

Rank	Reading	West Berks	Wokingham
1	Abbeyfield House	Walnut Close	Lord Harris Court
2	River View Care Centre	Birchwood Care Home	Suffolk Lodge
3	St Luke`s & The Oaks Residential Home	Hungerford Care Centre	Sunrise (assisted living)
4	Jasmine House	Bayford House Nursing Centre	Warren Lodge
5	Lakeside Residential Home	Willows Edge	Woodbury House Care Home

Phase 2 - 15 Care Homes

Rank	Reading	West Berks	Wokingham
6	Parkside House Nursing Home	Hollies Care Home	The Berkshire Nursing Home
7	The Willows Specialist Dementia	Holly Grange	Glebelands Care Home
8	The Boltons	Donnington Nursing Home	Westminster West Oak
9	Life Care Home	Argyles Nursing Home	The Liberty Of Earley House
10	Navara Lodge	Thatcham Nursing Home	Alexandra Grange Care Home

Phase 3 - 14 Care Homes

Rank	Reading	West Berks	Wokingham
11	Beacher Hall Nursing Home	Notrees	Down Lodge
12	Bath Lodge	Chestnut Walk EP Home	Austen House
13	Summerfield Rest Home	[redacted]	Wild Acres Care Home
14	Northcourt Lodge Nursing Home		The Mount
15	Mulberry House		Murdoch House
16	Moorlands Rest Home		Belamie Gables

Phase 4 - 8 Care Homes

Rank	Reading	West Berks	Wokingham
17	Pembroke Lodge	[redacted]	Bridge House Nursing Home
18	[redacted]		Valerie's Rest Home
19			Lynden Hill Clinic
20			Ravenswood Village
21			Lovat House
22			Beechbrook Residential Home
23			Hilltop House

PROGRAMME	WEST BERKSHIRE BCF PROGRAMME	INTEGRATION LEAD	Patrick Leavey	OVERALL RAG (JCP + PRG)	AMBER
REPORT PERIOD	1 – 30 November 2015	REPORT ISSUE DATE	1/12/15	REPORT STATUS	DRAFT

AUTHOR	Patrick Leavey, WBC Integration Lead	DATE APPROVED	1.12.15		
APPROVAL BY	Shannon Coleman-Slaughter, WBC Finance Lead				
	Sue White, BHFT Project Lead				
	Shairoz Claridge, Co-Project Sponsor (JCP & PRG)			RAG RATING PROVIDED FOR:	JCP + PRG
	Ian Mundy, Co-Project Sponsor (PRG)				PRG only
	Tandra Forster, Co-Project Sponsor (JCP)				JCP Only

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

PROJECT/ SCHEMES STATUS

Executive Summary: –the Joint Care Provider project (condition 1 – Discharge) has been adopted as business as usual and from 1st November has been extended 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 to be undertaken – closure report and post-project actions document to be prepared.

Finance - The S75 agreement has been signed off.

Project Status
Financial Status
Activity Status
Milestone Status

KEY ACHIEVEMENTS	
Project Level	1. extension of Discharge (condition 1) to North Hants, Great Western 2. Initial scoping to requirements for conditions 2, 3, 4 for introduction at RBH/WBCH 3. Monthly staff survey extended to all involved in Provider scheme (approx. 60 staff) 4.
BCF04 Joint Care Provider	**'Pathway Redesign' Work Package condition one - Discharge** • Completion of Innovation Phase and adoption of new processes as business as usual • New Pathway now route for service for all patients from full range of hospitals from 1st November 15.
BCF05 7 Day Services	**'7 Day Working':** • Pilot of weekend Social Worker presence at RBH has proved successful and beneficial to maintain momentum in discharge pathway. This servicel continued from 6th November and will provide a contact point for progressing discharge arrangements for patients in any hospitals as required.
BCF01 Community	**'Trusted Assessor' Work Package 3**

Nurses Directly Commissioning Care / Reablement Services	

NEXT STEPS / PLANNED ACTIVITIES	
Project Level	Project closure documentation to be prepared
BCF04 Joint Care Provider	**'Pathway Redesign' Work Package condition one - Discharge** • Full implementation of new pathway to continue •
BCF05 7 Day Services	**Work Package 2 – '7 Day Services'** • Care Management Staff to be operational at Weekends to continue discharge and community care planning processes across 7 days from . • Operational Management weekend cover to be established to support enhanced service.
BCF01 Community Nurses Directly Commissioning Care / Reablement Services	**Work Package 3 – 'Trusted Assessor'** • 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.

NEW ISSUES RAISED THIS PERIOD
None to report

NEW/REVISED RISKS IDENTIFIED THIS PERIOD
No new risks raised this period

PROJECT MILESTONES, DELIVERABLES

Project Milestones (Include all milestones from last month onwards)	*Task Owner*	*Original Delivery Date*	*Planned delivery Date*	*Conf H/M/L*	*Explanation for slippage, impact on work stream and actions being taken. Has any re-planning been approved by appropriate Board?*
Joint Care Provider (inc 7 day services and direct commissioning)					
Milestone 9: Project Closure	PL		Jan	M	

RESOURCE SUMMARY

Number of Main (FTE) Resources Required	*Number Now In Post*	*Explanation for variance, impact on work stream and actions being taken.*
1 x Project Manager	1	Shared across both projects, until 31 August
0.5 x Project Administrator	0.5	Administrator supports both projects and ICSG, until 31 August
1.4 x Subject Matter Experts	1.4	Shared across both projects

FINANCE *Explanation for slippage, impact on work stream and actions being taken. Has any re-planning been approved by appropriate Board?*
See finance tables below

PERSONAL RECOVERY GUIDE/KEY WORKER PROJECT

PROJECT/ SCHEMES STATUS PROJECT/ SCHEMES STATUS

Executive Summary –

The scheme is operational in pilot phase and some initial referrals have been made within the RBH. Initial feedback from RBH staff very positive.

Operational Summary

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 together with 3 Personal Recovery Guide.

There has been a gradual increase in referrals to the scheme as it has been more widely advertised. In October a total of 21 referrals were accepted on to the scheme.

Finance - The Section 75 agreements has been signed off.
Milestone Status –.

Project Status
Financial Status
Activity Status
Milestone Status

KEY ACHIEVEMENTS	
BCF03 Personal Recovery Guide / Key Worker (note project has single work package)	• Red Cross providing 7 day cover from 10am to 7pm from mid September. • AgeUK staffed to Manager plus 2 Personal Recovery Guides(PRG) from 30 September; 2 further PRG's being recruited. • West Berkshire Volunteer Centre: 1 PRG commenced on 1st September and volunteers being recruited. • Second contract review meeting completed • Publicity material for the scheme received on 1st October. • Project closure documentation prepared

NEXT STEPS / PLANNED ACTIVITIES	
BCF03 Personal Recovery Guide / Key worker (note project has single work package)	• Outcomes monitoring in development • Develop contract specification as preparation for upcoming tender exercise to be submitted to the Integrated Steering Group on 2nd December 15..

NEW ISSUES RAISED THIS PERIOD
No new issues this period

NEW RISKS/REVISED RISKS IDENTIFIED THIS PERIOD
Due to the uncertainty of funding for the BCF beyond 31st March 2017 there is a risk that providers will be unwilling to tender for the service for a single year contract; this may limit interest to the current providers.

PROJECT MILESTONES, DELIVERABLES

Project Milestones (Include all milestones from last month onwards)	*Task Owner*	*Original Delivery Date*	*Planned delivery Date*	*Conf H/M/L*	*Explanation for slippage, impact on work stream and actions being taken. Has any re-planning been approved by appropriate Board?*
Personal Recovery Guide					

Specification for ongoing contract based on learning from Pilot to be developed.	PL	2.12.15	2.12.15	H	

RESOURCE SUMMARY		
Number of Main (FTE) Resources Required	*Number Now In Post*	*Explanation for variance, impact on work stream and actions being taken.*
1 x Project Manager	1	Shared across both projects, until 31 August
0.5 Project Administrator	0.5	Administrator supports both projects and ICSG, until 31 August
1.4 x Subject Matter Experts	1.4	Shared across both projects

FINANCE *Explanation for slippage, impact on work stream and actions being taken. Has any re-planning been approved by appropriate Board?*

Call for Action monies to be retained by WBC to fund project slippage from financial year 2014-15 into 2015-16.

The PRGI s75 agreement has now been signed and invoicing for quarterly instalments has commenced.

Ref	BCF scheme Name	Budget Manager	Original Budget £k	Revised Budget £k	YTD as at 31/10 £k	Forecast to 31/03/16 £k	Variance £k	Variance (%)	FSG Tolerance £k	Report triggered (Y/N)
	Summary									
	West Berkshire Council Hosted Schemes	Tandra Forster	6,286	6,286	3,122	6,286	0			
	Newbury & District CCG Hosted Schemes		3,247	3,247	0	0	-3,247			
	Total		9,533	9,533	3,122	6,286	-3,247			
	West Berkshire Council Hosted Schemes									
BCF01	**BCF01 - Community Nurses Directly Commissioning Care/ Reablement Services**									
BCF01	No financial implications		0	0	0	0	0			
BCF01	**BCF01 - Community Nurses Directly Commissioning Care/ Reablement Services**		**0**	**0**	**0**	**0**	**0**	**#DIV/0!**	**250**	
BCF03	**BCF03 - Patient's Personal Recovery Guide / Keyworker**									
BCF03	Payment to providers		310	310	167	310	0			
BCF03							0			
BCF03	**BCF03 - Patient's Personal Recovery Guide / Keyworker**		**310**	**310**	**167**	**310**	**0**	**0**	**0**	
BCF04	**BCF04 Joint Care Provider**									
BCF04	Staffing (protecting social care service - national condition)		400	400	233	400	0			
BCF04	**BCF04 Joint Care Provider**		**400**	**400**	**233**	**400**	**0**	**0**	**0**	
BCF05	**7 Day Week Service**									
BCF05	Staffing		250	284	95	284	0			
BCF05	Payment to providers		250	216	0	216	0			

BCF05	**7 Day Week Service**		**500**	**500**	**95**	**500**	**0**	**0**	**0**	
	Protecting Social Care Services									
	Care Act Impact - eligibility change		1,213	1,213	707	1,213	0			
	Care Act Impact - new carer entitlements		294	294	171	294	0			
	Previous S256 transfer - Reablement Services		425	425	248	425	0			
	Previous S256 transfer - Integrated crisis and rapid response		425	425	248	425	0			
	Previous S256 transfer - Early Supported Discharge		370	370	216	370	0			
	Previous S256 transfer - other universal preventative services		573	573	334	573	0			
	Previous S256 transfer - carers support		321	321	187	321	0			
	Protecting Social Care Services		**3,621**	**3,621**	**2,111**	**3,621**	**0**	**0**	**0**	
BCF06	**BCF06 Hospital at Home**									
BCF06	tba - combination of staffing and providers		390	390	0	390	0			
BCF06	**BCF06 Hospital at Home**		**390**	**390**	**0**	**390**	**0**			
	WBC Contingency		**60**	**60**	**0**	**60**	**0**			
	Total Revenue		**5,281**	**5,281**	**2,606**	**5,281**	**0**			
BCF CAP	**Capital**									
BCF CAP	DFG Schemes		726	726	423	726	0			
BCF CAP	Capital Schemes		279	279	93	279	0			
BCF CAP	**Capital**		**1,005**	**1,005**	**516**	**1,005**	**0**	**0**	**0**	
	Total West Berkshire Council Hosted Schemes		**6,286**	**6,286**	**3,122**	**6,286**	**0**			

	Newbury & District CCG Hosted Schemes									

BCF02	**BCF02 - Access to Health and Social Care Services through a single Hub**						0			
BCF02	tba		70	70			-70			
BCF02							0			
BCF02	**BCF02 - Access to Health and Social Care Services through a single Hub**		**70**	**70**	**0**	**0**	**-70**			
BCF05	**7 Day Week Services**									
BCF05	tba		870	870			-870			
BCF05										
BCF05	**7 Day Week Services**		**870**	**870**	**0**	**0**	**-870**			
BCF06	**BCF06 Hospital at Home Service**						0			
BCF06	tba		738	738			-738			
BCF06							0			
BCF06	**BCF06 Hospital at Home Service Total**		**738**	**738**	**0**	**0**	**-738**			
BCF07	**BCF07 Enhanced Care and Nursing Home Support**						0			
BCF07	tba		167	167			-167			
BCF07							0			
BCF07	**BCF07 Enhanced Care and Nursing Home Support**		**167**	**167**	**0**	**0**	**-167**			
	Protecting Existing CCG Reablement Service						0			
	tba		740	740			-740			
							0			
	Protecting Existing CCG Reablement Service		**740**	**740**	**0**	**0**	**-740**			
	Enabler Connected Care (NHS number/Interoperability of IT)						0			
	tba		248	248			-248			
							0			

	Enabler Connected Care (NHS number/Interoperability of IT)		**248**	**248**	**0**	**0**	**-248**			
	Total Schemes		**2,833**	**2,833**	**0**	**0**	**-2,833**	**0**	**0**	
	Contingency		171	171			-171			
	Performance Fund		243	243			-243			
	Total		**414**	**414**	**0**	**0**	**-414**	**-1**	**0**	
	Total Newbury & District CCG Hosted schemes		**3,247**	**3,247**	**0**	**0**	**-3,247**			
	Total BCF		**9,533**	**9,533**	**2,606**	**6,286**	**-3,247**			

Finance Comments

The S75 agreement have been completed, it is expected that both the CCG and LA will then be able to draw down BCF funds in accordance with the agreed Expenditure Plan.

BCF/ Programme Name Highlight Report

+

PROGRAMME	Wokingham BCF Programme highlight report	**PROGRAMME MANAGER**	James Burgess	**OVERALL RAG**	**WISP TO DECIDE**
REPORT MONTH END	Nov 15	**REPORT ISSUE DATE**	02 Dec 2015	**REPORT STATUS**	

PROJECTS/ SCHEMES STATUS		
Overall amber due to some initial slippage due to slack of resource to progress certain project but the overall programme situation is improving.		**Project Status- WISP TO DECIDE**
		Financial Status WISP TO DECIDE
		Activity Status WISP TO DECIDE
		Milestone Status WISP TO DECIDE

KEY ACHIEVEMENTS	
Overall	Overall the BCF programme in Wokingham is progressing with current Step Up Step Down being fully utilised and will be expanded by a further 2 units, 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 project progressing. Quarter 2 returns were completed and submitted to DoH on 20/11/15 A presentationon BCF progress was made to Wokingham CCG governing board. The Wokingham Scuriny Task and Finsih group has ciommenced with an introduction to General Practice, the iwder BCF and schemes 8&9. Planning for 2016-17 BCF has commenced with each projectworking on a tenmplate for its 2016-17 delivery. The Connecetd Care pahse 3 tender process is underway and being marked by each partner oprgnaisdation and the Orion pilot has commenced. The RRAT team have commenced in Wokingham and have built links with Wokingham BC care quality system. Additional support finanancila support is available locally with Matt Marsden starting 9/11/15, the HWBB were briefed regarding 2015 Quarter 1 DoH return. Project leads meetings being held to improve communications and monitor dependency and risks.
Scheme 1- Health and Social Care Hub This Scheme aims to create an effective integrated single point of access for health and social care by: Providing one centralised point of contact across the whole system for patients, service users and health/social care professionals, available 24/7; and, developing a model that provides simplified processes, a consistent approach, equity of access to services, less bureaucracy and less duplication	The project RAG status is **GREEN/AMBER**. • Currently most identified tasks remain on schedule but to remain so requires the project board to agree the recommendations made in the cost to change and service model pathway option paper. The task to agree stakeholder integrated hub cost contributions is now one month overdue from the November project board. • A service pathway and 'cost to change' option paper has been submitted to the project board for the December project board meeting. The purpose of this paper is: o Re-affirm and clarify the projects strategic aims and objectives o Clarify the project outcomes and benefits o Build on and outline the change cost and staff modelling requirements o Outline the integrated hub service pathway options o Provide recommendations o Outline the Project Board next steps The project board are now required to make a decision on service costs and contact and referral pathway design to allow the next project steps to stay on schedule for April 2016 delivery. • WBC ASC OIG colleagues have engaged in the pathway and 'first time fix' design. • The transfer of the WBC lean pathways to the Health Hub Adastra system is now complete. The next design steps are subject the project board agreement for the integrated hub contact and referral pathway and where the recommended 'first time fix' requirements sit. • Engagement with WBC and BHFT staff is underway about the proposed service changes. The option paper submitted to the board has a direct impact on this: o Agreement is now required re: how many and who from WBC customer services will transfer to the integrated hub. o Informing WBC ASC staff who will transfer to the integrated hub. o Confirming the WIN team will transfer to the integrated hub.
Scheme 2 – Integrated short term health & social care team	The three teams are improving the way they are working together with increased communication and coordination of care. The work to define the revised integrated service model for short term care is being undertaken by the

will provide effective and efficient intermediate care and reablement services. The aim is to have a comprehensive fast response of a skilled short-term intervention to support a timely discharge and regain independence	Head of the WISH team.
Scheme 3 –Step Up Step down will deliver a comprehensive reablement service including social care as well as an ongoing assessment service of someone's needs prior to them returning home. According to their needs, residents will have a choice of service, step-up support to prevent unnecessary hospital or care home admission or step-down to support discharges from hospital.	Occupancy has been steadily increasing since end of August, now at 74% and improving each week. Re-circulated FAQs to GPs HLT manager in the WISH appointed SUSD service lead. Scheme vacancies now on Hub team 'sit rep' list. Project impact recording being undertaken as at 02/10/15 estimated saving on hospital stays £18,800 based on £650 per night for hospital stay, saving on residential care £1,698, plus other residential care admission avoidance. Customer experience feedback forms being used. Additional laundry facilities ordered WISP agreed to expand the service in September by 2 additional flats Landlord agreement to expand service. Updated FAQs with photos, referral pathway and documentation re-circulated. Resident consultation regarding expanded service completed with majority of residents in favour of the expanded service. Wokingham BC legal and property services instructed to vary the lease for the expanded units. 3 quotes obtaining for new flooring, to be installed early Dec.
Scheme 4- Domiciliary Care Plus will provide options for short term overnight care, support or supervision with use of assistive technology as well as scheduled visits, so that people who might otherwise need to be admitted to a residential service can be cared for at home.	Stakeholder meeting held to look at delays to project delivery and suggest remedial action Agreed with Optalis brokerage and support team (where the assistive technology expertise sits) to support project support required. Project ToR and PID redrafted. Serrvice specification for Responder service agreed . Night domiciliary care service pathway drafted and circulated for comments Forestcare pathway to responder service drafted Costings agreed with provider for service specification Performance information darfted and circulated for comment Opatlsi provider arm advertising for new posts FAQs drafted and circulated for comment.
Scheme 8 – Self Care / Primary Prevention / Neighbourhood Cluster Teams creating community-based multidisciplinary teams in each of the smaller geographical areas working together to provide joint care planning and coordinated assessment of need for people in that community. The NCTs will also more broadly support good health within the neighbourhood, focusing in particular on supporting and empowering those with long term and complex conditions to self-care and on primary	<u>Neighbourhood Cluster Teams</u> Proposal to expand the role of MDT administrators to become H&SC Cluster co-ordinators discussed at NCT Steering group. Outline BC drafted; job description regraded to band 4. Agreed there is value in making this a patient-facing role where actions are thoroughly followed through; high risk patients who are not included in top 2% are potentially missed so this could contribute to reducing non elective admissions. Potential issues around, eg: referral, and should link with GP care planning role. Agreed proceed to Service Spec stage with clear pathways and development of measurable outcomes. Who's Who directory - final version was almost complete. NCT Steering group discussed final format and preferred features of the directory. Publication to be progressed, initially discussing format options with Southern CSU, once final contact names and details have been added. GPs have decided against an alternative way of working, such as described by the "Modality" (formerly "Vitality") Partnership. There is still enthusiasm to work within a cluster arrangement, whereby individual practices are 'affiliated' within clusters; possibly sharing services (e.g. physio and pharmacist etc) within each cluster - further clarity required about how this would be coordinated. Developing a third party front end system for triaging on-the-day appointments also being explored. Overview & Scrutiny Review underway. 1st meeting provided overview of BCF and Neighbourhood Clusters. Next meeting on 15 Dec; members have identified areas they would like further detail about regarding Clusters; briefing paper being prepared. PH team working on ward profiles being matched to Clusters, although there will be some discrepancies where wards do not align with surgery catchment areas. Aim to have something for each GP surgery by mid Dec.

prevention.	Bespoke evaluation tool has been developed through Involve; one month pilot due to start 10 Dec. Discussions regarding how this could assist with monitoring Care Planning to be scheduled once the pilot work is evaluated. Community Navigator project – Community Navigator Co-ordinator has recruited 7 volunteers; first training event planned for Jan 2016 with official launch in Feb. Scheme to commence with navigators in 3 surgeries – 1 per Cluster; other local community venues will also be explored. Social Prescribing forms and pathways for referral are being developed. Still no decision about the bid for H&SC Voluntary funding from the Voluntary Sector Grants Hub. NCT Steering group discussed possible governance structures for Clusters – further work required. <u>Self Care / Primary Prevention</u> PH undertaking "ageing well" gap analysis, identifying areas where disinvestment might be considered due to lack of good quality evidence. WBC currently reviewing its existing voluntary sector services regarding provision of prevention services and support. The evidence collating from this formal review will assist in informing WBC's future strategic commissioning intentions and decisions. The National Self Care Forum has developed a Self Care App aimed at students, which is being launched in January. The SC Forum plans to develop similar App for older people; approach made to offer to pilot in Wokingham.
Scheme 9 – Access to general practice aims to create equity of services across General Practice, working to operating as a whole week programme of delivery	New enhanced service for enhanced hours developed and implemented. Practices providing the service are required to provide a minimum of 5 additional hours (outside of core hours of 8am-6.30pm, Monday-Friday) of clinical time. As a minimum these hours should be spread across three sessions (two sessions of at least one hour on weekday mornings or evenings and one Saturday morning session of at least three hours). Extended hours sessions run at the same time throughout the year, with the exception of Saturday morning sessions which run a minimum of 23 weeks per year with a trajectory to increase provision in future. 88% of patient population currently covered by the new enhanced service.

NEXT STEPS / PLANNED ACTIVITIES	
Overall	Planning for 2016-17 to be continued Project Manager meetings to monitor dependencies
Scheme 1- Health and Social Care Hub	• Option paper to be agreed by the board • Option requirements to be mapped by OIG • Further ASC Adastra transfer to be continued • Adastra pathway to be tested with customers • ASC scripts to be written • Staff to be transferred to the hub to be informed • Staff training to begin • IM&T and desks to be purchased or allocated Performance metrics to be agreed
Scheme 2 – Integrated short term health & social care team	Consider Generic Support Worker pilot. Progress the development of the Integrated Service redesign. Identify opportunities for service improvement in the short term.
Scheme 3 –Step Up Step down	Additional laundry facilities to be installed. Expand the service to 4 units New flooring and equipment for new unit to be purchased and fitted Case studies regarding outcomes of the service to be drafted and circulated.
Scheme 4- Domiciliary Care Plus	Complete contract with Optalis regarding expanding Domiciliary Care service to 24/7 and agree deployment plan. Get sign off from WISP for night responder service. Complete service specification for and pathway for night dom care service.
Scheme 8 – Self Care / Primary Prevention / Neighbourhood Cluster Teams	<u>Neighbourhood Cluster Teams</u> Expanding the role of MDT administrators to become H&SC Cluster co-ordinators - proceed to Service Spec stage with clear pathways and development of measurable outcomes Who's Who directory - Publication to be progressed, initially discussing format options with Southern CSU, once final contact names and details have been added.

	GPs to continue discussions regarding working within a cluster arrangement, whereby individual practices are 'affiliated' within clusters; and consideration of a third party front end system for triaging on-the-day appointments. Overview & Scrutiny Review of Neighbourhood Clusters underway and expected to report in Jan/Feb Ward profiles being matched to Clusters – 1st drafts expected mid Dec Evaluation tool to be piloted for 1 month from 10 Dec. Discussions regarding how this could assist with monitoring Care Planning to be scheduled once the pilot work is evaluated. Community Navigator project –training event planned for Jan 2016; official launch in Feb. Scheme to commence with navigators in 3 surgeries; other local community venues to be explored. Social Prescribing forms and pathways for referral to be finalised. Further work to take place on developing possible governance structures for Clusters. Outline proposal for exploring the role of Community Pharmacies in Cluster working to be completed, for consideration by both the chains and independent community pharmacies. <u>Self Care / Primary Prevention</u> "Ageing well" gap analysis to be completed. WBC review of provision of prevention services and support – recommendations due to be presented in Jan 16 Self Care App aimed at students to be launched nationally in January; Wokingham may be involved in piloting a similar App for older people.
Scheme 9 – Access to general practice	Commissioning access for patients not currently covered by the CES. Currently looking at the best way of doing this and hope to have something in place early 2016.

NEW ISSUES RAISED THIS PERIOD
None
NEW RISKS IDENTIFIED THIS PERIOD
Cost to Local Authority implementing Connected Care has been estimated at £65K and will require discussion at WISP and with Connected Care board as corresponding benefits to Local Authority are at present not apparent.

PROJECT MILESTONES, DELIVERABLES					
Project Milestones (Include all milestones from last month onwards)	*Task Owner*	*Original Delivery Date*	*Planned delivery Date*	*Conf H/M/L*	*Explanation for slippage, impact on workstream and actions being taken. Has any re-planning been approved by appropriate Board?*
Scheme 1- Health & Social Care Hub	DC				
Appoint Project Manager	DC	July 15	August 15		Complete
Scope initial specification	TW	Aug15	Sept 15		Complete
Project Board formed and meeting	DC	Aug 15	Sept 15		Complete
Operational Implementation Group formed and meeting	PF	Oct 15	Oct 15		Complete
WBC ASC Lean Pathway transfer to Adastra complete	PF/SW	Nov 15	Nov 15	H	Complete
Stakeholder Adastra pathway acceptance signed off	PF	Dec 15	Dec 15	H	Slippage. Further Adastra ASC construction required subject to PB pathway agreement. Likely slippage one month.
Integrated Hub staffing and cost model agreed by the project board	PF/PB	Nov 15	Nov	H	Paper submitted to the project board. Formal sign-off pending.
Staff engagement complete	PF/JW/SW	Feb 16	Feb 16	H	Ongoing
Integrated Hub staff training complete	PF	Feb 16	Feb 16	H	Scheduled to start January 2016
Integrated Hub 'go live'	DC/PF	Apr 16	Apr 16	H	
Scheme 2- Integrated short term health & social care team	DC				
Approval from HWBB for appointment of joint Head of Service hosted by BHFT	JB	June 15	Jul 15		Completed
Agree Contract between WBC and BHFT to host Head of Service	SR/DC		Jul 15		Completed
Advertise for Head of Service	DC	Jul 15	Aug 15		Completed
Interview for Head of Service	DC		Sep 15		Completed – start date 09.11.15
Scheme 3- Step Up Step Down	JBu				
Consultation with Alexandra Place residents regarding siting SUSD units there	JBu		28th Nov 14 complete		Action complete
Evaluate consultation responses	JBu		Early Dec 14		Action complete
Develop Step up and Step down pathways	JBu		drafted		Complete
Expand project group to include WISH managers	JBu		Nov 14 complete		Action complete
Specify service required	JBu	Dec 14 complete	Feb15 draft to be finalised		
Agree lease agreement with landlord for first 2 flats	JBu	Dec 14 being drafted	End of Mar 15		Delayed but signed 26/06/15- Action complete
Equip first 2 flats	JBu	Feb 15	End of June 15		Delayed due to lease not being signed now complete
Agree service structure and provider	JBu		Jan 15 complete		Action complete
Launch trials service with first 2 flats	JBu	01/01/15	1/7/15		Slippage due to lease not being concluded and equipment and furnishing not being in place- Action complete
Phase 2 of project to expand no of units from 2 to 6	JBu		Nov 15		Underway with plan to increase SUSD by two additional units.
Further consultataion with residents regarding	JBu		Nov 15		Action complete

expanded service					
Amend lease for additional flats	JBu		Dec 15		Underway only 1 flat currently vacant
Lay flooring and equip new flats	JBu		Dec 15		Underway only 1 flat currently vacant
Scheme 4- Domiciliary Care Plus					
Presentation to WISP regarding expanded AT element	SC/JBu		Nov 14 complete		
Appoint project manager	PM/JBu	Jan 15	Mar 15		Slipped – required action- Optalis Brokerage and Support to project manage from Aug 15
Establish project group	PM		Dec 14 complete		Needs to be re-constituted and re-established- to be completed by 3/8/15
Review service specifications for provision and installation of AT hardware and response service	PM and commissioning team		Complete		
Agree service specifications and procurement approach	PM and commissioning team				
Procure AT requirements	PM	Aug 15	Jan 16		Alternative approach agreed with existing AT provider
Expand Domiciliary Care services to cover 24/7			Sept 15		Pilot proposal received from Optalis revised business case to go to WISP 8/10/10
Agree referral pathways to out of hours domiciliary care services			Aug 15		Drafted
Review existing night sitting services and identify gaps			Aug 15		Completed and report sent to WISP
Start Pilot Night Dom care service			Dec16		
Scheme 8 – Self Care / Primary Prevention / Neighbourhood Cluster Teams					
PID - further amendments are likely as the project progresses; updates will be approved by the NCT steering group.	JBr/AP	Apr 15	ongoing		
Quarterly meetings with Reading to share plans for NCT development	JBr/AP/JBu		¼ ly		Awaiting notification that Reading BCF lead has been recruited so that meetings can be rescheduled
Detailed planning & design AND governance of Neighbourhood Cluster model to be further developed – incl consideration of resources required for Clusters and plans to improve self care & primary prevention	St grp	May 15	ongoing		
"Modality" (formerly "Vitality") Partnership to talk to GP council as examples of alternative ways of working; to be followed by meeting with Capsticks to explore legal framework	JZ / KS		Nov15		Complete
Community Navigator Coordinator in post; first volunteer navigators to be 'appointed' and trained by Jan. Formal launch being planned for Feb 16	JBr/SMcS		Jan 16 / Feb 16		
Key messages are to be presented at future meetings of Council exec and senior leadership team, CCG board, HWB, BHFT exec etc.	KS/SR		June 15		? Reschedule once OSC review complete and reported?
Awareness raising and publicity about Neighbourhood Clusters and volunteer Community Navigator project to continue; further public events to be scheduled for 2016	JBr/SMcS		Feb 16		
Memorandum of Understanding to be signed by all parties - all group members to ensure that key people in their organisation are clear about the intentions and agree to the MoU prior to signing	St grp		Aug 15		MoU agreed – one signature still required
Overview & Scrutiny Committee review to commence end Oct 15	JBu/St grp		Jan 16		Review commenced 5 Nov
Who's Who directory - Publication to be progressed, initially discussing format options with Southern CSU, once final contact names and details have	JBr		Jan 16		

been added					
Work in progress exploring expansion of MDT coordinator role to Cluster co-ordinator roles- proceed to Service Spec stage with clear pathways and development of measurable outcomes	HI		Jan 16		
Ward profiles being matched to Clusters – 1st drafts expected mid Dec	DG		Dec 15		
Outline proposal for exploring the role of Community Pharmacies in Cluster working to be considered by both the chains and independent community pharmacies	JBr		Jan 16		
Further work underway to define anticipated outcomes and impact; appropriate baseline measures to be identified. Bespoke evaluation tool developed by Involve; tool to be piloted for 1 month from 10 Dec. Discussions regarding how this could assist with monitoring Care Planning to be scheduled	CR / JBr / JZ		Jan 16		
Self-Care / Primary Prevention					
Self Care App aimed at students to be launched nationally in January; Wokingham may be involved in piloting a similar App for older people	JBr		Jan 16		
Comments from Self care / maximising independence workshop to be fed into NCT development plans	JBr	Apr 15	ongoing		
Wokingham Healthwatch event regarding developing an agreed Borough standard around information provision to take place in conjunction with launch of volunteer community navigator service	JBr		? Feb 16		Formal launch of volunteer Community Navigator project being planned for Feb 16, although publicity, awareness raising and recruitment will be underway before then
Further scoping / refine detail / development of options for progressing self care & primary prevention incl mapping dependencies between this and other local & Berks W wide projects	JBr		ongoing		
WBC review of all prevention services underway	JBu		Jan 16		
Self assessment form of preventive services commissioned against “Aging Well” evidence of best practice to be completed	DG		Dec 15		
Scheme 9 – Access to general practice					
Joint Primary Care Co-Commissioning Committee consider proposal	NJ		May 15		Complete
Consultation on proposal with providers	NJ		June 15		
QIPP and Finance to approve proposal	NJ		June 15		Consultation ends 15 June
Issue specification and contract	NJ		~~June 15~~		Issued July 15
New CES starts	NJ		~~Jul 15~~		Starts Sept 15.

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Title of Report:	**Governance review of health and social care integration arrangements across West Berkshire**
Report to be considered by:	Health and Wellbeing Board
Date of Meeting:	28th January 2016
Forward Plan Ref:	

Purpose of Report: To set out proposals for new governance arrangements with regard to the leadership of health and wellbeing and health and social care integration across West Berkshire.

Recommended Actions: To consider the recommendations set out in section 5 of the report.

Reason for decision to be taken: Governance was one of the issues it was agreed to review following the Development Session on November 26th 2015.

Other options considered: No change.

Key background documentation: N/A

Published Works: N/A

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

Health and Wellbeing Board Chairman details	
Name & Telephone No.:	Councillor Graham Jones (01235) 762744
E-mail Address:	Graham.Jones@westberks.gov.uk

Contact Officer Details	
Name:	Nick Carter
Job Title:	Chief Executive
Tel. No.:	01635 519101
E-mail Address:	nick.carter@westberks.gov.uk

Implications

Policy:	None
Financial:	None, although there should be some saving in time given the proposal involves integrating two separate meetings into one.
Personnel:	
Legal/Procurement:	None
Property:	None
Risk Management:	The current meetings have distinct agendas so there will be challenges in bringing them together into a single meeting.

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)		
Relevant to equality - Complete an EIA available at http://intranet/EqIA		☐
Not relevant to equality		☒

Executive Report

1. **Introduction**

1.1 At the recent Health and Wellbeing Board Development Session at Shaw House on 26th November 2015, it was agreed that I would have a look at the current governance arrangements surrounding health and social care integration in West Berkshire with a view to seeing if they could be improved. It was suggested that the current West Berkshire Locality Board and Health and Wellbeing Board Management Group might be merged. This paper explores the merits and drawbacks of such an approach.

1.2 It was also proposed at the session that we should alternate meetings of the Health and Wellbeing Board between being in public and in private.

2. **Background**

2.1 The current governance arrangements for health and social care integration in West Berkshire are borne from two separate origins;

(1) The creation of Health and Wellbeing Boards, formally from April 2013, and in shadow form from 2012. In 2014, it was agreed that a Management Group be established to support the work of the Board. The Board has generally always met in public except when Part II information was being discussed.

(2) The development of health and social care integration across Berkshire West where the governance arrangements have recently been revised and are reflected in Fig 1. In this case a Locality Board has been established with the primary remit of managing integration projects at a local level.

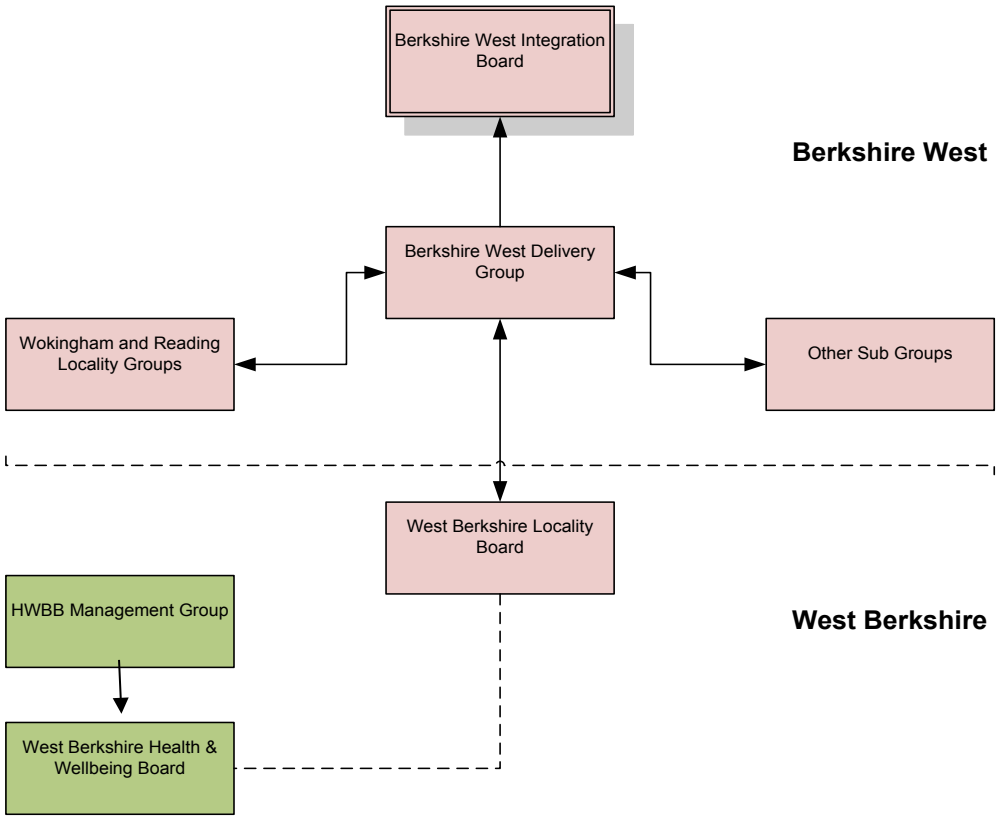
2.2 Membership of the Locality Board is drawn from West Berkshire Council, the Clinical Commissioning Groups (CCGs), the Berkshire Healthcare Foundation Trust (BHFT) and the Royal Berkshire Foundation Trust (RBFT). The Board is chaired by the Head of Adult Social Care at West Berkshire Council. Officer representation is significant. Membership of the Health & Wellbeing Board (HWBB) Management Group is smaller and reflective of the Board's own membership. It comprises the Council, CCG and Healthwatch. It includes GP membership and an elected Member from West Berkshire Council. Appendix 1 includes the current membership details of both groups.

2.3 There are no formal links between the West Berkshire Locality Group and the HWBB Management Group although there is common membership to both Groups. The Locality Group has a direct link to the Berkshire West Delivery Group which in turn, supports the Berkshire West Integration Board. Its primary purpose has been to oversee integration work that is taking place within West Berkshire and in this regard there has been a strong focus on the Better Care Fund projects which have focused on the Frail Elderly Pathway.

2.4 The HWBB Management Group's role has been to support the work of the Health and Wellbeing Board. It does this primarily through forward planning its agenda and

ensuring that papers are prepared in a timely manner. It has also played a role in the ongoing development of the Board itself. Inevitably the HWBB does receive updates on integration work but the Management Group has no formal role in the integration agenda even though the Board itself has an important role in this regard.

Fig 1. Current Governance Arrangements with regard to health and social care integration in West Berkshire



2.5 The Integration Board meets monthly and the Management Group every six weeks.

3. Potential new arrangements

3.1 Both the Locality Group and Management Group are largely operational in nature and officer driven. Their functions are distinctly different and at first sight there is relatively little common ground between the two.

3.2 There is however common membership between both Groups and in bringing both together there would undoubtedly be a saving in time. Perhaps more importantly, the separation between the two Groups has left some partners, most notably BHFT and RBFT, isolated from the broader work of the Health and Wellbeing Board. By the same measure drawing the work of the Locality Board closer to the Health and Wellbeing Board may also help create a stronger focus on the integration work that is being done.

3.3 Recently enacted governance proposals in respect of arrangements across Berkshire West identified a need to engage elected Members more closely in the integration programme. A proposal was made to invite the Chairs of the three Heath and Wellbeing Boards (all elected Members) to the Berkshire West Integration Board. This is now likely to take place in early 2016. Bringing together the Locality Board and Management Group at a local level would further strengthen this developing link.

3.4 If the two groups were to amalgamate there would undoubtedly be a sense of a 'meeting in two parts'. The functions of both groups need to continue and whilst some duplication can be omitted, there will remain two distinct functions to perform.

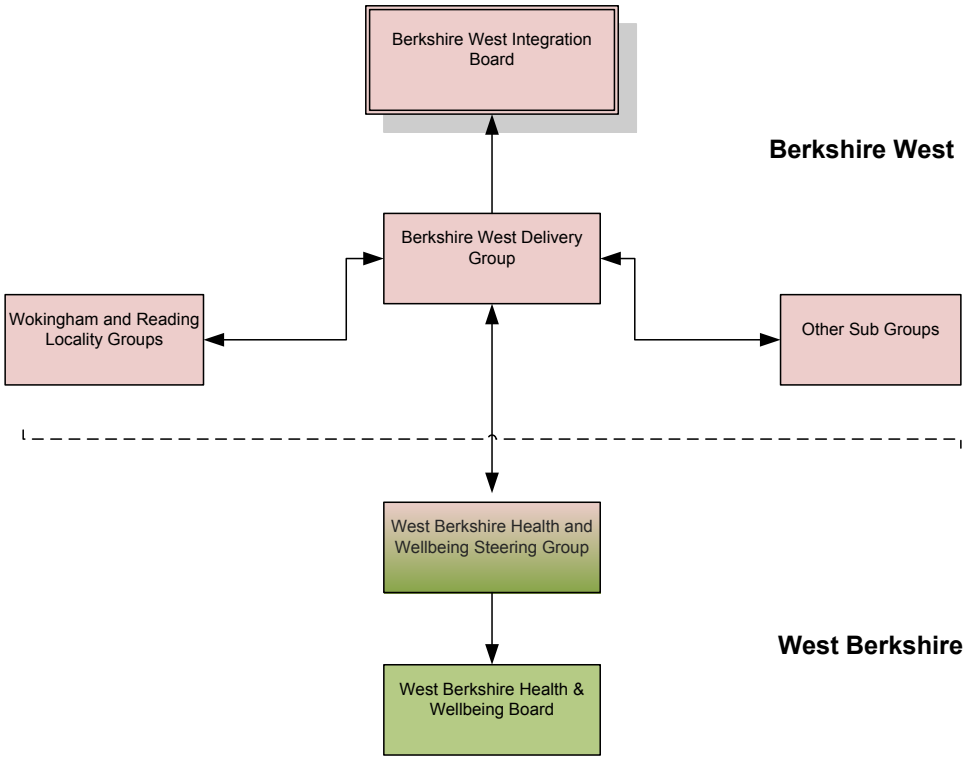
3.5 Taken in the round the benefits are seen to outweigh the disadvantages and it is therefore recommended that as from April 2016 the two groups are merged.

4. A new West Berkshire Health and Wellbeing Steering Group

4.1 Fig 2 shows diagrammatically how the proposed new governance arrangements would work. It is suggested that membership of the proposed Steering Group would comprise the combined membership of both existing groups. It is suggested that Chairmanship of the new Group rests with the current Chair of the Locality Board. This is currently the Head of Adult Social Care at West Berkshire Council. The new Steering Group would meet monthly and there would be a need to ensure that the meetings of this Group align with that of the Berkshire West Delivery Group and the West Berkshire Health and Wellbeing Board. It is suggested that quoracy and more detailed issues of governance are debated and agreed by the Steering Group once it is established.

4.2 At the Development session in November last year it was also agreed that it would be helpful if meetings of the Board could be alternated between being in public and in private. This would engender a more informal discussion similar to that which emerges in the Development sessions. Agendas would be reshaped accordingly so that public meetings of the Board focused on decision making and other more formal matters whilst those meetings that took place in private would be devoted to more strategic and developmental concerns. Given the support for this proposal in November it is now being formally recommended so that it can be implemented.

Fig 2. Proposed Governance Arrangements with health and social care integration in West Berkshire



5. Recommendations

(1) As from April 2016 the current West Berkshire Locality Board and Health and Wellbeing Management Group are disbanded and replaced by a single West Berkshire Health and Wellbeing Steering Group.

(2) That the Terms of Reference for the new group reflect those of the two extant groups and that membership of the new group is drawn from the two current groups. It is proposed that the new group meets monthly and is chaired by the current chair of the West Berkshire Locality Board.

(3) A more detailed governance paper is prepared by the Policy Officer supporting the Board and that this is considered at the first meeting of the new Steering Group.

(4) As from April 2016 meetings of the Board are alternated from being in public and in private and that the agendas of the respective meetings are altered to reflect this and reflected accordingly in the Forward Plan.

Nick Carter

Chief Executive

4 January 2016

Appendices

1. Membership of the HWBB Management Group and the Berkshire West Locality Group.

Consultees

Local Stakeholders: N/A

Officers Consulted:

Trade Union: N/A

Appendix 1

Locality Board Membership

Gabrielle Alford	Director of Joint Commissioning, Berkshire West CCGs
Dr Abid Irfan	Chair and Clinical Lead, NHS Newbury & District CCG
Patrick Leavey	Service Manager ,West Berkshire Council
Shafik Nassar	Integrated Services Manager, WB BHFT
Susan White	Head of Adults, WB BHFT
Tandra Forster	Head of Adult Social Care, West Berkshire Council
Sharon Herring	Director of Nursing, RBFT
Andrew Sharp	Healthwatch, West Berkshire
Ian Mundy	Locality Director, BHFT
Dr Bal Bahia	Clinical Lead, Newbury & District CCG
Shairoz Claridge	Director of Operations, Newbury & District CCG
Nick Carter	Chief Executive, West Berkshire Council
April Perbedy	Programme Manager, Public Health & Wellbeing West Berkshire Council

Management Group Membership

Dr Bal Bahia	Clinical Lead, Newbury and District CCG
Nick Carter	Chief Executive, West Berkshire Council
Shairoz Claridge	Director of Operations,Newbury and District CCG
Tim Cooling	Newbury and District CCG
Andy Day	Head of Strategic Support, West Berkshire Council
Tandra Forster	Head of ASC, West Berkshire Council
Moira Fraser	Democratic & Electoral Services Manager, West Berkshire Council
Mac Heath	Head of Children and Family Services, West Berkshire Council
Cllr Graham Jones	Executive Portfolio Holder: Health and Wellbeing
Maureen McCartney	North and West Reading CCG
Andrew Sharp	Healthwatch
Cathy Winfield	Berkshire West CCGs
Sarah Wise	North and West Reading CCG
Lesley Wyman	Head of Health and Wellbeing, West Berkshire Council

Title of Report:	**New Health and Wellbeing Priorities**
Report to be considered by:	The Health and Wellbeing Board
Date of Meeting:	28th January 2016

Purpose of Report: **To put forward a new set of priorities for the Health and wellbeing Strategy**

Recommended Action: **For the Health and Wellbeing Board to agree a new set of priorities for the remaining 2 years of the current H&WB Strategy, 2016-2018.**

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 Public Health and Wellbeing
Tel. No.:	01635 503434
E-mail Address:	lesley.wyman@westberks.gov.uk

Executive Report

1. Introduction

1.1 The current Health and Wellbeing Strategy that covers the period 2015-2018 contains 11 strategic priorities that were agreed by the Health and Wellbeing Board. These priorities were developed from the Joint Strategic Needs Assessment and went out to a public consultation in November 2014, run by West Berkshire Health Watch.

1.2 At the November Board Development session a discussion took place regarding the difficulty of trying to address such a large number of priorities at the same time. Thus the Board requested that a smaller number of priorities be developed in order to enable them to achieve against the agreed priorities more effectively over the remaining two years of the strategy.

1.3 The current priorities are:

Emotional Wellbeing	1. We will promote emotional wellbeing in children and young people, through prevention, early identification and provision of appropriate services.
Looked After Children	2. We will improve the health and educational outcomes of looked after children through prevention and the provision of high quality health and social care support and services.
Tackling inequalities	3. We will improve the educational achievement of children on free school meals to bring them into line with the overall achievement of all children.
Mental health and wellbeing	4. We will promote mental health and wellbeing in all adults through prevention, early identification and provision of appropriate services. We will tackle loneliness and social isolation.
Health damaging behaviours	5. i. We will promote sensible and safe drinking and increase the numbers of people receiving effective and timely support for alcohol and drug related problems' ii. We will promote smoke free lifestyles and environments.
Healthy weight and physical activity	6. We will maintain or increase the number of people who are a healthy weight, by: promoting physical activity and healthy eating, by providing a range of evidence based weight management interventions and by increasing opportunities for residents to be more physically active.
Cardiovascular disease and cancer	7. We will improve the prevention and early identification of cardiovascular disease and cancer in primary care and community settings through the provision of NHS health checks and screening and ensure the provision of high quality secondary care services.
Carers	8. We will promote the health and wellbeing of carers, including young carers.
Long term Conditions	9. We will deliver integrated services to support and maintain the independence of people with long term conditions and disabilities and ensure end of life care needs are addressed.
Falls prevention	10. We will maximise independence in older people by preventing falls, reducing preventable hospital admissions due to falls and improving rehabilitation services.
Dementia	11. We will improve the lives of residents with dementia through early identification, the provision of excellent, integrated care and support and increased community awareness of dementia.

1.4 These health and wellbeing priorities remain the key areas to be addressed in West Berkshire, since needs do not tend to change significantly over just one year. Consequently rather than attempt to develop completely new priorities it is suggested that two main priorities will be the focus for the Health and Wellbeing Board in 2016/17 followed by another two in 2017/18. A certain amount of grouping of the original 11 priorities will enable everything to be covered in the remaining two years of the Strategy.

1.5 Priorities for 2016/17:

i. Mental health and wellbeing in children and young people and adults (includes social isolation)

ii. Older people living independently (includes Long term conditions, falls prevention and dementia)

1.6 Priorities for 2017/18:

i. Cardiovascular disease and cancer pathways (includes all preventative work in the current priorities: healthy eating, weight management, physical activity, smoking and alcohol).

ii. Health and wellbeing of carers including young carers.

1.7 The Health and Wellbeing Board has expressed a desire to focus in an over arching way on tackling inequalities in health and therefore this is not listed as a separate priority. Inequalities in health will be considered in all areas of work that the Board oversees. Inequalities in health may be affected by deprivation or being part of a vulnerable group such as people with learning disabilities, physical disabilities, ethnic groups, mental health conditions, age etc.

1.8 Delivery groups and delivery plans will still be required to report back to the Health and Wellbeing Board on how each of the areas is being progressed. Where possible existing groups will be utilised.

1.9 In 2016/17 the West Berkshire Mental Health Collaborative will finalise the development of the delivery plans for mental health and wellbeing and whatever group is overseeing the Emotional Wellbeing Academy will be responsible for the delivery plans for the mental health and wellbeing of children and young people.

1.10 Also in 2016/17 there is a suggestion that the West Berkshire Integrated Care Steering Group could develop the delivery plans for older people living independently.

1.11 In 2017/18 there will need to be a cardiovascular disease and cancer pathway group set up, although much of the prevention is already being addressed within West Berkshire Healthy Lifestyles Network.

1.12 Finally the West Berkshire Carers Strategy Group has already begun to develop the delivery plan for the health and wellbeing of carers.

1.13 Once these priorities are agreed there will be Hot Focus sessions run in support of the delivery plans and ensure that Health and Wellbeing Board members are fully informed about the different areas of need.

2. Equalities

2.1 * (Briefly outline any consultation that has taken place on the decision, the issues and vulnerable groups that have been identified and the mitigation measure that will be put in place and any information that Members/Officers need to consider before a decision is made.)

OR

2.2 This item is not relevant to equality.

Appendices

There are no Appendices to this report.

West Berkshire LSCB

LSCB Key Messages The Annual Report 2014-2015

Welcome to the summary of the Annual Report of West Berkshire Local Safeguarding Children Board for 2014/15. The vision of the LSCB is that every child and young person in West Berkshire grows up safe from abuse, neglect, exploitation and crime. We aim to sustain a strong safeguarding culture and arrangements where the focus is firmly on the experience of the child or young person and their journey to getting early help and support.

A new Independent Chair was appointed in October 2014 and following a self assessment process a development programme to improve effectiveness of the board was put in place. The Ofsted inspection of Children and Families Services and the LSCB in March 2015, judged the board as 'requires improvement'. Their findings mirrored those identified though the self assessment and acknowledged that the impact of the development programme would be demonstrated in the next annual report (2015-2016).

The LSCB has statutory functions that must be complied with in addition to work on priority areas. Full information on how West Berkshire LSCB met its statutory responsibilities can be found in the full annual report on the LSCB website.

The 5 Priorities for the LSCB during 2014-2015 were:

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

To view the full LSCB annual report for 2014-2015 please visit the LSCB website:
www.westberkslscb.org.uk

Key achievements in the priority areas during 2014-2015 were:

Early Help

- Ofsted recognized
- How strong early help services are in West Berkshire with specific reference to the Family Resource Service and Help for Families.
- The tier 2 anxiety project (Psychology and Social Inclusion) worked with over 850 pupils across Primary and Secondary schools. Feedback from the project showed 78% of students significantly decreased their anxiety levels.

Child's Voice & Journey

- The LSCB challenged agency attendance at Child Protection Conferences, leading to an increase in attendance by Thames Valley Police and completion of reports by GP's.
- The Youth Offending Team has demonstrated strength in proactively seeking feedback from young people and families, and using this to shape the delivery of their services.

Child Sexual Exploitation & Missing Children

- 100% compliance with statutory responsibilities for return interviews for children who go missing, with learning linked to service planning and criminal justice intelligence.
- Return interview process responds to the child's needs and focuses on hearing the child's voice and experience.
- Substantial reduction in missing episodes from 2013 to 2014.
- The CSE Strategic Group championed the use of integrated plans for young people allowing risk to be shared across agencies.

Domestic Abuse & Vulnerable Groups

- Pilot programme on healthy relationships intervention for young people (DAY Programme) was delivered in targeted services. The programme was well received with a measurable positive impact on outcomes for children and young people. This has led to a proposal for wider implementation.
- Information sharing arrangements put in place with schools to share domestic abuse information has resulted in increased targeted support for children, young people and families.
- Increased domestic abuse training across organisations has resulted in a rise in recorded Domestic Abuse incidents (both crime and non crime).

Effectiveness of the LSCB

- Streamlined business processes allow for increased discussion and challenge at board meetings resulting in increased scrutiny of safeguarding services for young people.
- Use of performance data directly focuses scrutiny on areas of concern, resulting in increased challenge to improve services for young people.
- Effective links between performance data, auditing, quality assurance and learning allows development of frontline practice and staff training which positively impacts on the services young people receive.
- Clear communication and shared learning from case reviews supports development of best practice.
- Mechanisms to hear the child's voice allows the board to be focused on the issues that are a priority for young people and allows services to learn from the direct experience of service users.

To view the full LSCB annual report for 2014-2015 please visit the LSCB website:
www.westberkslscb.org.uk

West Berkshire LSCB

Local Safeguarding Children Board

Annual Report 2014-2015







"The West Berkshire Local Safeguarding Children Board was established in 2004, as a major element in the Every Child Matters Change for Children agenda and in support of the five key outcomes with a particular focus on staying safe."

Contents

Foreword by Independent Chair

Welcome to the Annual Report of West Berkshire Safeguarding Children's Board for 2014/15. This report provides an account of the work undertaken by the Board and its multi-agency partners over the last year and the extent to which it is making a difference in terms of safeguarding children and young people and the effectiveness of front line services. Our vision is that every child and young person in West Berkshire grows up safe from abuse, neglect, exploitation and crime. We aim to sustain a strong safeguarding culture and arrangements where the focus is firmly on the experience of the child or young person and their journey to getting early help and support and beyond. The report seeks to summarise the journey of the Board to become more effective and to better evidence its impact for children and young people.

I was delighted to start as the new Independent chair of West Berkshire LSCB in October 2014. I met with as many partners and Board members individually as I could, to find out their views about how the impact and effectiveness of the Board could be improved and their views on the key issues and challenges for safeguarding children in West Berkshire. A self-assessment exercise undertaken by the Board in Spring 2015 showed that there was a shared view that the Board required improvement. This was confirmed by the Ofsted Inspection in April 2015. During the Ofsted inspection the Local Authority was found to be inadequate for help and protection of children and young people.

Although it is clear that there was a high level of commitment across the partner agencies in the work of the Board and its sub-groups, there was not always the evidence to show the added value the Board was giving local people and accountabilities were not as clear as they needed to be. Since that time the Board arrangements have been streamlined to accelerate the rate of progress and to strengthen the information available to the Board on the quality and performance of local services in safeguarding children and to drive and inform the Board's priorities. There is a shared view across the partnership about the work which remains to be completed. For example, in relation to Child Sexual Exploitation, Child and Adolescent Mental Health Services, Female Genital Mutilation and further strengthening involvement of young people in the work of the Board. However, we are now in a very different place than we were nine months ago and I look forward to our progress being reviewed again by Ofsted in due course. I hope our collective efforts will be seen as making good progress to achieving a 'Good' rating and our ambition is to become an 'Outstanding' LSCB.

Priorities have been reviewed and five priorities were agreed by the Board for 2015-17. These are:

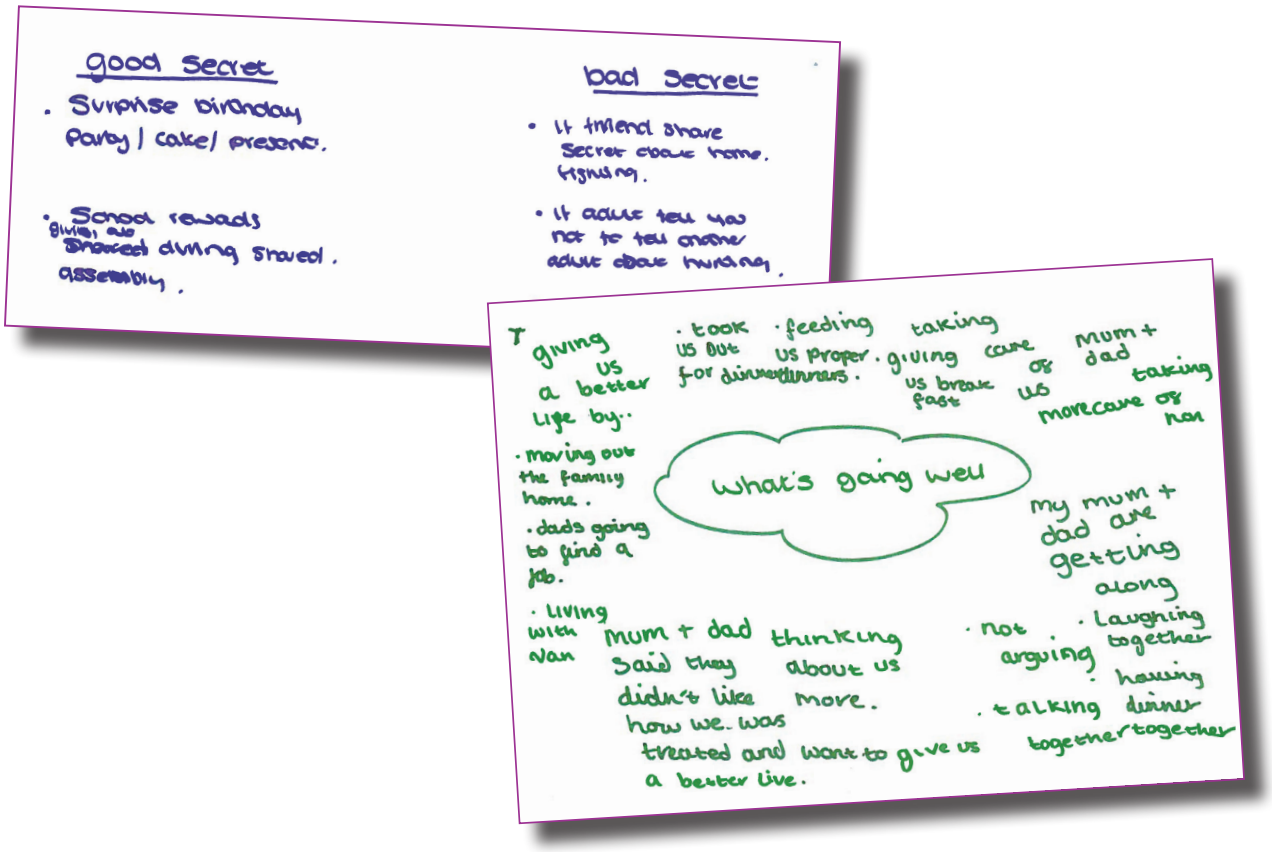
- Early Help
- Improving the Child's Voice and Journey
- Reducing Child Sexual Exploitation and Missing Children
- Domestic Abuse and Vulnerable Groups
- Improving the effectiveness and impact of the LSCB

Some of the highlights for me over the past nine months include:

- Hearing the views of front line staff at various staff learning and development events;
- Having the progress the board has made acknowledged by Ofsted;
- Hearing the voice of children and young people on the impact of the 'Safe in our Hands Project';
- Seeing the focus on individual young people through attending the CSE and Missing Children Operational Group;
- The contribution of Lay Members to improving the networking with voluntary, community and faith sector groups;
- Finalising the WBSCB dashboard for Safeguarding which has a focus on the child's journey; and
- Seeing the significant increase in member contributions to Board and sub-group meetings and the higher level of challenge, support and creative thinking now evident.

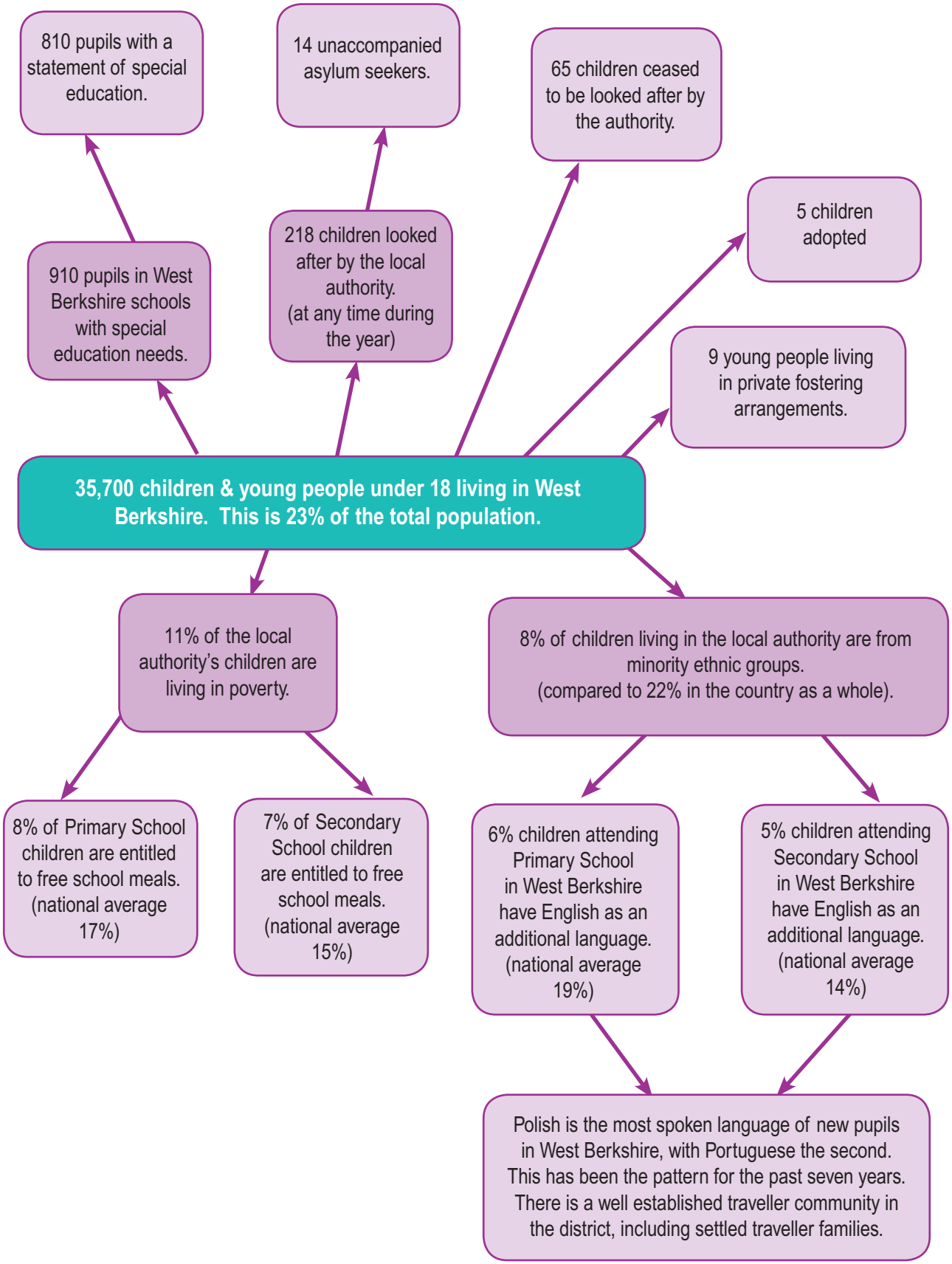
I would like to thank and recognise the contributions of the LSCB Team, Lay Members and Sub-Group Chairs and members who play a huge role in delivering the Board's priorities and in supporting and challenging agency practice.

Frances Gosling-Thomas, Independent Chair



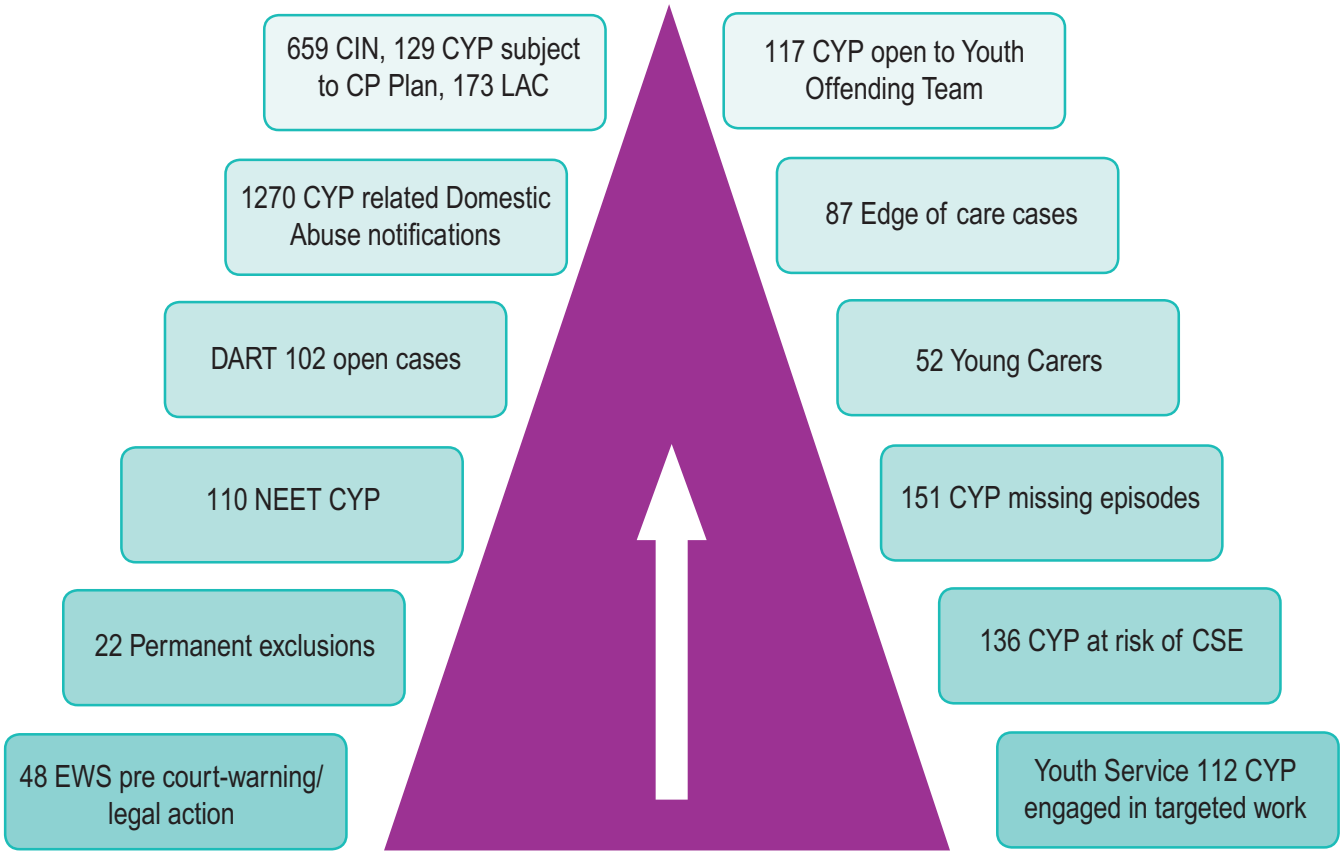
Local Context

Figures from local performance data and local analysis work.
These figures relate to April 2014 - March 2015



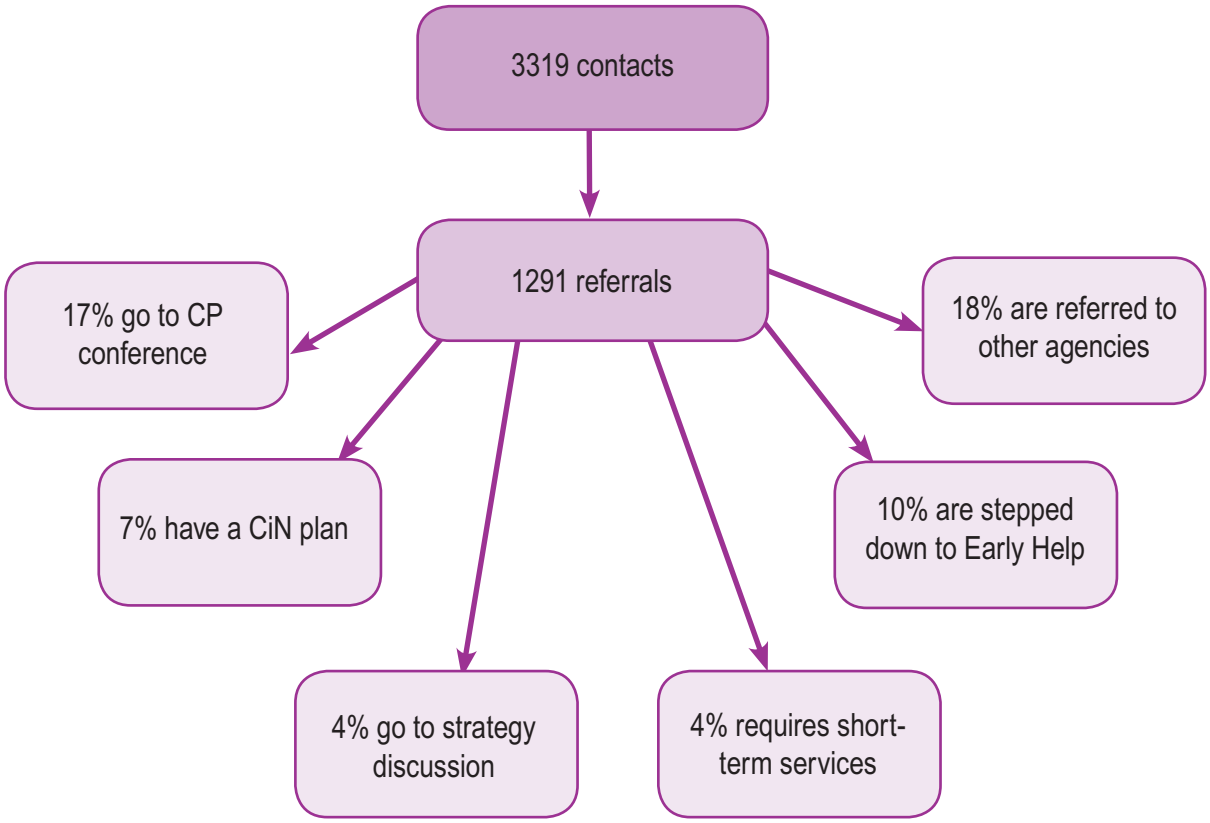
What are the needs? (figures as at 31st March 2015)

The diagram below shows the types and levels of specialist need in West Berkshire. This relates to levels 3 and 4 outlined in the Threshold Criteria for West Berkshire Children and Families Services. Some focused analysis work took place in March 2015 and a maximum of 2500 children were identified as receiving specialist services in the district. The majority of these identified young people were accessing 3-5 services at the same time, so the number of children accessing specialist services is likely to be in the region of 625. The challenge to the LSCB arising from this data is how partnership processes can be streamlined for families with multiple needs. West Berkshire Communities Directorate is implementing Restorative Practice as a key strand of this work.

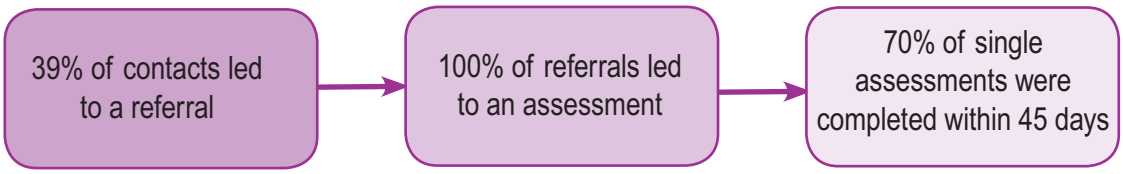


The analysis work referenced above also highlighted the impact of parental risk factors on assessment, practice, service design and planning for child protection services. Within the CP arena 43% of cases had DA as a factor, 16% had drug misuse concerns, 21% had alcohol misuse concerns and 22% had emotional and mental health issues as a feature. Domestic Abuse numbers are a consistent trend in West Berkshire, with drug misuse concerns show a decreasing trend and alcohol misuse and emotional/mental health issues on the rise. Audit activity across the partnership suggests that the toxic trio risk factors have not been given the attention they would benefit from.

What's coming in our Children's Social Care front door? (during April 2104 - March 2015)



In January 2015 the front door to West Berkshires Children's Social Care developed to become the Contact, Advice & Assessment Service. Since these changes have been implemented the following performance of the front door has been observed:



The service has stated in its strategic plan that it aims to increase the number of single assessments completed within the 45 day timescale and to also continue increasing the quality of the assessments. From analysis work presented to the LSCB in March 2015, these aims were agreed and have been linked to the LSCB exception reporting framework and audit framework, which can be viewed in appendix 7.

Our Board

West Berkshire's Local Safeguarding Children Board (LSCB) makes sure that key agencies work together to keep local children and young people safe. Our job is to safeguard and promote the welfare of children, and ensure the effectiveness of what is done by each agency that works with children.

Section 13 of the Children Act 2004 requires each local authority to establish a Local Safeguarding Children Board (LSCB) for their area and specifies the organisations and individuals (other than the local authority) that should be represented on LSCBs. Our current membership is listed in appendix 4.

Partners in the Board financially contribute specifically to the LSCB to enable it to operate and undertake work against the priorities. Information relating to financial contributions can be found in appendix 5.

West Berkshire LSCB meets six times per year for standard Board meetings, where updates on the work against priorities is expected, performance and audit information is reviewed and emerging issues discussed. The Board also convenes twice a year for business planning sessions. These sessions allow us to review our impact, recent performance data and audit evidence, to decide if our priorities remain relevant. In October 2014 we agreed our current priorities:

Priority 1: Early Help

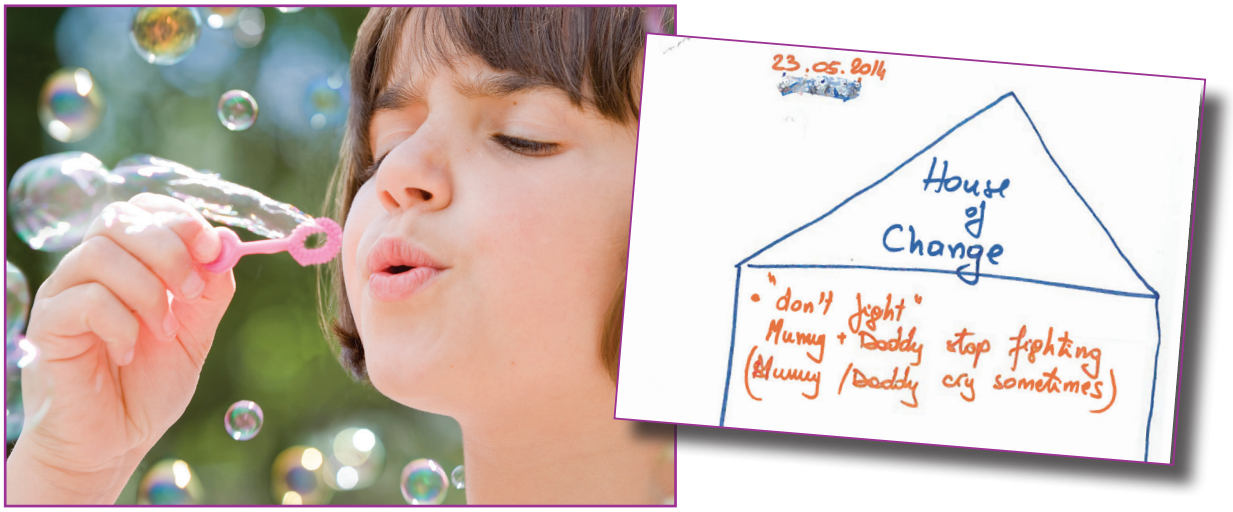
Priority 2: The Child's Voice and Journey

Priority 3: Child Sexual Exploitation and Missing Children

Priority 4: Domestic Abuse and Vulnerable Groups

Priority 5: Effectiveness of the LSCB

West Berkshire is one of six Unitary Authorities in Berkshire and as such we endeavour to work collaboratively with our neighbours to ensure a more joined up approach to safeguarding concerns. The children and young people and their families should receive the same level of service no matter where they live in the county.



The six Berkshire LSCBs work closely together and many partners are represented on all six Boards. We have three sub-groups of the Board which operate across the whole of the county, and two which focus on the West of Berkshire. Specific sub groups for quality assurance and performance, and child sexual exploitation are West Berkshire specific to maintain a local focus on current issues. Our LSCB Structure chart can be found in appendix 3.

LSCB Business Managers and Chairs from across the county, and Thames Valley wide, meet regularly to ensure concerns, issues, impact and processes are shared.

The LSCB has strong links with the Safer Communities Partnership and the Health and Wellbeing Board.

West Berkshire Children and Families Services and the LSCB were inspected by Ofsted under the Single Inspection Framework in March 2015. The overall judgement by Ofsted was that children's services were inadequate. Within that judgement children looked after and achieving permanence was rated as 'requires improvement'; leadership, management and governance 'as requires improvement' and children who need help and protection as 'inadequate'. This was a limiting judgement which resulted in the overall judgement of 'inadequate'. The review of the LSCB was judged as 'requires improvement'.

Ofsted made the following challenges to West Berkshire partners and for the LSCB to ensure the effectiveness of the improvement journey:

- Improve the quality and timeliness of assessments and plans, which are outcome focussed, for children who are most vulnerable to harm.
- The local authority to improve the stability of its social care workforce.
- Increase consistency of the risk assessment of children vulnerable to sexual exploitation.
- Reduce drift and delay in cases where children and young people are subject to plans.
- Develop robust quality assurance frameworks that ensure children's needs are met.
- Independent Reviewing Officers to drive forward plans to ensure progress for Looked after Children.
- Increase use of management information and data to oversee and improve practice and performance.
- Looked after Children to achieve timely health and dental assessments.
- Looked after Children, and care leavers, to have prompt access to services from CAMHS.
- Improve effectiveness of existing forums for hearing the voice of children and young people, and that this consistently contributes to service developments.

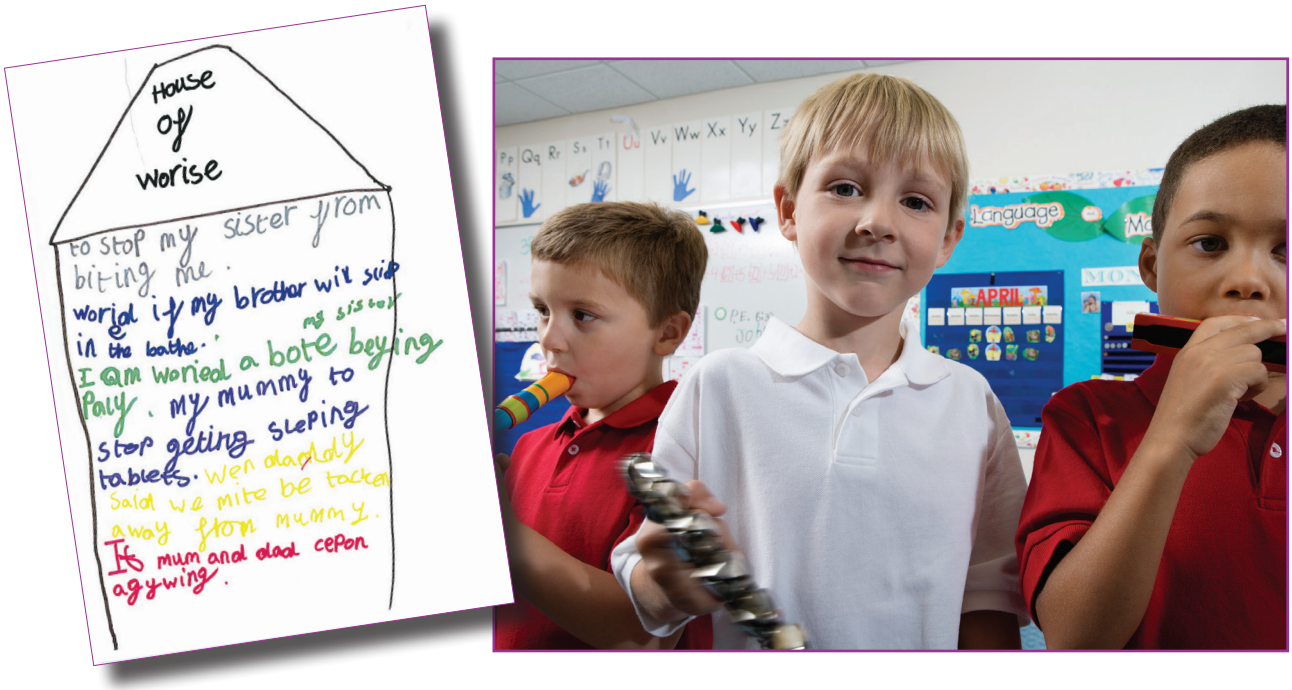
Ofsted highlighted the following strengths which support the LSCB's key priorities and business plan:

- The Family Resource Service is effective in delivering intensive and bespoke support to children and families in need of early help.
- Implementation of the Help for Families multi-agency team has seen an increase in referrals for early help resulting in children and families receiving swift access to the most relevant services.
- The quality of Personal Educational Plans (PEPs) is of a consistently good or very good standard.
- Placement stability for looked after children is strong and the proportion of looked after children in family placements is high.
- Unaccompanied asylum seeking children receive sensitive and effective support.

With regard to the review of the LSCB, Ofsted highlighted the following points to be addressed as part of the board's ongoing improvement journey:

- Increase its oversight of frontline practice through the use of comprehensive and accurate performance data.
- Views of service users and staff being consistently heard and used to inform the work of the board.
- Develop a clear strategic plan in relation to child sexual exploitation.
- Improve and increase the use of multi-agency audits.
- Review the financial resourcing of the board to ensure it can effectively undertake the full range of business.
- Reinforce the existing systems of sharing learning from case reviews.
- Continue to monitor the impact of training and ensures this feeds into the ongoing development of learning courses and events.

The identified areas for improvement will be taken forward through a new performance data dashboard and audit framework (appendix 7), the LSCB risk log (appendix 6) and the business plan.



Our Priorities

The following section addresses each of the LSCB's priorities. Each priority has a story board which highlights why it is a challenge in West Berkshire, and therefore why it is a priority for the LSCB; what the situation has been, what work has been done around the issue and what impact this work has had for children and young people in West Berkshire.

Priority 1: Early Help: To ensure early help services are effective.

Ofsted recognised how strong early help services are in West Berkshire with specific reference to the Family Resource Service and Help for Families;

> ***"The Family Resource Service (FRS), comprising the Domestic Abuse Referral Team (DART), the Family Intervention Team (FIT) and the Family Support Team (FST), is effective in delivering intensive and bespoke support to children and families who may be subject to domestic abuse, at risk of family breakdown or who are on the edge of education and care. Good outcomes have been achieved with families and their children, and these outcomes are well evaluated and documented, ensuring that lessons can be learned and practice further improved"***
> **Ofsted, 2015**

> ***"The implementation of the Help for Families (HFF) multi-agency team has seen a steady increase in referrals for early help from across services and from families themselves. Professionals bring a wide range of experience and knowledge from diverse backgrounds, including health, youth services, schools and children centres. They make sure that children and families receive swift access to the most relevant services that will result in positive and sustainable changes for them."***
> **Ofsted, 2015**

The LSCB continues to recognise that there are continuing pressures for the partnership around early help for children and young people experiencing emotional health difficulties. The work in this issue will continue to build on the existing good work highlighted in the storyboard on the next page.

Priority 1: Early Help: To ensure early help services are effective.

The storyboard below depicts the journey of the tier 2 anxiety project: Psychology and Social Inclusion

Why is it a challenge in West Berks?

- The Secondary Behaviour review (2009) we conducted highlighted that secondary school staff believe the thresholds for Tier 3 mental health services were too high
- West of Berkshire needs assessment of promotion, prevention and early intervention services for emotional health and wellbeing (2010) stated 6,500 of 11 to 16 yr olds will have a mental health disorder
- Public health survey (2014) of the perceived Health and Wellbeing needs of our schools indicated mental health as their major priority
- It is a national estimate that 1 in 10 children and young people will have a mental health problem at any one time and that over half of all adults with mental health problems began by 14yrs old.

Where were we?

- Lack of available alternative services for CYP who were suffering from anxiety
- Lack of awareness of CAMHS capacity led to unrealistic expectations from schools
- Schools were not using 'anxiety' as part of the language describing young people's difficulties, i.e. they didn't recognise the anxiety component in challenging behaviour
- Schools were not accurate at identifying those pupils with high levels of anxiety
- Pupils didn't have the language to describe, share and communicate their difficulties, and were not aware that others had similar problems.

What is the impact on outcomes for CYP?

- We reach approx 28 primary schools each year: 820 pupils
- We carry out 8 secondary packages a year: 60+ pupils
- Over 4 years we have offered approx 100 primary programmes reaching approx 3280 pupils. Over 4 years we have offered approx 50 secondary packages reaching approx 600 pupils
- Each year the evaluation confirms a highly effective intervention. Last year 78% of students significantly decreased their anxiety levels
- Longevity of effectiveness is also measured. A year later, 88% of students said the programme still helped them. 100% of students surveyed said they would recommend the programme to others. Parents have been very positive.
- Schools are more aware of anxiety as a disorder and a barrier to learning and social competency.

What has been done?

- A literature review highlighted the need for effective targeted interventions, school-based, such as Cognitive Behaviour Therapy
- 2010/11 A project was set up to address some of the unmet needs of pupils requiring Tier 2 support and to also support school staff
- All yrs 7 & 8 pupils are screened to identify, with the school, those with high levels of anxiety
- The secondary programme (Managing Worries) is 8 group sessions for those pupils identified led by an EP with an assistant. It teaches relaxation and CBT techniques, and an opportunity to share and learn.

Priority 2: The Child's Voice and Journey: to ensure services take children's views into account and child protection processes operate effectively.

There are pockets of good practice across West Berkshire in relation to hearing the voice of the child, but this is inconsistent. The challenge for the LSCB is to ensure that the voice and experience of children and young people routinely informs service design, reviews and evaluation of effectiveness. The LSCB will hold a challenge event in 2015/2016 for partners on how the voice of the child is heard and used to effect change.

Why is it a concern in West Berkshire?

- Munro report highlighted the need for the child to be at the centre of safeguarding processes.
- Lack of established forums for the voice of the child to be heard.
- The views of Children & Young People (CYP) are not routinely heard at the LSCB.
- CYP report that their experiences through the CP process are not always positive.
- CYP are not receiving medical assessments within prescribed timescales.
- CYP face long waiting times to access effective emotional and mental health support.
- CP conferences do not always have full agency attendance or information provided to them.

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What barriers and challenges have been encountered?

- Staff resourcing issues impact on the ability of agencies to attend safeguarding meetings.
- Process and organisational issues impacting on the ability to arrange health assessments for looked after children and share the reports.

What has been done?

- LSCB has received presentations from a variety of young people to inform board members on particular topics.
- LSCB is working with local youth organisations to recruit a young person to join the LSCB as a board member.
- LSCB is working with the local authority to develop a youth participation strategy.
- SCAS are actively recruiting a young person to their board of governors.
- YOT regularly inform young people of the complaints process, and complete self assessments with young people which are used to inform their intervention plans. YOT regularly seek young people's views to review stages and at the end of their work which is used to inform service delivery.
- YOT utilise the skills of a Speech Therapist to help develop resources for young people to increase engagement, and also to screen for any communication difficulties.
- Education services engage young people in the SEN process and in discussions and target setting around attendance and behavioural issues.
- Public Health are developing Young Person Health Zones in Secondary schools.
- CAFCASS ensure that the voice of the child is heard in family court proceedings.
- Early Years settings have developed the integrated two year old check and best practice work on the child's journey.
- TVP have developed two dedicated roles for attending CP meetings and producing reports for CVP conferences
- CCG's have developed a Named Nurse Primary Care role to work with GP's to increase contributions to CP conferences.

Priority 3: Child Sexual Exploitation and Missing Children: To ensure agencies recognise and respond effectively to child exploitation.

Ofsted found work to protect young people from CSE is developing within West Berkshire. Although there is no overarching strategy, a framework enables professionals to work together supported by an information-sharing protocol and risk-assessment tool. The CSE action plan contains relevant actions linked to prevention, identification and support, and prosecution. Regular operational meetings are held to coordinate work on missing children. The CSE sub-group is well attended and effectively monitors partner activity. Awareness raising in schools and the community has taken place. A co-ordinated programme of performances and workshops using 'Chelsea's Choice' has been delivered to local secondary schools. Return interviews of missing children are appropriately undertaken. Thames Valley Police have undertaken several local operations to disrupt perpetrator activity. The LSCB has undertaken a thematic audit of work to protect children from sexual exploitation, which produced some good learning.

Why is it a problem in West Berkshire?

- Learning from national case reviews with a focus on CSE, including serious cases in neighbouring authorities with which we share a SARC.
- 38 young people identified at risk of CSE in the last financial year.
- Nationally and locally there have been inconsistent responses to children who go missing.
- Limited information available about West Berkshire LAC placed out of area, who have gone missing.

What is the impact on outcomes for Children and Young People?

- 100% compliance with statutory responsibilities for return interviews for children who go missing, with learning linked to service planning and criminal justice intelligence.
- Return interview process responds to the child's needs and focuses on hearing the child's voice and experience.
- Substantial reduction in missing episodes year on year; 610 episodes in 2013 to 416 episodes in 2014.
- Integrated plans for young people allow risk to be shared.

What barriers and challenges have been encountered?

- No single point of contact with responsibility for missing children.
- Low numbers of missing young people receiving a return interview from appropriately trained staff.
- Information sharing around CSE and missing children, both inter and intra agency.
- West Berkshire has a well developed operational framework, with an under developed strategic framework.
- Low attendance at operational group meetings from some partners.
- Issue with the completion of actions from the operational group by some partners.
- CSE risk assessments not recorded on the raise system, or integrated into the most relevant plan for children and young people.
- Lack of CSE training pathway across the West of Berkshire.

What has been done?

- Police now differentiate between Missing Children and those who are absent.
- Missing co-ordinator post created in September 2014.
- Missing children panel merged with the CSE operational meeting.
- Over 40 staff, from a wide variety of agencies, trained to undertake return interviews.
- Detailed multi-agency audit into the CSE systems and CSE response within West Berkshire, with corresponding action plan mapped against the 'See Me, Hear Me' framework.
- Development of a CSE risk assessment tool which is used across Berkshire.
- Increased attendance and completion of actions in the CSE and missing operational group.
- Development of CSE profile by Thames Valley Police, and the development of a local profile has begun.
- CSE Information Sharing Agreement developed and agreed.
- Commissioning of online learning and face to face training as part of the LSCB training calendar.
- Development of a West of Berkshire CSE training pathway has started.
- Process established for integrating CSE plans with other plans for children and young people.
- Amendments to Berkshire wide CP procedures around CSE and missing.
- Development of an over-arching CSE strategy for West Berkshire has begun with focus on responding to the local profile and how to ensure process become imbedded in practice.

Priority 4: Domestic Abuse (DA) and Vulnerable Groups: to ensure agencies recognise and respond effectively to Domestic Abuse and vulnerable groups.

The Safer Communities Partnership has made it a strategic priority to increase the number of first time reports of domestic abuse, and reduce the number of repeat referrals. Following a Berkshire wide audit of MARAC some areas for improvement have been identified. There is a focus on increasing the overall number of referrals, increasing the number of referrals made by partner agencies and completing a survey to find out what the victim's views of the process are and if it has assisted them. There will be continued strategic work in 2015/2016 on the impact of toxic trio risk factors as an area of future development. The storyboard below also reflects the rationale behind the creation of the Domestic Abuse Response Team (DART) in 2011.

Why is it a problem in West Berkshire?

- Domestic Abuse continues to be one of the most prevalent and hidden crimes.
- Despite the size of West Berkshire there have been four domestic homicides since 2003.
- In 2014-2015 there were 764 DA incidents recorded as crimes by TVP and 1638 non-crime domestic incidents.
- The DA helpline received 809 calls between April 2014 and March 2015.
- West Berkshire still has relatively low numbers of referrals to MARAC especially from non-Police agencies.
- Audit of 36 YOT cases highlighted that 28 of the cases had witnessed or been a victim of DA. 29 of the cases were currently open or previously known to Children's Social Care. 19 of the cases are known to be or previously be abusive towards partners of family members.
- In West Berkshire in 2011, there were 1261 DA referrals to the social care front door. 28% led to assessment with 72% not receiving a service. There was a lack of whole family support in response to DA. The DART team was established to work with perpetrators, victims and children, in a holistic way following standard to medium risk DA incidents.

What has been done?

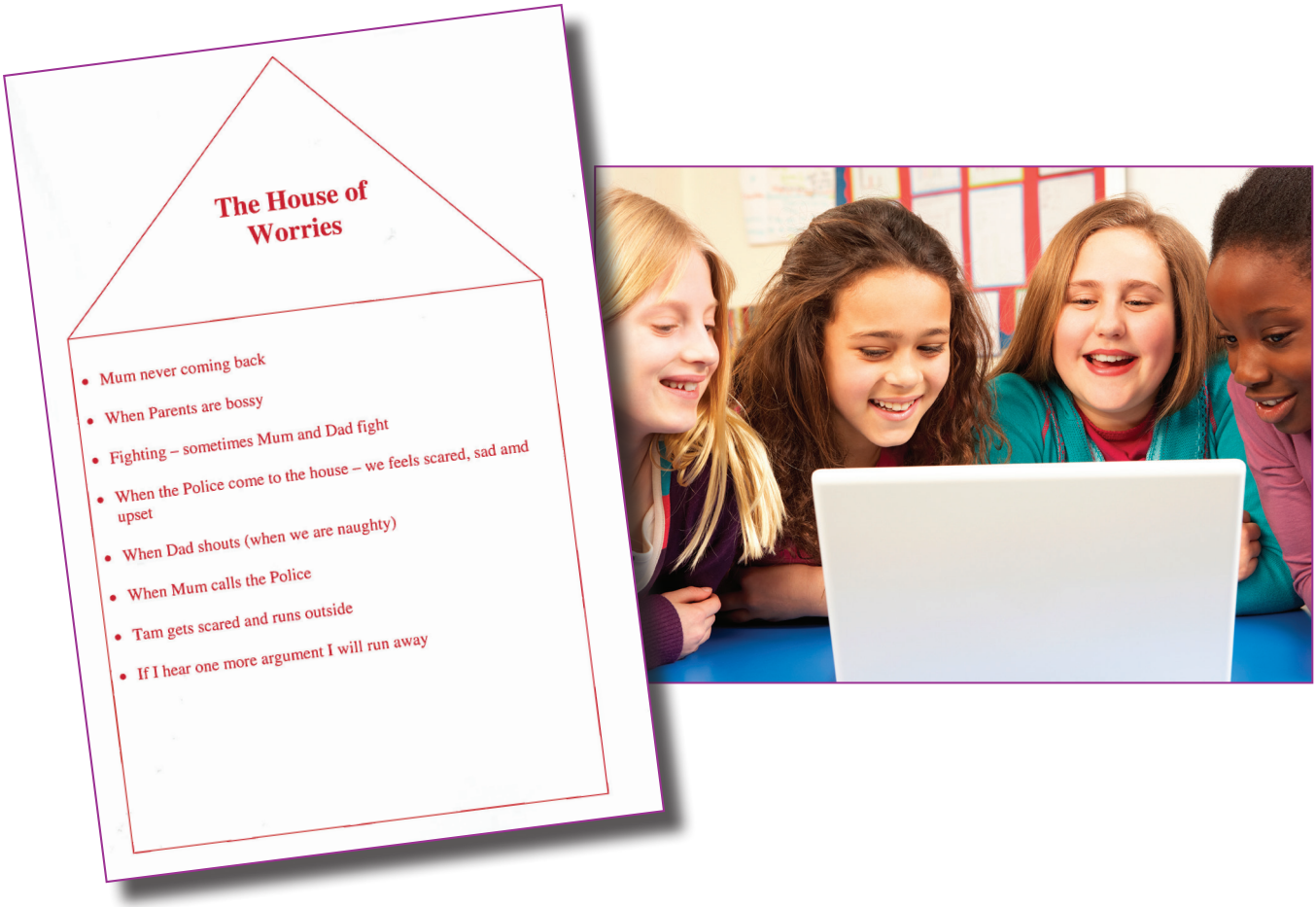
- Awareness raising in partner agencies via free training packages on DA, DASH & MARAC. 12 out of 15 GP Surgery's have received specialist training from the DA reduction co-ordinator. There has also been training with the staff at the Minor Injuries Unit, Royal Berkshire Hospital and OPut of Hours GP's (Westcall). 172 GP's, Nurses, Receptionists, Midwives, Dispensers and Phlebotomists have been trained as a result.
- The introduction of DA Champions. There are now 89 training DA champions across the partnership.
- Strategic commitment for 2015/16 to increase first time referrals to MARAC and decrease repeat referrals. The target is a 10% year on year increase, the 2015-2016 target number is 112 cases. A further aim will be that 30% of these referrals are from non-Police agencies.
- Information sharing agreement for schools introduced allowing schools that have attended specialist training to be notified that a DA incident has occurred. Currently 80% of Primary Schools and 70% of Secondary and Academy schools have signed up to the agreement. 100% of Children's Centres and Alternative Curriculum providers and 16 nurseries have received the training and can all receive notifications.
- DA notifications continue to be shared with Health Visitors, School Nurses, Midwives, and GP's for each child. High risk notifications are screened by a specialist practitioner and advice given to staff.
- In response to the YOT audit, the YOT DA Champions were trained to use the Domestic Abuse for Young People Programme (DAY), and facilitate a group work programme for young people identified in need of support via the audit process.
- The DAY programme has been separately offered to local PRU and CYP drug and alcohol service. This programme engaged with 15 young people.
- DART continues to work with families where there has been a standard or medium risk DA incident. These numbers have increased from 16 families in 2012 to 38 families in 2014. Higher risk cases are escalated to MARAC.

What barriers and challenges have been encountered?

- Awareness of DA and MARAC in partner agencies.
- Impact of funding cuts has resulted in a loss of refuge spaces in neighbouring areas.
- Domestic Abuse notifications were not historically shared with education providers and children's centres.
- YOT group work has proved difficult due to small cohort numbers but DAY programme has been adapted to allow 1:1 work.
- DAY programme could not be rolled out to all schools in West Berkshire due to limited resources. An evaluation report with proposals for future developments of this intervention will be completed for the financial year 2015/2016 and shared with all partners.
- Unable to facilitate a survey in schools on healthy relationships.

What is the impact on outcomes for Children and Young People?

- Following delivery of the DAY programme (healthy relationships intervention for YP) facilitated in the PRU and CYP SMU service, the young people reported the following: 74% said they would recognise abuse, compared to 34% at the start of course. 100% said they would know what to do if they were suffering abuse compared to 40% at the start of the course.
- Ability to share information with education settings has allowed professionals to increase support for young people and families, in addition to better informing safeguarding referral decisions.
- Increased awareness within partner organisations has enabled increased identification and reporting of DA. This is reflected in the number of DA incidents recorded as a crime and the number of non crime domestic incidents- which have both seen a rise each year, for the past 3 years.



Priority 5: Effectiveness of the LSCB: To ensure the LSCB works effectively as an inter-agency partnership to safeguard and promote the welfare of children and young people

The LSCB conducted a self assessment exercise with board members to highlight the areas for development and create a shared vision for its improvement journey. The findings of the Ofsted inspection very much mirrored the priorities for improvement the board had identified. These findings are reflected in the storyboard below.

What barriers and challenges have been encountered?

- During 2014/2015 the post of LSCB Business Manager was vacant from June 2014- October 2014.
- The Independent Chairing arrangements changed, with a new Chair taking over in October 2014.
- After a benchmarking exercise the LSCB has challenged whether its revenue investment from partners was sufficient.
- A lack of multi-agency audits, and an established multi-agency audit programme with ability to share learning was identified.
- Board members highlighted the need to be aware of frontline practice via regular use of performance data.
- The effectiveness and impact of multi-agency training and the links between audits and case reviews to the learning and improvement framework were not clear.
- Challenge and scrutiny from partners needed to be more explicit in board meetings.

What are we doing?

- Amended agenda for board meetings with all items listed under the business plan priorities so that board members can see a clear reason for each item of business being discussed.
- Development of a risk/concern log to be used at each board meeting to highlight challenge from partners on specific topics and the actions taken.
- Performance data- development of a local multi-agency data set, with an exception reporting dashboard that is brought to each LSCB meeting. The exception reporting dashboard is linked to the risk/concern log and agreed by all board members. It is a dynamic dashboard with items able to move back down to the larger data set once the board has been assured of the change in performance, and items able to be escalated if they show concerns.
- A revised multi-agency audit programme has been developed which directly links to the exception reporting dashboard and the risk/concern log. Clear outcomes and timescales have been identified for the programme, with clear routes for sharing and embedding learning and monitoring actions identified.
- Effectiveness and Impact of training is being explicitly looked at by the Learning and Development sub-group. New system in place for monitoring the impact of LSCB training courses, 3 months after course completion.
- Increased communication between the LSCB and its sub-groups via the introduction of sub-group report that is presented by the Business Manager at each board meeting.
- Joint case review group established across the West of Berkshire to make decisions about serious incidents and case reviews. The group will also look at disseminating learning from other local and national reviews with strong links to the Learning and Development sub-group, local Quality and Performance groups and CDOP.
- New format for the LSCB annual report that focuses on progress and challenge under each LSCB priority area.
- Developing the role of hearing the child's voice within the LSCB arena by exploring the recruitment of a young person to attend board meetings, use of peer mentoring networks to develop resources and establishing links with local forums for young people as part of a wider local authority youth participation strategy.

What is the intended impact on outcomes for Children and Young People?

- Streamlined business processes allow for increased discussion and challenge at board meetings resulting in increased scrutiny of safeguarding services for young people.
- Use of performance data directly focuses challenge on areas of concern, resulting in increased challenge to improve services for young people.
- Effective links between performance data, auditing, quality assurance and learning and development allows development of frontline practice and staff training which positively impacts on the services young people receive.
- Clear communication and shared learning from case reviews increases the knowledge base of staff and decreases the chance of similar incidents occurring in the future.
- Mechanisms to hear the child's voice allows the board to be focused on the issues that are a priority for young people and allows services to learn from the direct experience of service users.

Our Compliance with Statutory Functions

Statutory Legislation

Section 13 of the Children Act 2004 requires each local authority to establish a Local Safeguarding Children Board (LSCB) for their area and specifies the organisations and individuals (other than the local authority) that should be represented on LSCBs. Our current membership is listed in the appendices.

The core objectives of the LSCB are as set out in section 14(1) of the Children Act 2004 as follows:

a) To co-ordinate what is done by each person or body represented on the Board for the purposes of safeguarding and promoting the welfare of children in the area,

b) To ensure the effectiveness of what is done by each such person or body for that purpose.

The role and function of the LSCB is defined by Working Together to Safeguard Children 2015, and key extracts can be found in the appendices.

Policies and Procedures

Regulation 5 of the Local Safeguarding Children Boards Regulations 2006 sets out that that LSCB must develop policies and procedures for safeguarding and promoting the welfare of children in the area of authority.

To meet this function an established LSCB Policies and Procedures sub-group, which is shared across Berkshire, meets to maintain the child protection procedures. Some concerns with the governance of this group over the last financial year have been noted and an annual evaluation from the group was not forthcoming due to the vacancy for the position of chair. An extraordinary meeting of the group has been called with all LSCB's and partner agencies represented. The sub-group will be identifying a new chair, refreshing its terms of reference and membership, increasing its meetings to quarterly and developing a forward plan of work. The main priorities for the group will be ensuring that all the policies and procedures are updated in line with current legislation and that the procedures are accessible for practitioners.

Learning and Development

In order to fulfil its statutory functions under Regulation 5 an LSCB should monitor and evaluate the effectiveness of training, including multi-agency training, to safeguard and promote the welfare of children.

West Berkshire LSCB shares a Learning and Development sub-group with Reading and Wokingham LSCB's. The purpose of the sub-group is to lead the strategic planning and oversight of the LSCB training calendar alongside the operational oversight for this. The aim of the group is to coordinate the provision of sufficient high-quality, multi-agency learning and development opportunities that is responsive to local need and has a positive impact on safeguarding outcomes for children and young people; holding partner organisations to account for operational delivery and uptake.

Specific activity that has been undertaken over the year April 2014-March 2015 includes;

- Support given to organise and deliver the annual Safeguarding Conference which is joint with the Safeguarding Adults board
- Daniel Pelka Serious Case Review learning shared
- Training sub-group away day held to review past, present and future
- Training sub-group split in to east and west
- Priorities for action agreed in line with revised LSCB Business Plan
- Voluntary sector became part of sub-group membership
- Current and emerging needs discussed and prioritised for future L&D opportunities
- Training programme for 2015-16 created and approved
- A new action plan agreed for 2015-16

The training programme was created by the Operational L&D Sub-Group, based on past trends and emerging needs. The headline figures associated with the programme from April 2014-March 2015 include;

- 22 courses were run through the LSCB programme (92% of the planned programme)
- 355 candidates attended the courses, (over 16 candidates per course)
- 46% of the places were taken by Local Authority workers, with 21% from Health and 33% from others (12% of these being from PVI)
- Allegations management was the most popular course for other agencies, including schools (32 candidates)
- 53% of people felt the immediate impact of the training was significant or very significant with 45% stating there was some immediate impact.

The e-Learning offer in West Berkshire for the LSCB Programme focused on three main learning opportunities, this being Child Sexual Exploitation (CSE), Universal Safeguarding (USC) and Domestic Abuse (DA). The headline figures for the programme include;

- 1982 candidates completed the USC e-learning in the financial year 2014-15.
- 73 candidates completed the CSE e-learning in the financial year 2014-15.
- 58 candidates completed the DA e-learning in the financial year 2014-15.

These figures do not represent a total number of candidates accessing e-learning across the partnership as some partners working across authorities can access the same courses using different authorities' log-ins details. However, the numbers above do indicate that e-learning continues to used and there is benefit to the e-learning offer alongside face to face training programmes.

Impact of the work of the learning and development sub-group:

Serious Case Review learning has been successfully shared within the sub-group and used to inform revisions to learning and development interventions (e.g. training courses or e-learning content). This has meant that candidates were aware of current cases and the learning they provide. The training figures suggest the learning and development programme has had an impact on a significant number of attendees, meaning that that candidates work practices and behaviour are influenced, leading to a positive impact on the outcomes for Children and Young People.

Challenges to the learning and Development sub-group:

- The training needs analysis for the LSCB training calendar is under developed and will be a focus of the sub-groups work for the forthcoming year.
- Effectiveness and impact of training continues to be a key theme to continue developing.
- Marketing of LSCB training courses to be increased in the next financial year, and demand to be monitored throughout the training calendar to allow more courses to be added if required.

Section 11 Panel

Section 11 of the Children Act 2004 places duties on a range of organisations and individuals to ensure their functions, and any services that they contract out to others, are discharged having regard to the need to safeguard and promote the welfare of children.

Pan Berkshire Approach

The six Berkshire LSCBs work together through the Section 11 (S11) Panel. Its purpose is:

- To oversee the S11 process for all pan Berkshire organisations and to support improvement. This currently involves Berkshire wide statutory and voluntary organisations of which there are 9 of a significant size and scope.
- To set clear expectations with the LSCBs and those organisations about the timeframe and process for submission of a self-assessment section 11 audit, and ongoing development towards compliance.
- Review and evaluate S 11 returns of the full three yearly audit (including a mid-term review) of s11 Children Act 2004 for pan Berkshire organisations, in order to make an assessment of agencies compliance with the duty to safeguard. The new round of assessments will commence from May 2015.

Achievements:

- Reviewed S11 Panel Terms of Reference to ensure the Panel is meeting the LSCB's statutory requirements.
- S11 Self-Assessment Tool has been updated and it is now available electronically
- S11 self assessment timetable has been agreed to ensure all agencies submit a response over the next 18 months and then receive a mid-term review 18 months after submission.
- There has been consistent attendance by most agencies although police and children's social care representation remains a significant challenge that requires escalation.
- Good practice was identified in terms of the process of self-assessment and how organisations can learn from each other to ensure it is routine practice.

Challenges:

- Chairing of the group has seen some change.
- Going forward there needs to be clearer links with Learning and Development sub-groups.
- LADO representation on the group would be beneficial given their wider 'safer workforce' responsibility.
- There has been confusion as to the frequency and nature of reporting from the group to individual LSCBs and proposals regarding single point reporting directly to the Independent Chairs is welcomed.

Section 11 Panel

Themes from the first round of S11 returns:

- There is a need for greater understanding of 'safeguarding supervision' across the children's workforce and explore opportunities for multi-agency developmental supervision or case supervision
- There is a need for easy access to safer recruitment training. Although this is happening, it does not appear to be sufficiently well co-ordinated. It is suggested that all partner agencies are cognisant of their individual responsibilities and that LSCB's incorporate this into their training strategy. It would seem essential that responsibility for commissioning and delivering training is evident, and its quality is routinely monitored.
- S11 Submissions from Local Authorities were variable, although with the new methodology going forward a standard expectation will become clearer
- CAF and early help arrangements appear to differed across organisational boundaries, which can be of challenge to pan-Berkshire organisations utilising different referral methods and subsequent pathways.
- Although organisations did have a named senior person responsible for safeguarding, but at times it was unclear how this influenced operational practice. The responsibility to have a named person was well understood but there was little evidence of understanding of the actual range of responsibilities this entailed.
- The process for obtaining DBS checks, particularly for those in smaller voluntary organisations needs to be made clearer. This is intelligence that has come from individual LSCB's.
- While training is available the demand for multi-agency training appears to be greater than the volume of staff in some organisations demands. The need for employers to clarify the required pathways together with clearer guidance regarding the relevance of inter-agency training by LSCBs would appear to be important as delivery of such events becomes separated across the East and West of the region.
- Information sharing is a feature in SCR's but this did not come out strongly as an issue in Section 11. Going forward this should be explored further when returns are being presented.

Future Plans for the Panel for 15/16

- 3 year cycle of S11 audits to be commenced on an ongoing rolling programme which incorporates an 18 month mid-term review to monitor progress of action plans.
- Agencies to be invited to present their S11 self-assessments to the Panel to enable scrutiny and challenge of each agency enabling greater discussion and learning.
- Agree a process to ensure that best practice evidence is incorporated into Berkshire processes and that learning is shared.

Case Review Group

This group receives and reviews all cases referred to the group where staff from any partner agency of the Safeguarding Children Boards in Berkshire West have identified potential learning. The group will also consider cases where a referral has been made to the group from the Berkshire Child Death Overview Panel (CDOP).

Recommendations will be made to the Chair of the Berkshire West Local Safeguarding Children Boards (LSCBs) when the group agrees that the criteria has been met to undertake a serious case review (SCR) as defined in Working Together to Safeguard Children (2015). Where the group agrees that the criteria for a SCR has not been met it might recommend a partnership review of the case.

Learning from published SCRs will be shared by the group for dissemination across partner agencies of the LSCBs.

The Berkshire West Case Review Group was formed from an amalgamation of the three previous serious case review groups across Berkshire West at the beginning of 2015. The group is currently meeting every two months, and has so far only met three times. In this time six cases have been reviewed, with the recommendation that an SCR be undertaken in two cases, although one had a query regarding the criteria. In one of these cases, further information meant that an SCR was no longer appropriate but a partnership review will be completed. In the other case, the National Panel of Independent Experts in Serious case Reviews was consulted and they confirmed it did not meet the SCR criteria. A partnership review will be undertaken instead. One further case identified good practice and a storyboard will be produced to aid learning. No serious incidents put forward from West Berkshire have progressed to either a serious case review or partnership review.

Impact:

This is a new group and therefore its impact and outcomes are yet to be measured. It is envisaged that the amalgamation of the previous three SCR groups will:

- Enable a shared process for referral to the group.
- Enable shared learning from serious case reviews and partnership reviews across the three areas of Berkshire West and ultimately across Berkshire, via the Learning and Development sub group of the three LSCBs.

Ongoing challenge:

- Representation from the local authorities has not been consistent for either meeting.
- Representation from Early Years has now been agreed.
- LSCBs to be clear about the content and regularity of reports from the group to the LSCB.

Under the previous arrangements for making decisions on SCR's, a serious case review, Child G, was instigated by West Berkshire LSCB and published in July 2014. Child G, aged 18 months, was admitted to hospital via ambulance following an incident at home. He sustained two fractures to his jaw bone and lacerations to his tongue. His mother, after initially saying the child had fallen down the stairs, then revealed to paramedics that she had deliberately thrown her son down the stairs. The serious case review identified the following key actions:

- Health visitors to have access to maternal mental health notes and for a flagging system to be developed to aid access to the relevant information.
- Increased communication and information sharing between mental health workers and health visitors, above just the joint accessing of records.
- Improved communication between the crisis team and Children's Services, including revision of the joint protocol to include circumstances when a joint visit would be appropriate.
- Psychiatric reviews to be available within 48 hours. To include access to advice and face to face meetings.
- To improve information sharing across services and professionals.
- South Central Ambulance Service to clarify its safeguarding referral process.

The above actions were monitored by the Quality and Performance sub-group, and the action plan is now complete and considered closed. Alongside the closure of the serious case review and in light of the challenges of increased staff turnover in West Berkshire it was agreed by the LSCB that the summary of the serious case review and key learning would be disseminated again to all partners for cascading. In addition to this the quality and performance sub-group will oversee an audit in 12 months time to ensure that leaning from the case continues to be embedded in frontline practice.

Child Death Overview Panel

The LSCB is responsible for ensuring that a review of each death of a child normally resident in the LSCB's area is undertaken by a CDOP. The CDOP will have a fixed core membership drawn from organisations represented on the LSCB with flexibility to co-opt other relevant professionals to discuss certain types of death as and when appropriate.

In Berkshire as a whole, there has been an overall reduction in reviewed deaths from 58 in 2012/13 to 60 in 2013/14 to 50 in 2014/15 It is difficult to attribute causes for the reduction however the panel took consistent action to promote;

- neonatal reviews and thematic risk factor monitoring;
- the 'one at a time' message for those undergoing IVF treatment
- a consistent set of recommendations for 'safe sleeping' – which all agencies adopted

The annual number of child deaths reported in West Berkshire in 2014-15 was under 10 which compares with similar total of deaths in 2013-14. Of those reviewed so far, 33% were classified as perinatal/neonatal deaths and 17% were classified as trauma.

Infant mortality was statistically lower than England in West Berkshire in 14/15 in the CDOP records and as reported in the child health profile for 2015. The main categories of death are; chromosomal, genetic and congenital anomalies, perinatal and neonatal deaths, malignancies and that as yet no deaths have been reported with modifiable risk factors.

Achievements:

- Regular reporting on risk and preventative factors for infant and child deaths through the CDOP newsletter and JSNA.
- Facilitating the development of an asthma and viral wheeze website/ app for the Thames Valley as a response to two local child deaths in Berkshire in 2013-14. This is now live at www.puffell.com
- Asthma and viral wheeze GP and practice training is being implemented across the Thames Valley which will ensure that all children have an asthma plan in line with national recommendations.
- Designing and testing an emotional health and wellbeing website/app which includes sections on self harm, anxiety and depression, anti-bullying and domestic abuse as part of the public mental health approach to CAMHS service redesign has been undertaken elsewhere in the county.
- A paper was presented at the national CDOP conference based on a detailed analysis of all child deaths in relation to congenital anomalies and is planning to audit the implementation of the consanguinity programme in secondary schools this year.
- All cancer deaths have been reviewed by an external expert panel and no trends of common modifiable factors have been found.
- The service continues to promote safe sleeping advice
- A GP practice improvement programme for the early identification of sepsis has been rolle out via the network.

Ongoing Challenges:

The key challenge remains the reduction of pre term births and the death of children in their first year of life. The panel are assured that work on reducing pre term births is also a regional health priority as many of the risk factors relate to the health of the mother antenatally and the care she receives within that period. The Thames Valley Children's and Maternity network has been promoting training to increase awareness of the optimum way to measure fundal height through the midwifery services.

Quality Assurance and Performance

Working Together states that in order to fulfil its statutory functions under regulation 5 an LSCB should use data and, as a minimum, should:

- assess the effectiveness of the help being provided to children and families, including early help;
- quality assure practice, including through joint audits of case files involving practitioners and identifying lessons to be learned;

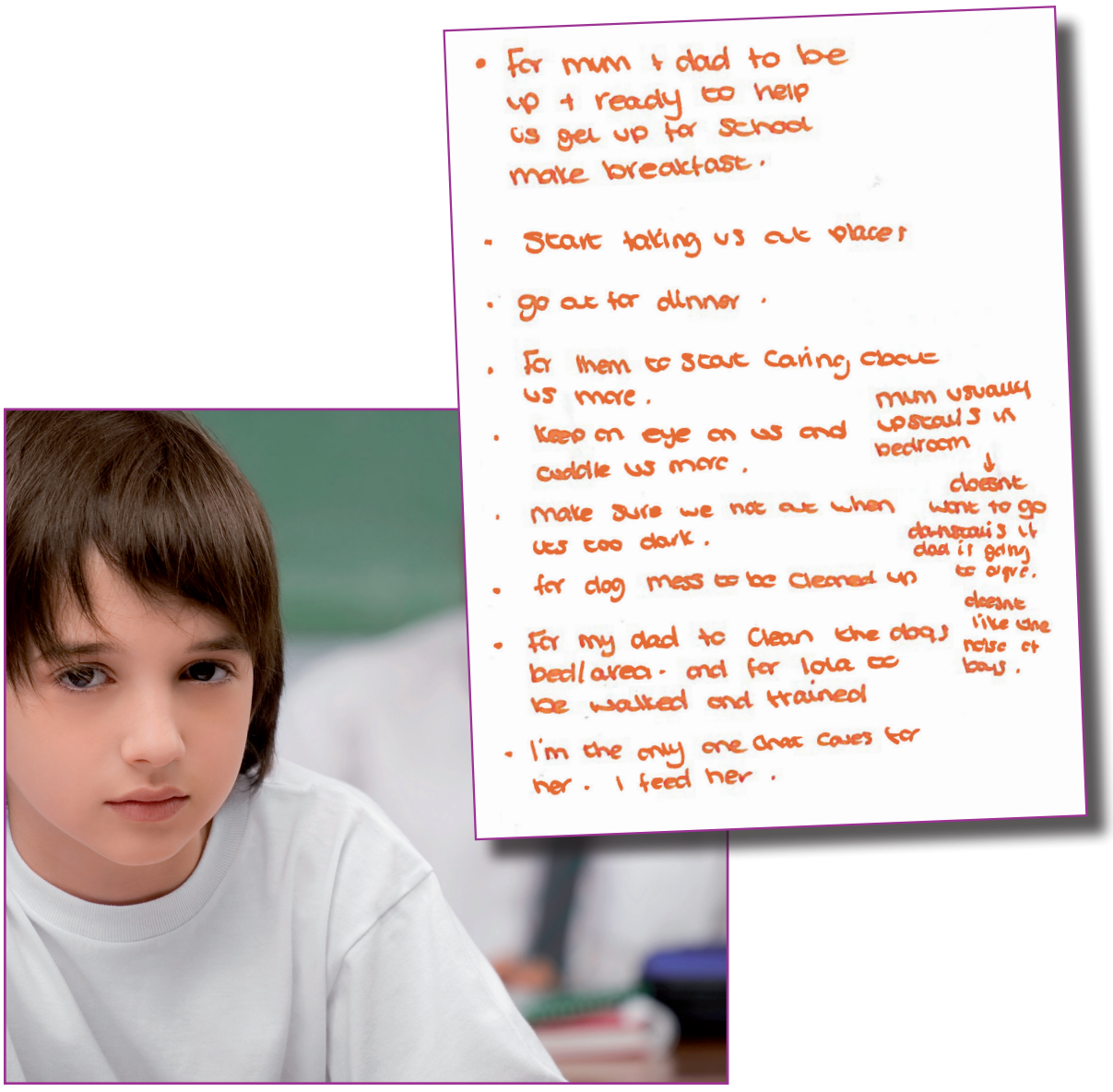
With the change of LSCB Independent Chair in October 2014 the decision was made to bring the collection and analysis of performance data back in house to West Berkshire. Previously it had been managed across the three authorities in the West of Berkshire. The performance data management has been combined with the quality assurance sub-group within West Berkshire which has allowed the development of a strong quality assurance framework. The multi-agency performance data highlights areas of concerns across the partnership which is shared with the LSCB at each board meeting via an exception report dashboard, and links to the LSCB risk/concern log. This in turn informs the multi-agency audit programme, which is clearly linked the LSCB business plan priorities. The new audit programme is outcome driven with clear reporting timeframes to the LSCB and how learning will be shared with agencies and influence training and development. The quality assurance framework document can be viewed in Appendix 7.

The quality and performance sub-group also manages the local authorities section 11 compliance with the aim that the board can be assured of the quality and consistency of completion of the return and that local themes can be identified and shared. The return also feeds into the pan Berkshire Section 11 sub-group. The return includes the compliance of the education sector with its section 11 responsibilities. The Education Service in West Berkshire conducts an annual audit of safeguarding and section 11 compliance. This audit is sent to all primary, secondary, academy and independent schools as well as all alternative curriculum providers, further education colleges and children's centres. There is a 100% completion rate for the audit and key themes identified are shared with this sub-group and the LSCB. This piece of work is well established within West Berkshire and is held in high regard by those completing the audits.

Child Sexual Exploitation

Working Together to Safeguard Children (2015) sets out that LSCBs should conduct regular assessments on the effectiveness of Board partners' responses to child sexual exploitation and children missing from care.

West Berkshire LSCB has child sexual exploitation (CSE) and missing children as one of its key priorities for work, and this will continue into the next financial year. It has an active and well established CSE strategic and operational group alongside a CSE co-ordinator and a co-ordinator for missing children. The achievements and challenges of the work around CSE can be viewed in detail on the storyboard on page 8. The LSCB also has planned a challenge event in July 2015 which will seek to continue to assure itself of the work across the partnership around the issue of CSE and missing, and to identify any areas for development.



Appendices

1. Glossary

BHFT	Berkshire Healthcare NHS Foundation Trust
BME	Black and Minority Ethnic
CAFCASS	Children and Family Court Advisory and Support Service
CAMHS	Child and Adolescent Mental Health Services
CAAS	Contact, Advice and Assessment Service
CCG	Clinical Commissioning Group
CDOP	Child Death Overview Panel
CMoE	Children Missing out on Education
CSC	Children's Social Care
CQC	Care Quality Commission
CSE	Child Sexual Exploitation
DBS	Disclosure and Barring Service
DfE	Department for Education
EHC	Education, Health and care Plan
FGC	Family Group Conference
FGM	Female Genital Mutilation
IRO	Independent Reviewing Officer
JSNA	Joint Strategic Needs Assessment
LAC	Looked After Child
LADO	Local Authority Designated Officer
LDD	Learning Difficulties and Disabilities
LSCB	Local Safeguarding Children Board
MAPPA	Multi-Agency Public Protection Arrangements
MARAC	Multi-Agency Risk Assessment Conference
MASH	Multi-Agency Safeguarding Hub
NEET	Not in Employment, Education or Training
ONS	Office of National Statistics
RBFT	Royal Berkshire NHS Foundation Trust
SAPB	Safeguarding Adults Partnership Board
SARC	Sexual Assault Referral Centre
SCR	Serious Case Review
SEN	Special Educational Needs
TVP	Thames Valley Police
VCFS	Voluntary, Community and Faith Sectors
YOT	Youth Offending Team

2. Extracts from Working Together 2015

Chapter 3.1: Statutory objectives and functions of LSCBs

Section 14 of the Children Act 2004 sets out the objectives of LSCBs, which are:

(a) to coordinate what is done by each person or body represented on the Board for the purposes of safeguarding and promoting the welfare of children in the area; and
(b) to ensure the effectiveness of what is done by each such person or body for those purposes.

Regulation 5 of the Local Safeguarding Children Boards Regulations 2006 sets out that the functions of the LSCB, in relation to the above objectives under section 14 of the Children Act 2004, are as follows:

1 (a) developing policies and procedures for safeguarding and promoting the welfare of children in the area of the authority, including policies and procedures in relation to:
(i) the action to be taken where there are concerns about a child's safety or welfare, including thresholds for intervention;
(ii) training of persons who work with children or in services affecting the safety and welfare of children;
(iii) recruitment and supervision of persons who work with children;
(iv) investigation of allegations concerning persons who work with children;
(v) safety and welfare of children who are privately fostered;
(vi) cooperation with neighbouring children's services authorities and their Board partners;
(b) communicating to persons and bodies in the area of the authority the need to safeguard and promote the welfare of children, raising their awareness of how this can best be done and encouraging them to do so;
(c) monitoring and evaluating the effectiveness of what is done by the authority and their Board partners individually and collectively to safeguard and promote the welfare of children and advising them on ways to improve;
(d) participating in the planning of services for children in the area of the authority; and
(e) undertaking reviews of serious cases and advising the authority and their Board partners on lessons to be learned.

Regulation 5 (2) which relates to the LSCB Serious Case Reviews function and regulation 6 which relates to the LSCB Child Death functions are covered in chapter 4 of this guidance.

Regulation 5 (3) provides that an LSCB may also engage in any other activity that facilitates, or is conducive to, the achievement of its objectives.

Chapter 3.4: Statutory Board partners and relevant persons and bodies

Section 13 of the Children Act 2004, as amended, sets out that an LSCB must include at least one representative of the local authority and each of the other Board partners set out below (although two or more Board partners may be represented by the same person). Board partners who must be included in the LSCB are:

Chapter 3.4: Statutory Board partners and relevant persons and bodies

Section 13 of the Children Act 2004, as amended, sets out that an LSCB must include at least one representative of the local authority and each of the other Board partners set out below (although two or more Board partners may be represented by the same person). Board partners who must be included in the LSCB are:

- district councils in local government areas which have them;
- the chief officer of police;
- the National Probation Service and Community Rehabilitation Companies;
- the Youth Offending Team;
- NHS England and clinical commissioning groups;
- NHS Trusts and NHS Foundation Trusts all or most of whose hospitals, establishments and facilities are situated in the local authority area;
- Cafcass;
- the governor or director of any secure training centre in the area of the authority; and
- the governor or director of any prison in the area of the authority which ordinarily detains children.

The Apprenticeships, Skills, Children and Learning Act 2009 amended sections 13 and 14 of the Children Act 2004 and provided that the local authority must take reasonable steps to ensure that the LSCB includes two lay members representing the local community.

Section 13(4) of the Children Act 2004, as amended, provides that the local authority must take reasonable steps to ensure the LSCB includes representatives of relevant persons and bodies of such descriptions as may be prescribed. Regulation 3A of the LSCB Regulations prescribes the following persons and bodies:

- the governing body of a maintained school;
- the proprietor of a non-maintained special school;
- the proprietor of a city technology college, a city college for the technology of the arts or an academy; and
- the governing body of a further education institution the main site of which is situated in the authority's area.

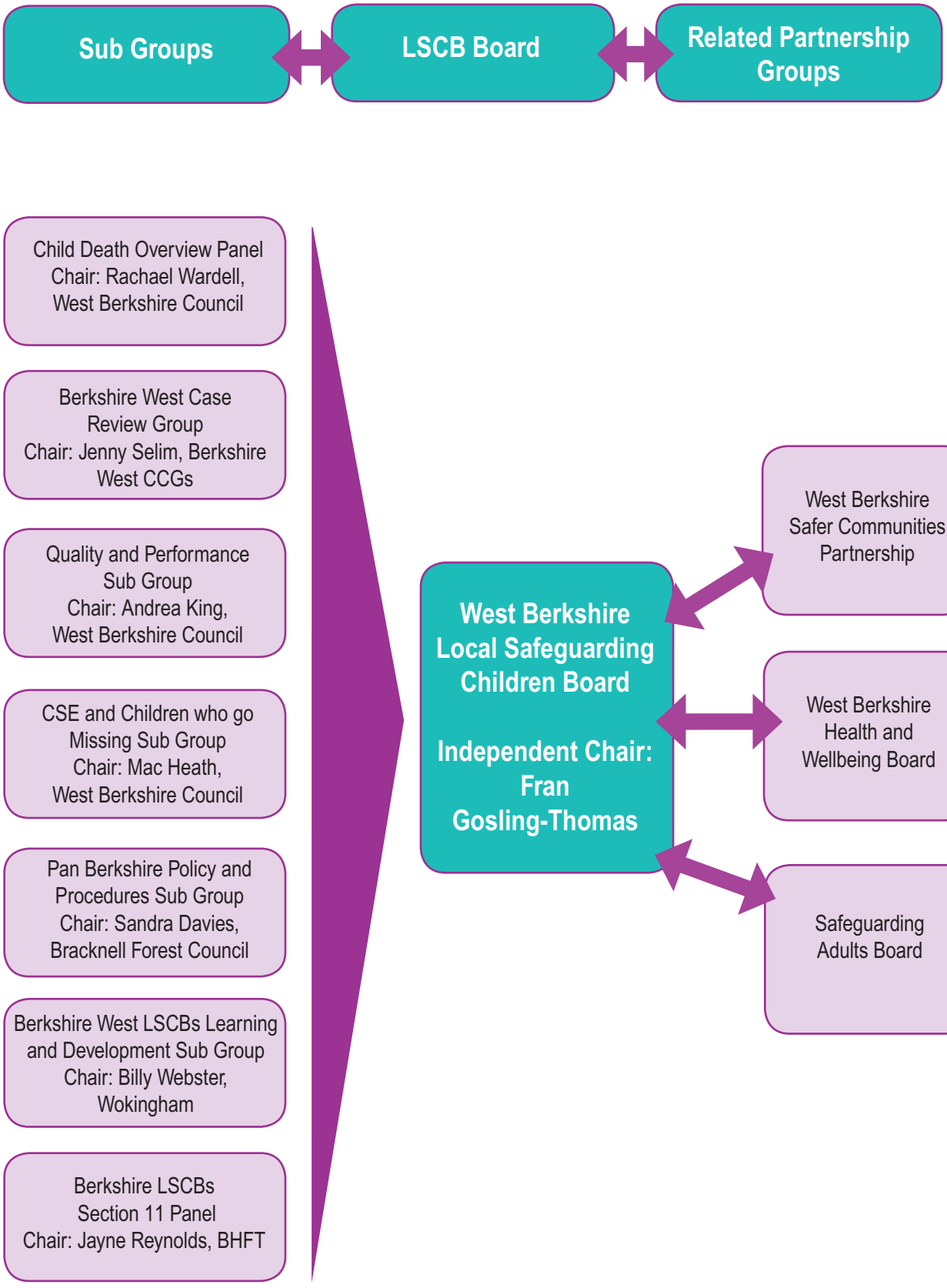
Chapter 5: Child Death Reviews

The Regulations relating to child death reviews:
The Local Safeguarding Children Board (LSCB) functions in relation to child deaths are set out in Regulation 6 of the Local Safeguarding Children Boards Regulations 2006, made under section 14(2) of the Children Act 2004. The LSCB is responsible for:

(a) collecting and analysing information about each death with a view to identifying -
(i) any case giving rise to the need for a review mentioned in regulation 5(1)(e);
(ii) any matters of concern affecting the safety and welfare of children in the area of the authority;
(iii) any wider public health or safety concerns arising from a particular death or from a pattern of deaths in that area; and
(b) putting in place procedures for ensuring that there is a coordinated response by the authority, their Board partners and other relevant persons to an unexpected death.

Working Together 2015 can be viewed via this link: http://www.workingtogetheronline.co.uk

Structure Chart



4. Board Membership and Attendance (May 2015)

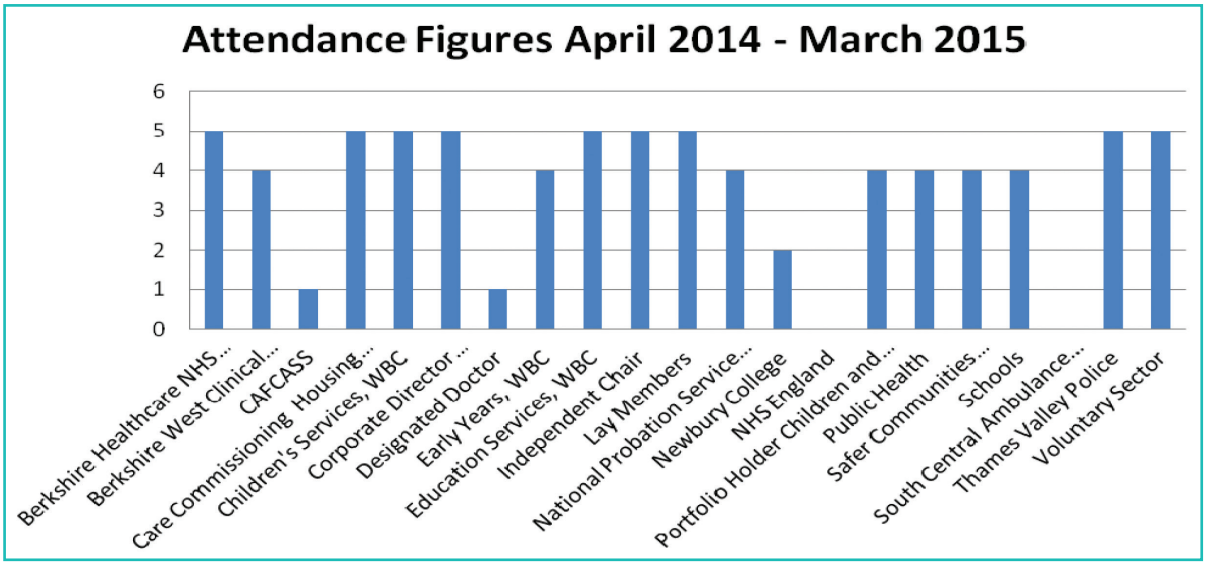
Name	Agency
Frances Gosling-Thomas	Independent Chair
Avril Allenby	School Improvement Adviser, West Berkshire Council
Robin Askew	Vice Principal (Care), Mary Hare School
Amanda Braund	Service Manager, Children and Family Court Advisory and Support Service (CAFCASS)
Judith Colby	Lay member
Debbie Daly	Nurse Director, Berkshire West Clinical Commissioning Group Federation
Geoff Davis	Senior Probation Officer, Thames Valley Community Rehabilitation Company Limited (TV-CRC)
Lynne Doherty	Portfolio Holder Children and Young People, West Berkshire Council
Leila Ferguson	Lay member
June Graves	Head of Care Commissioning, Housing and Safeguarding, West Berkshire Council
Mac Heath	Head of Children and Family Services, West Berkshire Council
Liz Housden	Headteacher, St Finians Catholic Primary School
Kat Jenkin	Head of Clinical Governance, South Central Ambulance Service
Debbie Johnson	Senior Probation Officer, National Probation Service
Julie Kerry	Associate Director for Patient Experience, Thames Valley Area Team, NHS South of England
Andrea King	Head of Prevention and Developing Community Resilience, West Berkshire Council
Rosemary Lilley	Voluntary Sector representative
Alexandra Luke	Head of Mental Health Service West Berkshire, Berkshire Healthcare NHS Foundation Trust
Ian Mundy	Locality Director (West Berkshire), Berkshire Healthcare NHS Foundation Trust
Ian Pearson	Head of Education Service, West Berkshire Council
Karen Pottinger	Principal Education Welfare Officer, West Berkshire Council
Susan Powell	Safer Communities Partnership Team Manager, West Berkshire Council
Maureen Sims	Deputy Headteacher, St Bartholomew's Secondary School
Rachael Wardell	Corporate Director, Communities (statutory DCS), West Berkshire Council
Louise Watson	Consultant Paediatrician, Designated Doctor
James Weems	Superintendent, Thames Valley Police
Dave Wraight	Youth Offending & Youth Support Service Manager, West Berkshire Council
Lesley Wyman	Head of Public Health and Wellbeing

5. Board Meeting Attendance

LSCB members have a responsibility to attend all meetings and disseminate relevant information within their agency. Attendance at meetings is monitored to ensure attendance is regular and at an appropriate level. These records are presented to members on an annual basis as part of the LSCB's quality assurance process.

Attendance in West Berkshire is generally good and, if a member is unable to attend, they are asked to send a deputy to ensure all messages are disseminated to each agency. Any lack of agency attendance is addressed directly by the Business Manager or escalated to the Chair. NB The Designated Doctor attends meetings once a year by arrangement.

Attendance figures by agency, based on five meetings held from April 2014 to March 2015, are shown below.



6. Financial Contributions

The budget is monitored by the Business Manager with the majority of the budget spent on staffing to support the work of the Board.

The LSCB budget 2014-2015 is made up of contributions from the Local Authority, the CCG, Police, Probation, CAFCASS and Berkshire Healthcare NHS Foundation Trust.

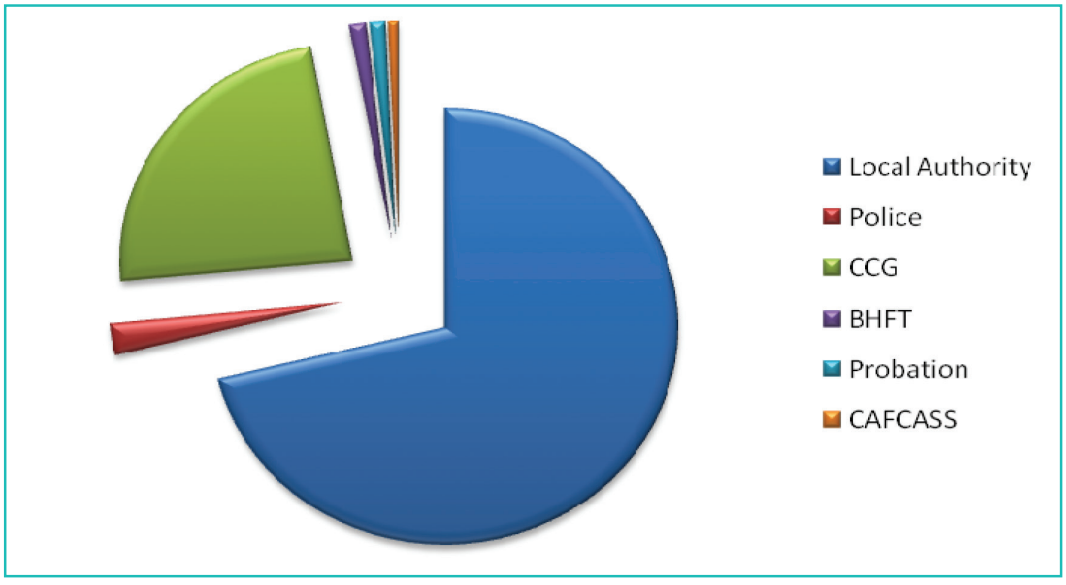
Ofsted has questioned whether the revenue investment from partner agencies is sufficient "The Board is under-funded when compared with LSCBs in comparable areas. Not all member agencies contribute enough to meet the costs of the Board's activities. This limits the Board's effectiveness to undertake the full range of business".

Supplies and services include expenditure for the cost of an Independent Chair, updates of the child protection procedures and the costs associated with administering the LSCB training programme and the annual conference. This also covers any printing costs for publicity materials and leaflets.

In addition a small amount is spent under premises to cover the hire of meeting rooms, refreshments and venues for LSCB activities and meetings.

Local Authority	**£60,250**
Police	**£2,00**
CCG	**£20,000**
BHFT	**£1,000**
Probation	**£895**
CAFCASS	**£550**

*



* The Local Authority offered additional funds which were not needed due to a staff vacancy and no SCR initiated.

7. Exception Reporting and Audit Framework

West Berkshire LSCB Business Plan Audit Programme 2015-2017

The use of performance data within the LSCB has a clear development plan which has been shared with the board and agreed by all partners. A multi agency data set has been developed within the Quality and Performance sub group with a dashboard of data going to each LSCB meeting. The dashboard comprises of data on an exception reporting basis and highlights key issues that the board need oversight and challenge of. The dashboard data reflects the risk log held by the LSCB and any concerning trends in the data set that are noted. This dataset directly links with the LSCB annual audit plan to provide quality assurance and context to the key issues raised in the dashboard. The audit reports produced will be shared with the board and key themes identified will be shared with the Learning and Development sub group to ensure that existing training courses are kept updated with local information and that new training can be commissioned if a need is identified.

The data contained in the dashboard is contained below, and is subject to change when the LSCB is assured that the item is no longer a concern or if new data is identified as in need of board oversight.

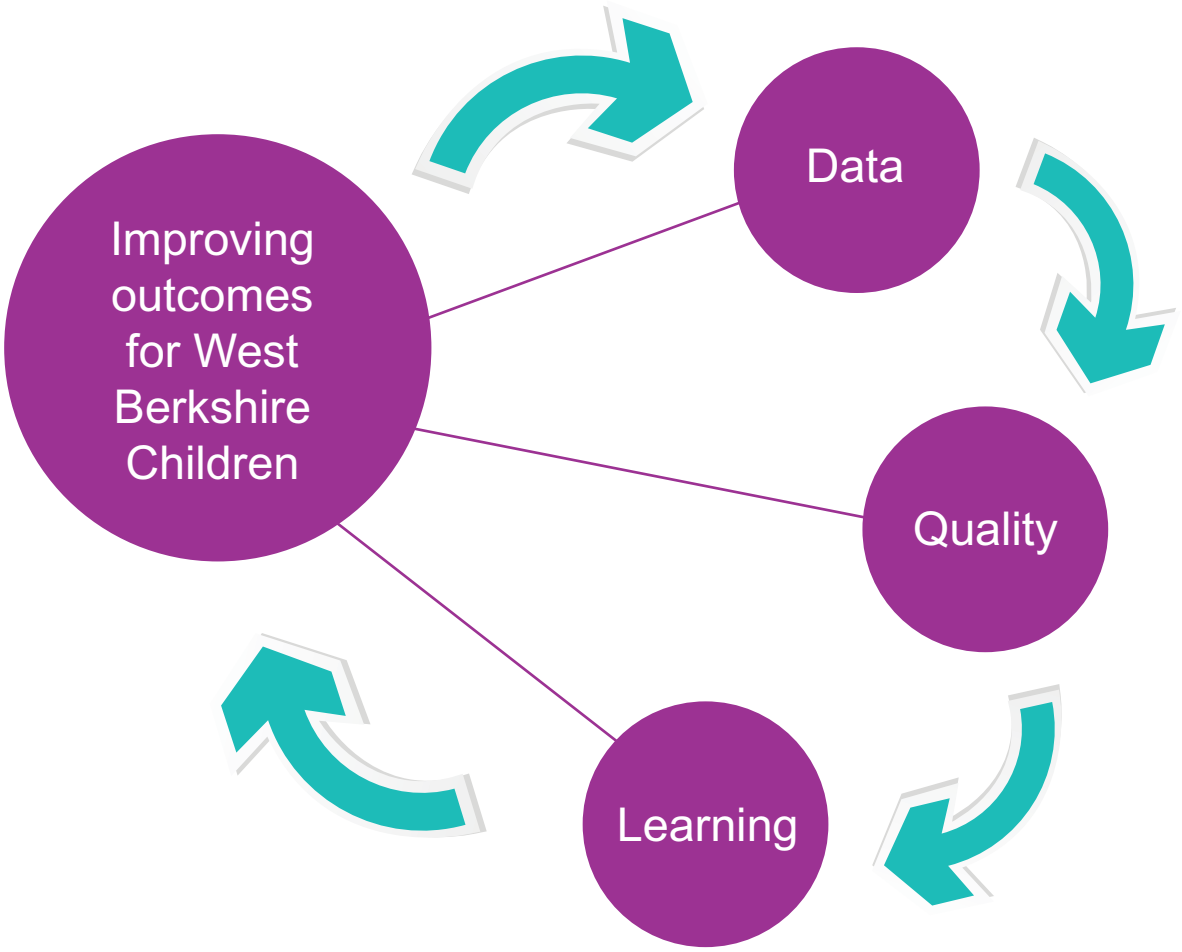
1. Children's Social Care (CAAS):
1.1. the number of contacts;
1.2. the number of contacts converted to referrals;
1.3. the number of referrals converted to single assessments;
1.4. the number of re-referrals.
2. Numbers of Looked After Children.
3. Child Protection Plan's:
3.1. The numbers of children and young people (CYP) subject to a Child Protection Plan;
3.2. The numbers of CYP subject to Child Protection Plans for longer than 12 months;
3.3. The numbers of CYP subject to 2nd/subsequent Child Protection Plans.
4. Child Sexual Exploitation (CSE):
4.1. The numbers of referrals to the CSE Operational Panel;
4.2. The numbers of CYP classified as high and medium risk of CSE.
5. Percentage of Looked After Child health assessments completed on time.
6. Domestic Abuse:
6.1. The number of Domestic Abuse notifications received;
6.2. The number of re-referrals for Domestic Abuse;
6.3. The number of referrals to MARAC.
7. Waiting list for Tier 2 and Tier 3 CAMHS service.
8. Substance Misuse:
8.1. Public Health data on numbers of local service users that are also parents/carers
8.2. Numbers of CYP accessing substance misuse services.
9. School exclusions:
9.1. Numbers of permanent exclusions and fixed term exclusions used in Secondary settings;
9.2. Numbers of permanent exclusions and fixed term exclusions used in Primary settings.
10. Children's Services Workforce: numbers of social workers and agency staff.
11. Health Service Work force: numbers of Health Visitors and School nurses.

Audit Programme

What are we seeking to understand?	What are the anticipated outputs, outcomes or products of the audit?	When will we start the audit?	When will we report the audit?
To understand the extent of existing auditing activity within Early Help and analyse emerging themes.	Exemplar Early Help audit tool to support Early Help services that are not yet auditing to 'ensure the effectiveness' of their safeguarding arrangements. To ensure this learning informs training, development and communications across the partnership	26th May 15	17th March 2016 LSCB to tie in with Early Help themed meeting
Drift & Delay - To understand the reasons for child protection plans lasting longer than 12 months, and to understand the reasons why young people are subject to 2nd or subsequent child protection plans.	To ensure that the learning arising from this audit of care planning for children and young people subject to CP Plan is proactively disseminated, implemented, monitored and reviewed to support improved outcomes for children and timely decision making.	June 2015	October 2015 1st October 2015 LSCB
The quality of professional challenge and improvement in relation to Child Protection assessment and planning, and to consider how the Child's voice influences planning and review.	To ensure that the learning arising from this audit is proactively disseminated, implemented, monitored and reviewed to ensure that the voice and lived experience of children and young people has a direct impact on planning and review.	September 2015	January 2016 1st October 2015 LSCB
The progress and impact of our Section 20 arrangements for our Looked After Children.	To identify where improvement has been made and what the impact of practice change has been on outcomes for children and young people.	February 2016	May 2016 10th December 2015 LSCB

To understand the effectiveness of the CSE Operational group and the interventions for young people identified at high risk of CSE.	To identify improvements to the systems and processes used within the CSE operational group. To determine to what extent the interventions in place for young people at 'high risk' of CSE are effective and have improved outcomes.	October 2014	January 2015 Re-audit 21st January 2016 LSCB to tie in with CSE themed meeting
To what extent the Toxic Trio risk factors for children, young people, parents and carers are understood, analysed and used to inform assessments, risk assessments and plans.	To understand the prevalence of these needs within West Berkshire. To ensure the effectiveness of professional analysis of risk, and the extent to which this informs assessment and planning. To identify areas for practice improvement and disseminate learning.	(April 2016) To be brought forward to October 2015	To be brought forward to March 2016 14th July 2016 LSCB to tie in with domestic abuse and vulnerable groups themed meeting
To what extent recommendations from the Child G Serious Case Review has become embedded in practice	To ensure that learning arising from the Serious Case Review has been proactively disseminated and implemented across agencies	July 2016	17th November 2016 LSCB
Frontline staff have a good awareness of the work of the LSCB and the Berkshire Child Protection Procedures.	The work of the LSCB will need promotion and to have increased visibility and accessibility to practitioners.	September 2015	10th December 2015 LSCB to tie in with effectiveness of the Board themed meeting

What we learn from the audits on the previous pages will inform the content of our existing training courses, the commissioning of new training/learning opportunities in response to identified workforce development needs, the content of our annual conference and our communications to staff and volunteers via newsletters and briefing notes.



8. LSCB Board Information

Independent Chair:	Fran Gosling-Thomas	LSCBChair@westberks.gov.uk
LSCB Business Manager:	Clair Gill	cgill@westberks.gov.uk 01635 503528
LSCB Clerk:	Claire Fletcher	cfletcher@westberks.gov.uk 01635 519982

West Berkshire LSCB
West Berkshire Council
West Street
Newbury

Website: www.westberkslscb.org.uk

Berkshire Local Safeguarding Children Boards Child Protection Procedures available on line:
http://berks.proceduresonline.com/index.htm

Author: Clair Gill, LSCB Business Manager
Date published: 06/11/2015

If you have any queries about the report or you require this information in an alternative format or translation, please contact Clair Gill.

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Title of Report:	**Syrian Vulnerable Person Relocation Scheme - Summary Report**
Report to be considered by:	The Health and Wellbeing Board
Date of Meeting:	28th January 2016

Purpose of Report:

This report sets out the background to the Syrian Vulnerable Person Relocation Scheme, the implication of the scheme on the Council and other agencies; the scoping work undertaken by Council Officers and the suggested way forward to receiving refugees into West Berkshire.

Recommended Action:

It is proposed that the Board note the details of the scheme and consider their implications for their own organisations.

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

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?	x	☐
• Is it a major policy, significantly affecting how functions are delivered?	☐	x
• Will the policy have a significant impact on how other organisations operate in terms of equality?	☐	x
• Does the policy relate to functions that engagement has identified as being important to people with particular protected characteristics?	☐	x
• Does the policy relate to an area with known inequalities?	x	☐
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:	Carolyn Richardson
Job Title:	Civil Contingencies Manager
E-mail Address:	crichardson@westberks.gov.uk

Executive Report

1. Introduction

1.1 In September 2015 the Government announced the expansion of the refugee resettlement programme with a commitment that over the term of the parliament 20,000 vulnerable Syrians would be resettled across the UK.

1.2 Since September this Council, through a working group have been considering the implications, working with other agencies, other local authorities and the voluntary sector to develop a plan for integrating any refugees accepted.

1.3 Positive engagement has been received from the other partners and the key issue of housing appears to be nearing resolution with 2 – 3 new private sector homes being made available for the scheme.

1.4 There have been a number of challenges to resolve and there will be challenges to overcome during the period of the scheme. Some of these challenges include cultural understanding, housing availability, language barriers and having the ability to work with some of the statutory rules. Many of these are now being resolved and others are progressing as a result of positive engagement with other agencies and partners.

1.5 The Council Resettlement Plan is now in its final stages of development (Appendix C) such that an offer to the home office could be made at the end of December 2015 early January 2016 with a view to receiving our first refugees in February/March 2016.

1.6 Currently it is estimated that the impact on the Council be limited over the 5 year period of the scheme by way of staff resourcing and costs. The staff impact for the first families is likely to be more intense than future families as the processes and learning are put in place. All costs for the first few years will be covered by the Government.

2. Conclusion

2.1 The Council has spent the last 3 months preparing with local partners and have now identified housing to commence Phase 1 (2-3 families). The Government will be funding the scheme and we are confident that our costs will be covered. As a result the impact on the Council is likely to be minimal.

2.2 The Full Council has agreed to support the Scheme (ref meeting on 10th December) and therefore an offer to the Home Office will be made in soon initiating the process. To this end:

(1) The Steering Group will progress the plan;

(2) In Phase 1 we plan to accommodate 2-3 families (10 – 15 people);

(3) A review is undertaken 3 months post the arrival of the first refugees and a report prepared for this Board detailing successes, issues, costs and process;

(4) External communications will be low key for safeguarding reasons.

3. Equalities

3.1 A full Equalities Impact Assessment has been carried out as part of the scheme and can be made available on request.

Appendices

3.2 Appendix A - Supporting Information

3.3 Appendix B – Equalities Impact Assessment

3.4 Appendix C - Syrian Refugee Vulnerable Person Scheme, DRAFT, West Berkshire Resettlement Plan Version 1 Dec 2015

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Appendix A

Syrian Vulnerable Person Scheme – Supporting Information

1. Introduction/Background

1.1 In September 2015 the Government announced the expansion of the refugee resettlement programme with a commitment that over the term of the parliament 20,000 vulnerable Syrians would be resettled across the UK.

1.2 The proposed number for resettlement equates to 4000 per year across the whole of the 450 Housing Authorities (365 England, 32 Scotland 31Nothern Ireland and 22 Wales). When calculated in this manner it suggests that it would be reasonable to offer resettlement packages for 8-10 refugees per Local Authority per year.

1.3 Local Authorities have been supporting resettlement schemes for many years. However, the current scheme is an expansion of one which had been trialled in Glasgow, Coventry and Bradford over the last 15 months focusing on Syrian refugees.

1.4 The focus of this scheme, as opposed to other refugee programmes, is that the refugees are coming to the UK directly from Refugee Camps and are deemed to be the most vulnerable thus requiring more assistance to help them out of the situation they find themselves in.

1.5 The existing process has been condensed to 4-5 weeks in order to meet the intense pressure to support resettlement of highly vulnerable people.

1.6 The UNHCR is working within the refugee camps to undertake health and security checks for proposed individuals which might be resettled. If the results of these checks meet the pre identified criteria then the Home Office would work with the UNHCR to match against offers for resettlement which had been provided by Local Authorities.

1.7 Detailed information will then be sent to the receiving Local Authority and an assessment would take place, in conjunctions with partner agencies, to make sure that the refugees could be effectively supported. Based upon this assessment the Local Authority would accept or decline the proposal.

1.8 If the offer is accepted then the Home Office conducts final checks and liaises with the receiving Local Authority to organise collection following final Border Control checks at the airport. The refugees would then be relocated to their new accommodation and the resettlement programme would commence.

1.9 The Government has issued a funding scheme for the first year which details the costs associated with refugee resettlement. The scheme specifically lists costs associated with Education, Special Education Needs, Primary Care, Department of Work & Pensions, Secondary medical costs and Local Authority Costs.

1.10 The Council would be expected to issue a claim based upon the resources used to support the resettlement process and this would follow a clear audit trail.

1.11 Subsequent funding schemes have not yet been defined. The Local Government Association is encouraging the Government to review the success for the funding scheme for the first year after 18 months of the scheme being in place – to ensure the Local Authorities are not being disadvantaged.

1.12 So far in the South East in Phase 1 (pre Christmas) 11 authorities have offered support and following matching 6 authorities have now received refugees. This has translated to approximately 50-60 people.

2. West Berkshire Progress to Date

2.1 Since the announcement in September this Council has been developing a plan in order to consider the implications for this Council and whether there is capacity to support the scheme.

2.2 The Council has been working on a number of strands An Officer led working group has been set up with officers from key services chaired by the Chief Executive and supported by Cllr Doherty. The group has been meeting fortnightly over the last few months to ensure the national process is understood; best practice is adopted and a robust plan are put in place.

2.3 An action plan has been developed which has covered a number of key areas including:

(1) **Engagement with other Councils** – this has been a key piece of work in order to understand the implications, the issues and importantly the likely needs of those coming to us. There is also a piece of work developing in relation to joint working across Berkshire.

(2) **Housing** – this is already under pressure in the area. As a result engagement has taken place with Housing Associations, Private Landlords and owners of empty homes in order to encourage homes that may not already be available to rent to become available (not just for refugees but for the wider population). This has resulted in a positive response with direct offers now being pursued by the Housing Officers.

(3) **Working with Partners** – this action has taken a number of strands including engagement with health partners who will have a key role to play. This is not just by way of access to GPs but also dentistry and the health community.

(4) **Working with voluntary agencies** – a group has been set up to work with us in ensuring a smooth integration. This includes National (British Red Cross, CAB) and local groups (Reading Refugee Support Group, – West Berkshire Refugee Support Group & Al2gether).

(5) **Developing a 'welcome pack' & integration programme** – this is being developed at the moment with an aim to have a comprehensive pack and initial integration programme in order to support the refugees. This will include details of day to day life in the UK and in West Berkshire including English classes, going to school, going to work, how to pay for bills, what the post office does etc. The final format of the pack will depend very much on the profile of the people received.

3. Resourcing

3.1 It is anticipated that Officer input into the scheme will be relatively high for the first cases however that this will reduce over the time of the integration and reduce with each case coming since the lessons will be put in place.

3.2 There are likely to be additional Officer resource requirements by way of a case worker to support the families. However this impact may be reduced by involving the voluntary agencies and by undertaking the work and therefore costs across Berkshire.

3.3 Officers from the Communities Directorate consider that an increase in 2 families would be manageable within their current workload.

3.4 The costs of any additional resource should be included in the annual unit costs for the Council.

4. Challenges

4.1 There are likely to be many challenges in the integration process not least because the people involved have already had a traumatic time.

4.2 It should be noted that the general public may perceive that refugees have accessed Social Housing as a priority resident - above those who have been on the Housing Register for a period of time. At the moment this can be addressed since the hosing offered was not in the current market as an option. However pre-prepared media statements will be put in place and combined with a low profile integration scheme.

4.3 We may experience obstacles in terms of language barriers. We have existing channels to access translation services and have also identified Voluntary Agencies who can provide the same services if the need arose. Equally, the resettlement plan will provide opportunities for the refugees to learn English either through Newbury College and/or Voluntary Agencies.

4.4 It is likely that they may encounter some difficulties locating work, Voluntary Agencies have offered their assistance and experience to assist with preparing and locating work. The resettlement scheme will also provide avenues to register themselves with the Department for Work and Pensions as they will be entitled to work in the UK.

4.5 It is possible that the pre screening will not highlight all medical conditions – for example dentistry needs and/or deeply engrained psychological issues. The resettlement scheme would seek to ensure that all refugees can be registered and access the appropriate medical facilities. A plan would be constructed between the Local Authority and Health colleagues if new medical conditions became apparent.

4.6 We may encounter an influx of support from the public and we must ensure that this is utilised in a safe and effective manner. In order to harness the support we propose that they would be directed to local Voluntary Agencies and the GOV.UK website.

4.7 It is likely that they may not understand the local culture around money, education and the operation of local emergency services. The Induction Programme will offer the information and advice to assist with understanding.

5. Proposed Way Forward

5.1 The Council is in a good position at the moment with some key elements now progressing well including:

(1) at least 2 -3 houses being offered from the private sector to support the scheme. These are currently being followed up by Housing Officers in order to secure the tenancies;

(2) A draft action plan has been developed and is attached at Appendix B. This will be refined with detail as to responsibilities as the work progresses. This has been based on the learning from other Local Authorities in an attempt to reduce the issues for this Council;

5.2 It is therefore considered that subject to the tenancies being secured that the Council could place an offer to the Home Office in late Dec/Early Jan with the likelihood of the first refugees being welcomed to West Berkshire in late February/early March 2016.

6. Communication

6.1 Nationally there continues to be a great deal of media attention on the refugee crisis and this includes media enquiries locally about the preparations undertaken to settle refugees and the numbers arriving in West Berkshire.

6.2 Public comment following media coverage is divided with those sympathetic to their plight and those who feel they are jumping the queue.

6.3 In order to allow refugees to settle away from the spotlight it is suggested that a low-key approach is taken to communications about their settlement. This would be consistent with the approach taken in other areas with no other local authority, apart from in Scotland, making public announcements despite 60 people arriving in the south-east.

6.4 In contrast to this, we can be proactive in talking about the preparations being put in place to receive them. It is proposed that:

(1) A press release is issued in December announcing that West Berkshire Council is finalising its' plans to accept some refugees in early 2016.

(2) An internal article for staff is published on the intranet and in Reporter updating them on the council's involvement in settling refugees and promoting the role of different services in helping make it possible.

(3) A separate written briefing is provided to key professional partners – e.g. the police – who not be directly impacted by the integration but may have to respond to any issues which emerge.

(4) Holding statements to be prepared to cover both the period before they arrive and after in anticipation of further media enquiries.

7. Options for Consideration

7.1 The Full Council supported the national scheme.

8. Conclusion

8.1 The Council has spent the last 3 months preparing with local partners and have now identified housing to commence Phase 1 (2-3 families). The Government will be funding the scheme and we are confident that our costs will be covered. As a result the impact on the Council is likely to be minimal.

8.2 The Full Council has agreed to support the Scheme (ref meeting on 10th December) and therefore an offer to the Home Office will be made soon initiating the process.

8.3 Progress is being made by way of:

(1) The Councils Steering Group is progressing an integration plan along with other agencies;

(2) In Phase 1 we plan to accommodate 2-3 families (10 – 15 people);

(3) A review is undertaken 3 months post the arrival of the first refugees and a report prepared for this Board detailing successes, issues, costs and process;

(4) External communications will be low key.

9. Consultation and Engagement

Internal Consultation:

- Nick Carter, Chief Executive
- Racheal Wardell, Communities Director
- Andy Day, Head of Strategic Support
- June Graves, Head of Housing
- Mac Heath, Head of Children Services
- Andy Walker, Head of Finance
- Martin Dunscombe, Communications Manager
- Cllr Lynne Doherty
- Corporate Board

Appendix B

Equality Impact Assessment - Stage One

We need to ensure that our strategies, polices, functions and services, current and proposed have given due regard to equality and diversity.

Please complete the following questions to determine whether a Stage Two, Equality Impact Assessment is required.

Name of policy, strategy or function:	Refugee Resettlement
Version and release date of item (if applicable):	
Owner of item being assessed:	Carolyn Richardson
Name of assessor:	
Date of assessment:	10 December 2015

Is this a:		**Is this:**	
Policy	**No**	**New or proposed**	**Yes**
Strategy	**Yes**	**Already exists and is being reviewed**	**No**
Function	**No**	**Is changing**	**No**
Service	**No**		

1. What are the main aims, objectives and intended outcomes of the policy, strategy function or service and who is likely to benefit from it?	
Aims:	To provide an effective resettlement programme for Syrian Refugees allocated to West Berkshire.
Objectives:	To provide a comprehensive integration plan, induction pack and means for longer term support for individuals or families resettling in West Berkshire.
Outcomes:	It is hoped that the plans and support from Voluntary Agencies will enable the refugees to integrate into the community comfortably.
Benefits:	The strategy will guide agencies through the resettlement process to make sure that the system is used without major disruption or exacerbating existing anxieties for the refugees resettling into the community.

2. Note which groups may be affected by the policy, strategy, function or service. Consider how they may be affected, whether it is positively or negatively and what sources of information have been used to determine

this. (Please demonstrate consideration of all strands – Age, Disability, Gender Reassignment, Marriage and Civil Partnership, Pregnancy and Maternity, Race, Religion or Belief, Sex and Sexual Orientation.)		
Group Affected	**What might be the effect?**	**Information to support this**
TBC	This is not known at this stage since the people who will be receiving the support are those that will be arriving into the area and this information is not known yet. It is not anticipated that the impact to other service users will be impacted however by the proposals.	Attached plan for integration
Further Comments relating to the item:		

3. Result	
Are there any aspects of the policy, strategy, function or service, including how it is delivered or accessed, that could contribute to inequality?	**No**
Please provide an explanation for your answer: It is intended that the refugees will received the relevant support related to any vulnerabilities they may have.	
Will the policy, strategy, function or service have an adverse impact upon the lives of people, including employees and service users?	**No**
Please provide an explanation for your answer: It is intended that the refugees will received the relevant support related to any vulnerabilities they may have. In addition at this stage the indication from the service providers are that the numbers proposed should be manageable.	

If your answers to question 2 have identified potential adverse impacts and you have answered 'yes' to either of the sections at question 3, then you should carry out a Stage Two Equality Impact Assessment.

If a Stage Two Equality Impact Assessment is required, before proceeding you should discuss the scope of the Assessment with service managers in your area. You will also need to refer to the Equality Impact Assessment guidance and Stage Two template.

4. Identify next steps as appropriate:	
Stage Two required	
Owner of Stage Two assessment:	
Timescale for Stage Two assessment:	
Stage Two not required:	

Name: **Date:**

Please now forward this completed form to Rachel Craggs, the Principal Policy Officer (Equality and Diversity) for publication on the WBC website.

Appendix C

Syrian Refugee Vulnerable Person Scheme

DRAFT

West Berkshire Resettlement Plan

Version 1 Dec 2015

Contents

1. Background

1.1 In September 2015 the Government announced the expansion of the refugee resettlement programme with a commitment that over the term of the parliament 20,000 vulnerable Syrians would be resettled across the UK.

1.2 The proposed number for resettlement equates to 4000 per year across the whole of the 450 Housing Authorities (365 England, 32 Scotland 31Nothern Ireland and 22 Wales). When calculated in this manner it suggests that it would be reasonable to offer resettlement packages for 8-9 refugees per Local Authority.

1.3 Local Authorities have been supporting resettlement schemes for many years. However, the current scheme is an expansion of one which had been trialled in Glasgow, Coventry and Bradford over the last 15 months and specifically focusing on Syrian refugees.

2. Who does it help?

2.1 The focus of this scheme, as opposed to other refugee programmes, is that the refugees are coming to the UK directly from Refugee Camps and are deemed to be the most vulnerable thus requiring more assistance to help them out of the situation they find themselves in.

2.2 The programme prioritises help for survivors of torture and violence, women and children at risk, and those in need of medical care. Under the UK's expanded VPRS programme the UK is accepting refugees under all the United Nations High Commissioner for Refugees eligibility criteria as set out below:

Profile for prioritization	Description
Women and girls at risk	Women and girls who are heads of household with no effective adult male support or protection; or who have other protection risks related to their gender.
Survivors of violence and/or torture	Survivors or witnesses of torture, violence, severe mistreatment, or SGBV.
Refugees with legal and/or physical protection needs	Individuals who face serious threats to their physical security, particularly due to political opinion or belonging to a minority group, for whom the authorities are unable to provide protection.
Refugees with medical needs or disabilities	Individuals with medical conditions or disabilities who fall within the medical needs resettlement category.
Children and adolescents at risk	Children and adolescents who face serious protection risks.
Persons at risk due to their sexual orientation or gender identity (actual or perceived)	Lesbian, Gay, Bisexual, Transgender and Intersex refugees at risk. UNHCR submits this cases under Legal and Physical Protection Needs category.
Refugees with family links in resettlement/HAP countries	Refugees who have family links in a resettlement country, or are in need of family reunification, recognizing the definition of family based on the principle of dependency.

2.3 The refugees who are accepted under the VPRS are granted humanitarian protection giving them leave to remain for five years with full access to employment and public funds and rights to family reunion comparable to refugees.

2.4 At the end of the five years, if they have not been able to return to Syria, they may be eligible to apply for settlement in the UK.

3. Current Situation

3.1 Following on from the trial locations the scheme has been expanded across the UK. In addition due to the desperate nature of the refugees in the camps the process has been increased in tempo such that the process has been condensed to 4-5 weeks.

3.2 West Berkshire has committed to up to 10 individuals by way of 2 families of refugees per year with a review at the 1 year point.

4. Aim and Objectives of this plan.

4.1 The aim of this plan is to provide information and a framework to ensure as far as possible a welcoming transition for the Syrian refugees placed in West Berkshires care.

4.2 The objectives of this plan are:

a. to set out the actions to do before arrival, on arrival and for the next year;
b. to set out the roles and responsibilities of services and agencies
c. to provide check lists and action cards.

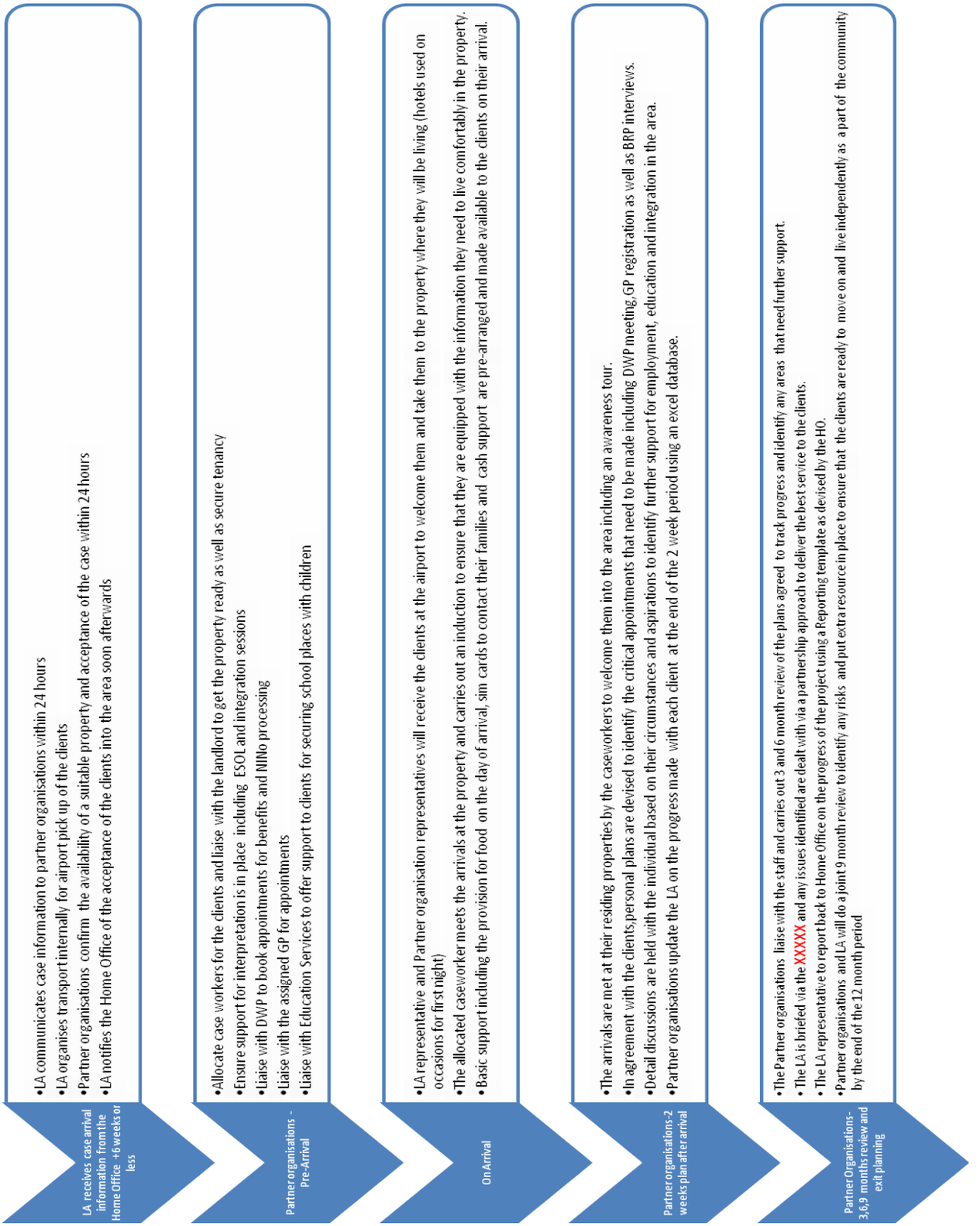
5. Action Plan

5.1 Below is the action plan setting out what needs to be done before arrival, on arrival and post arrival with details of who is responsible and any supporting documents to the action.

Ser	Action	Responsibility	Supporting Documents
	Pre Arrival		
	Submit offer to Home Office	SPOC	
	Property tentatively confirmed	Housing	Annex G
	Six to eight weeks before the arrival date, information is sent via a secure portal with basic information about the refugees and their needs (including information about any medical conditions or disabilities).	SPOC	
	Information sent to: a. Education Service b. Children Service c. Adult Social Care Service d. Housing team e. Primary Care Services f. Other agencies as necessary based on the information	SPOC	
	Services and Agencies Review the data and assess whether there are any issues – esp in relation to the Health care package required if likely to be over £25k.	All Services	
	Confirmation sent to Home office or additional questions sent.	SPOC	
	Multi –agency meeting put in place with all affected services and agencies to confirm all the arrangements and needs	All agencies – arranged by SPOC	Annex A

	to be put in place (this will be on a case by case basis)		
	All processes put in place as agreed at the MA meeting in advance of arrival	All agencies	Annexes B,C, D
	Day 1		
	Transport and 3 x people arranged to meet the refugees at the airport (this is likely to be a full day with briefings in advance by Home Office etc)	Lead Communities Transport Plus a translator	Annex E
	Brought back to West Berkshire to the home.		
	Basic information provided		Annex F
	Day 2		
	Start of welcome process		Annex F
	Week 1		Annex F
	Week 2		Annex F
	Periodic reviews		Annex H
	3 Month, 6, 9 & 12 months		
	Submit Finance Returns	Finance Service	Annex I

6. Summary of Process



Annex A Multi-Agency Meeting

Suggested Attendees based on case needs:

1. West Berkshire Council Officers including:
    a. Housing Officers
    b. Education Officers (schools allocation, SEN etc)
    c. Adult Social Care Officers
    d. Transport Officer
    e. Property Services Officer
    f. Finance Officer
2. Housing Association
3. DWP
4. CCG
5. Other Health agencies as necessary
6. Newbury College
7. Voluntary agencies as appropriate.

Suggested Agenda:

1. Introductions
2. Case review of each refugee expected to arrive using case tracker (Annex B)to include:
    a. Housing needs – are there any adaptations necessary, is the house available appropriate
    b. Children Education needs
    c. Adult Education needs
    d. Adult work opportunities
    e. Specific equipment needs based on case notes – eg wheel chairs, push chairs, cots
3. Confirm arrangements for setting up the house to a basic home
4. Confirm arrangements for pickup (Annex C)
    a. Representatives
    b. Transport
    c. Translator
    d. Date & Timings
5. Confirm programme for first 2 weeks (Annex D)
6. Set review date

Annex B Case Tracker

HO grouping	Proposed Arrival Date	VPR	Count	Name	Address	Individuals- Gender and Age	Medical Needs	Caseworker	Council Referrals	Accommodation Provider	Other support

Annex C Case File Details for Family Groups

Ref No.	Group No.	Arrival Date	No in Group

Name of Main Adult:		Surname:			
D.O.B.		M/F	Marital Status		
Passport/Travel Doc	Biometric done : Date			BRP rec : 	Date
NI No.		Religion:			
JSA/ESA/IS	Date:	Amount:			
CHB/CTC	Date:	Amount:			
NHS No:		Hosp No:			
Other:					
Benefit changes:					
Medical updates:					

Property Info:

Address and tel:			
Landlord:			
Rent:	HB	CTR	
Notes:			

Adult 2:		Surname:			
D.O.B.		M/F	Marital Status		
Passport/Travel Doc	Biometric done : Date			BRP rec : 	Date
NI No.		Religion:			
JSA/ESA/IS	Date:	Amount:			
CHB/CTC	Date:	Amount:			
NHS No:		Hosp No:			
Other:					

Adult 3:		Surname:			
D.O.B.		M/F	Marital Status		
Passport/Travel Doc	Biometric done : Date		BRP rec :	Date	
NI No.		Religion:			
JSA/ESA/IS	Date:	Amount:			
CHB/CTC	Date:	Amount:			
NHS No:		Hosp No:			
Other:					

Child 1:

Name:					
D.O.B.		M/F			
NHS No		Hosp No:			
School:		Date Started:			
School meals done:	Date:	Bus Pass done:	Date:		

Child 2:

Name:					
D.O.B.		M/F			
NHS No		Hosp No:			
School:		Date Started:			
School meals done:	Date:	Bus Pass done:	Date:		

Child 3:

Name:			
D.O.B.		M/F	
NHS No		Hosp No:	
School:		Date Started:	
School meals done:	Date:	Bus Pass done:	Date:

Child 4:

Name:			
D.O.B.		M/F	
NHS No		Hosp No:	
School:		Date Started:	
School meals done:	Date:	Bus Pass done:	Date:

Annex D Property Set Up

Furniture	Purchased By	Cost
1 fridge Freezer		
1 Cooker		
1 Washing machine		
2 sofas		
1 Dining set		
1 coffee table		
1 bed per child		
1 double bed for parents		
1 double wardrobe per bedroom		
1 chest of drawers per bedroom		
Window blinds/curtains (if required)		
Bedding		
1 duvet per bed		
1 duvet set per bed		
1 Afghan blanket per bed		
1 pillow pp		
Essential Housing Items		
1 hand towel pp		
1 bath towel pp		
1 ironing board		
1 iron		
1 toilet brush per bathroom		
1 dustpan and brush		
1 serving plate		
1 dinner service		
1 set of kitchen utensils		
4 tea towels		
1 dish drainer		
1 washing up bowl		
2 chopping boards		

1 set of kitchen knives		
1 set kitchen scissors		
1 set of glasses (1pp)		
1 set of mugs (1 pp)		
1 bathroom mirror		
1 mop bucket		
1 mop		
1 vacuum		
1 pressure cooker		
1 frying pan/wok		
1 saucepan set		
1 kettle		
1 toaster		
Cutlery 1 place setting per person		
1 jug		
1 kitchen bin		
1 small box of soap powder		
1 kitchen cleaner		
1 bathroom cleaner		
Shampoo		
Shower gel		
Toothpaste		
Washing up liquid		
Bleach		
Scouring sponges		
Dish clothes		
Bin bags		

Groceries	Purchased By	Cost
Tea		
Coffee		
Sugar		
Jam		
2 pkt biscuits		
Fruit juice / children juice		
Eggs		
Tortilla wraps /flat bread		
Tinned tuna		
Tinned tomato chops		
Tomato paste		
Green olives		
Pasta		
Rice 5kg		
Cooking oil		
Salt		
Ground Black pepper		
Ground Cinnamon		
Ground Cumin		
Cardamom		
Paprika		
Fruit and Veg:		
Apples		
Oranges		
Bananas		
Lemon		
Tomatoes		
Lettuce		
Onions		
Potatoes/frozen chips		
Garlic		
Dairy and meat		
Milk		
Feta cheese		
Yoghurt		
Halal chicken		
Toiletries		
Shampoo (adult and/or baby)		
Shower gel (adult and/or baby)		
Soap bar		
Hand wash liquid		
Tooth paste		
Tooth brush		

Annex E Arrival Day Arrangements Checklist

Action	Details	
Confirm Flight Details		
Confirm Transport requirements (specialist lifts etc)		
Confirm representatives to meet at airport		
Confirm Translators details		
Final Checks of Home		
Provision of fresh food into the home		
Check with Home office re any changes		

Annex F Programme for first 2 weeks.

Those in red text are week one priorities

Action	Date	Appointment with:	Lead agency & Officer
Welcome meeting			
Biometric Residence Permit BRP (Post Office)			
Social and Financial			
Housing			
Allocation, moving in and welcome pack			
Furniture			
House introduction			
Tenancy agreement			
Gas company register			
Electricity company register			
Water company register			
4 week bus pass for adults and children (first month)			
Mobile sim card and top up			
Introducing the area and main places for shopping (halal), advice, travel, routine appointments, GP Surgery, Walk in Centre, ESOL, DWP, etc.			
Council Offices, CAB Offices,			
Bank account			
Debit card			
Benefits			
DWP appointment			
National Insurance Number			
Job Seekers Allowance JSA			
Employment and Support Allowance ESA			
Income Support			
Child benefit			
Child Tax Credit			
Housing Benefit			
Council Tax			
Medical			
GP register			
Nurse appointment			
Health visitor			
Hospital appointment			
Education			
ESOL			
School for children			

Other:
Comments:

Annex G Tenancy Agreements

To insert

Annex H Review Process

Review	Aim	How it is evidenced	Client Wellbeing
2 Week Review	To ensure all of the critical registrations are done in line with the Home Office Requirements	• Full Completion of the front sheet. • Highlighted areas if any registration has not been possible and the reason	Check the client is settled and record any issues that the client has. Explain all the appointments as you attend with them.
2 Month Review	To follow through all appointments and check that Medical, Education, Social Care, DWP, Banking and ESOL needs are met	• Update any information on the Front Sheet. • File Recording • Review Form	Discuss with the client/s their plans for the future now they are more settled and draw up an action plan and discuss who needs to do what to achieve their goals.
4 Month Review	Continue to follow up appointments and escalate if any are outstanding. Ensure that clients understand how to liaise with schools, medical professionals and other authorities	• Update any information on the Front Sheet. • File Recording • Review Form	Review the clients action plan and work with them to achieve this
6 Month Review	Continue to support the clients with more complicated issues	• Update any information on the Front Sheet. • File Recording • Review Form	Review Clients action plan
9 Month Review	To check that the client would have the tools to cope when the support ends	• Update any information on the Front Sheet. • File Recording • Review Form	Work with the client to identify issues that they still need support with. Identify where the client would seek support after the 12 month support has ended
EXIT PLAN	To Support	Close the case file	Ensure that the client has full details of how to access future support in the area.

2 weeks' review

Date:	
Name:	VPR No:

The aim of this 2 week review is to ensure that you're most important and immediate needs are met in terms of:

a. housing
b. critical registrations in line with the Home Office requirements
c. other important social, educational and medical actions

Action	**Yes**	**No**	**Date**
Biometric Residence Permit BRP			
Welcome meeting			
Social and Financial			
Housing			
Allocation, moving in and welcome pack			
Furniture			
House introduction			
Tenancy agreement			
Gas company register			
Electricity company register			
Water company register			
4 week bus pass for adults and children (first month)			
Mobile sim card and top up			
Introducing the area and main places for shopping, advice, travel, routine appointments, GP Surgery, Walk in Centre, ESOL, DWP, etc.			
Council Offices, CAB Offices, Sorted			
Bank account			
Debit card			
Benefits			
DWP appointment			
National Insurance Number			
Job Seekers Allowance JSA			
Employment and Support Allowance ESA			
Income Support			
Child benefit			
Child Tax Credit			
Housing Benefit			
Council Tax			
Medical			
GP register			
Nurse appointment			
Health visitor			

Hospital appointment			
Education			
ESOL			
School for children			
Other:			
Comments:			

9 Month Review

Date:	
Name:	VPR No:

End of support:

Area	Outstanding issues	Support needed for independence at 12 months
Medical		e.g. making GP appointments
Housing		How to contact landlord Spire House for HB
Benefits		Job centre for DWP CAB if problems
ESOL		Adult ed, CRMC, colleges
Education		Contact at school and head MGSS if relevant
Employment/ Training		Job Shop
Home management		e.g. budgeting services available in West Berkshire
Other support the client may need:		

Annex I Financial Returns to the Home Office

To follow when received

Annex J Key Contacts

To follow when agreed

West of Berkshire
Safeguarding Adults Board
Reading, West Berkshire & Wokingham

West of Berkshire Safeguarding Adults Board

Annual Report 2014-15

West of Berkshire Safeguarding Adults Board Annual Report 2014-15

Contents

1. Introduction

The West of Berkshire Safeguarding Adults Board (SAB) covers the three local authority areas of Reading, West Berkshire and Wokingham. It is a statutory mechanism for ensuring that there is a robust multi-agency safeguarding framework in place and for monitoring the effect this has on protecting adults.

Care Act 2014

With the introduction of the Care Act 2014, Safeguarding Adults is now based on a legal framework. The safeguarding provisions of the Care Act include:

- A requirement for all areas to establish a Safeguarding Adults Board to bring together the local authority, NHS and police to coordinate activity to protect adults from abuse and neglect.

- A duty for local authorities to carry out enquiries (or cause others to do so) where it suspects an adult is at risk of abuse or neglect.

- A duty for Local Safeguarding Adults Boards to carry out safeguarding adults reviews into cases where someone who experienced abuse or neglect died or was seriously harmed, and there are concerns about how authorities acted, to ensure lessons are learned.

- A new ability for Safeguarding Adults Boards to require information sharing from other partners to support reviews of cases or other functions.

A development session took place in June 2014 to ensure a shared understanding of the SAB's functions as outlined in the Care Act. Between June 2014 and March 2015, the Board undertook a self-assessment exercise which has served as a foundation for the Strategic Plan 2015-2018.

2. Key Achievements of 2014-15

- Independent Safeguarding Adults Board website.
- Board's Constitution and Memorandum of Understanding.
- Safeguarding Adults Review Panel and supporting guidance and processes.
- Participation in SCIE Learning Together training.
- Multi-agency Performance Indicator set.
- Joint Children's and Adults Safeguarding Conference on Domestic Abuse.
- Threshold Guidance document.
- Out of Area Reviews Guidance document.

Partner Contribution to delivery of the Board's Goals

Through single- and multi- agency initiatives and an ongoing commitment to the work of the subgroups, partner agencies have contributed to the delivery of the SAB's four goals, to embedding Making Safeguarding Personal and to the learning and development of the workforce. Highlights are presented below.

Goal 1 - Establish effective governance structures to align the Board to new statutory requirements, improve accountability and ensure the safeguarding adults agenda is embedded within other organisations, forums and Boards.

- Representation of all six funding partner agencies on the Governance Subgroup. Review of function and Terms of Reference of the Governance Subgroup.

- Promotion of safeguarding adults through representation of Board members on a range of local boards, forums and network meetings.

- Development of stronger links between operational safeguarding and care governance frameworks within the three Local Authorities, enabling earlier identification of emerging themes and concerns and proactive quality assurance intervention in line with the prevention principles of the Care Act.

- Care Act training delivered to adult social care front line staff, providers and forums, including information about the Board and its statutory responsibilities.

- Safeguarding adults embedded within the CCG provider contracts, supported by a quality assurance schedule through which key areas for safeguarding are monitored quarterly.

- Annual Safeguarding Audit and Action Plan monitored by the CCG for Health Care Providers include adult and children safeguarding.

- Development of stronger links between health and social care professionals through quarterly meetings of the Partnership Group.

- Quarterly meeting of the Berkshire Healthcare Foundation Trust (BHFT) Safeguarding Group feed into the Trust governance structure.

- Six monthly meetings of the Royal Berkshire Foundation Trust (RBFT) Strategic Safeguarding Committee, chaired by the Executive Director of Nursing, with external scrutiny provided by a Designated Professional for Safeguarding provides Board assurance including monitoring the annual safeguarding plan and managing emerging safeguarding issues and risks.

Goal 2 – Develop oversight of safeguarding activity and need in order to target resources effectively and improve safeguarding outcomes.

- Development of forms, templates and IT systems to improve collection and analysis of key safeguarding data. Information from a range of reports generated from case recording and referral information provides detailed operational data and contributes to strategic oversight.

- Improved links between some partner agencies' IT systems allow the efficient extraction of more meaningful and relevant information on safeguarding.

- Monthly audits of 10% of safeguarding enquiries focussing on quality, outcomes and the voice of the person, their family and advocate. Themes arising from audits inform training.

- Sharing of performance and practice development information at the Berkshire Health and Social Care Safeguarding Leads group, enabling early identification of and appropriate response to interagency issues.

- Implementation of the CCGs' self-assessment safeguarding tool for adults and children for contracted providers. 100% of commissioned health service providers submitted a completed self-assessment, establishing a base line for compliance which will continue to be built upon and monitored in 2015-2016.

- Identification of local issues that may develop into safeguarding by the Care Quality Intelligence Group which includes a range of partners, including the CQC and local health representatives.

- Oversight of performance of contracted provider health services provided by the CCG's quality schedule, which includes information from on-site visits and the views of patients.

- Production of the CCGs' supervision policy for staff working in Continuing Health Care with the aim of improving oversight, participation and collaborative working across health and social care.

- Joint assessment and quality visits by the Continuing Health Care Team and Local Authority colleagues aimed at improving oversight and outcomes for adults in residential and nursing care.

- Implementation of Quality Assurance framework and audit programmes to meet the requirements of the Care Act and Making Safeguarding Personal. Performance information reported to management teams, committees and Health and Wellbeing Board Boards.

Goal 3 - Raise awareness of safeguarding adults, the work of the SAB and improve engagement with a wider range of stakeholders

- Care Act and Safeguarding training include reference to the SAB and its statutory role, with a focus on multi-agency participation in learning from local reviews.

- Introduction of a health network meeting for independent and contracted providers, to increase awareness of the SAB across the independent sector.

- Further development and widening membership of local authority safeguarding forums.

- Better Care Fund established and implemented locally to transform integration between health and social care with a focus on people's wellbeing. Safeguarding processes and the role of the SAB highlighted in the local implementation document.

- Links established with the Independent Trauma Advisor Steering Group, (pan-Thames Valley group supporting a Police and Crime Commissioner funded pilot to identify and support victims of Modern Slaver), leading to improved understanding, identification and support for people identified as living in conditions of modern slavery. Multi-agency support for survivors of modern slavery, involving Berkshire Healthcare Foundation Trust, Thames Valley Police and the voluntary sector organisation, Rahab.

- Development of toolkit for Trading Standards Officers by Wokingham's prevention worker in conjunction with the Chartered Trading Standards Institute, to aid understanding of Adult Safeguarding and provide examples of good practice.

- Good outcomes achieved by the "Choice Champions" project, an initiative delivered by people who use services to raise awareness of personal budgets, safer recruitment and safeguarding. The Champions attended many community events, delivering their own presentation to a wide range of stakeholders.

- New awareness raising publicity material has been developed. Members of Wokingham's CLASP (Caring Listening and Supporting Partnership) supported the production of "easy read" formats for awareness raising publicity material. "Easy read" publicity material will be published in West Berkshire and Reading in the following year.

- Raising awareness of safeguarding issues by health commissioners through the quarterly Safeguarding Practice Lead meetings at local GP surgeries that include safeguarding topics, external speakers and shared learning.

Goal 4 - Ensure effective learning from good and bad practice is shared in order to improve the safeguarding experience and ultimate outcomes for service users.

- Establishment of a Safeguarding Adults Review (SAR) Panel, chaired by an Independent Chair.

- Development of Berkshire-wide Guidance for Multi-Agency Reviews of Serious Cases to ensure:
  - Processes for learning and reviewing are flexible, proportionate and open to professional and public challenge.
  - Local decision about what type of review is appropriate, dependent on the nature of the case and the agencies involved.
  - A culture of transparency and shared learning.

- Increased local capacity for carrying out safeguarding adults reviews through participation of 16 staff in a three-day SCIE Learning Together Foundation Training. Two members of staff attained lead reviewer accreditation with two more committed to achieving it in the following year.

- Following the completed Safeguarding Adult Review (SAR) in 2014, bespoke workshops held to share findings and encourage staff to reflect on implications for practice and learning. The findings informed safeguarding refresher training, giving attendees the most relevant and up to date knowledge.

- Development of a learning log by the West Berkshire forum to share learning from local and national reviews.

- Learning reports provided for CCG committee meetings, board meetings, GP forums and training events. Care Quality Commission inspection reports and other local intelligence shared with health commissioners.

- Information from audits used to improve practice. A feedback mechanism aligned with line management structures developed between community and safeguarding teams.

- HealthWatch Reading presented to the Board during 2014 as part of an initiative to help bring alive the service user's voice. The story of 'Dorothy' was presented, a case study from a project on delayed discharges, which highlighted her journey from falling in sheltered housing to eventually dying in a care home, with many failures in care and missed opportunities to support her.

Making Safeguarding Personal

Making Safeguarding Personal (MSP) is a shift in culture and practice in response to what we now know about what makes safeguarding more or less effective from the perspective of

the person being safeguarded. Locally, steps have been taken to develop person centred, outcome-focused practice, including:

- Sign up to the national LGA Making Safeguarding Personal project by the three Local Authorities.

- Review and amendment of level 1, 2 and 3 training to reflect the MSP agenda and promote broader understanding of duty of care and legal requirements.

- Revision of internal templates, forms and processes to support frontline workers and promote best practice to ensure that people have an opportunity to discuss the outcomes they want at the start of safeguarding activity and have follow-up discussion at end of safeguarding activity to see to what extent their desired outcomes have been met.

- Development of data collection forms to scrutinise how MSP has been approached, recording the results in a way that can be used to inform practice and provide aggregated outcomes information.

- Implementation of QA audit tool designed to evaluate application of the six principles and give direct feedback to workers and supervisors.

- Review of the *Safeguarding Children and Adults At Risk Policy* by the CCGs to include MSP.

- The Continuing Health Care team have supported LAs in quality assurance visits and safeguarding cases allowing a more personalised approach by clinicians who know their patients.

- Choice Champions have received training and aim to promote MSP in all aspects of partnership work.

Learning and Development Activities

The annual Joint Adult and Children's Safeguarding Conference, planned with the three West of Berkshire's Local Safeguarding Children's Boards, took place on Friday 26 September at Easthampstead Park in Wokingham. The conference was based on the theme of domestic abuse and was again a well-attended and thought provoking event where delegates also had the opportunity to learn about support services available locally.

- Review of the Workforce Development Strategy and publication of the updated version in April 2014 .

- Safeguarding training level 1, 2 and 3 reviewed and delivered to a wide range of stakeholders from various sectors with very positive feedback. Training data is included in section 5 below. Specifically, targeted training was delivered to providers of concern to promote partnership working, engagement and compliance with the West of Berkshire safeguarding policy and procedures.

- Safeguarding Adults Train the Trainer programme reviewed to make the standards for the Level 1 Train the Trainer more robust and consistent in line with changes required to meet the Care Act. Train the Trainer programme offered to the independent sector to develop skills to deliver in-house training, to the SAB's agreed training standards. 10 delegates from the independent sector attended sessions in the reporting year. Quality assurance processes in place to ensure continued good practice.

- Royal Berkshire Hospital NHS Foundation Trust (RBFT) is the only Trust in the Thames Valley to have met Health Education England's target to train 75% of staff on the issues faced by patients with dementia by December 2014. As a result the Trust received £25k funding that has been used to employ a nurse to deliver level 2 dementia training. From April 2015, this additional training will be provided for staff who work frequently with patients who have dementia, including training in the simulation centre and e-Learning.

- Prevent awareness forms part of the level 1 training with the 1 hour WRAP training as part of the level 2 day. Additional WRAP (3) sessions delivered to Emergency Department staff.

- Reading BC contributed funding to the development of an e-learning safeguarding module through its partnership with Log onto Care, which is freely available across the sector.

- Mental Capacity task and finish group established by RBFT to identify which staff needed enhanced MCA training and agree structure and content of training. New awareness leaflet highlighting the Mental Capacity Act (2005) and Deprivation of Liberty Safeguards published.

- Secured funding via the Mental Capacity Act innovations bid to deliver two focused conferences to promote application in practice of the MCA across partnership agencies in Berkshire.

3. Safeguarding Adults Reviews

Safeguarding Adult Reviews (SARs) are about learning lessons for the future. They will make sure that Safeguarding Adults Boards get the full picture of what went wrong, so that all

organisations involved can improve their practice. Under the Care Act, each member of the SAB must co-operate in and contribute to the carrying out of a review.

In the past 12 months, the Board has undertaken and completed one Safeguarding Adult Review. The circumstances leading to this review had a devastating impact on the lives of the individual and her family, as well as all the carers and professionals involved.

An executive summary of the review is included as Appendix B. Partner agencies have cascaded the findings to staff and have considered how the learning can be embedded in their agency, leading to the development of action plans and also the delivery of workshop style learning sessions.

4. Priorities for 2015-16

Priority 1 - Establish effective governance structures, improve accountability and ensure the safeguarding adults agenda is embedded within relevant organisations, forums and Boards.

Priority 2 – Making Safeguarding Personal.

Priority 3 - Raise awareness of safeguarding adults, the work of the Board and improve engagement with a wider range of stakeholders.

Priority 4 - Ensure effective learning from good and bad practice is shared in order to improve the safeguarding experience and ultimate outcomes for service users.

Priority 5 – Co-ordinate and ensure the effectiveness of what each agency does.

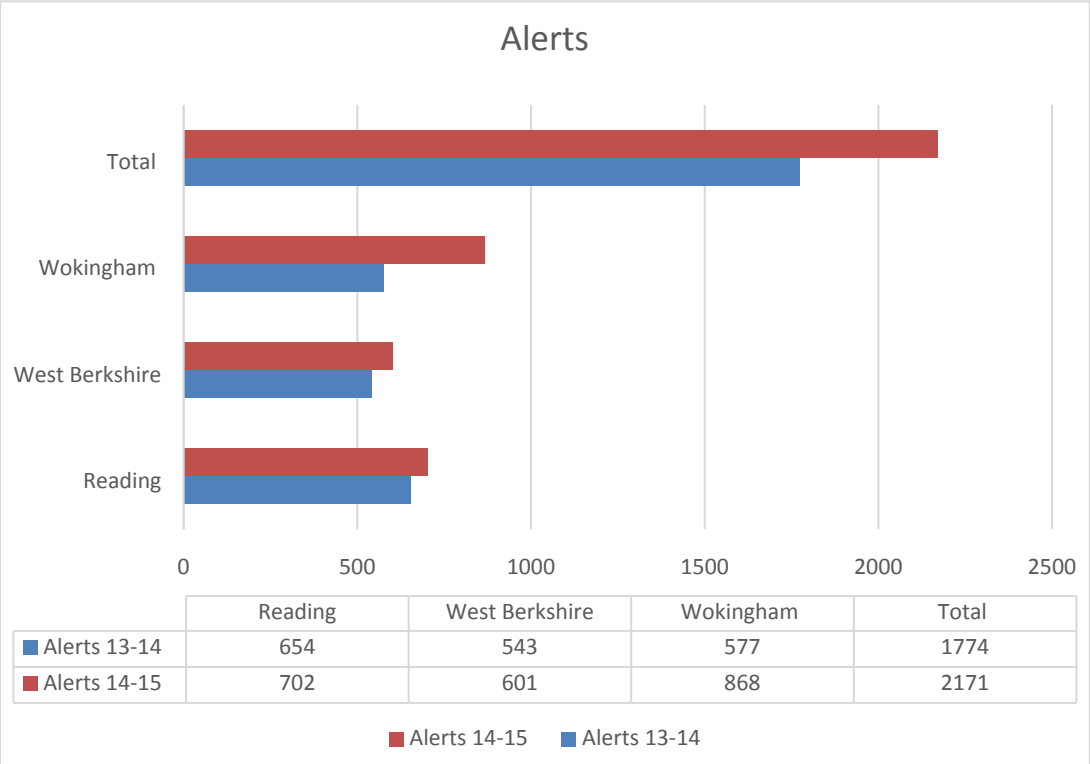
The Board's **Safeguarding Strategy 2015-18** is included as Appendix A. Further details about the way in which partner agencies will contribute to delivering these priorities can be found in the Business Plan 2015-16.

5. 2014-15 Combined Headline Data

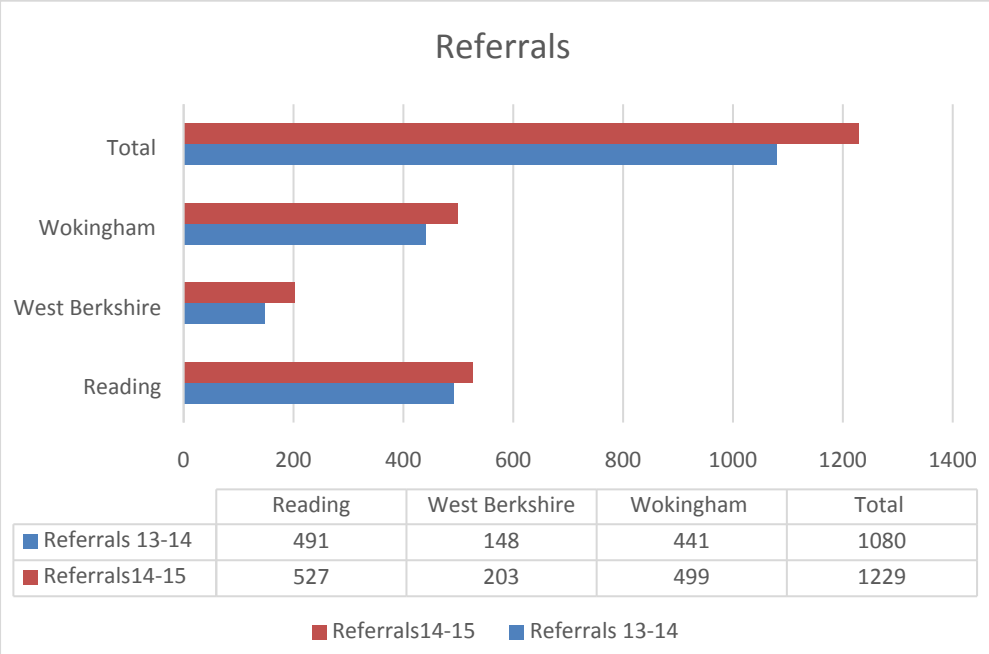
This report covers the year 2014-15, the last year before safeguarding adults became a statutory duty under the Care Act (2014). Much of the terminology used in this report, therefore, is no longer in use under current practices. Direct comparison with previous years cannot always be achieved due to changes in reporting requirements. However, it is envisaged with the introduction of new Safeguarding Adults Collection requirements for 2015/2016 greater consistency will be achieved.

Total no. Alerts and Referrals,

Last year, 2171 alerts were made, an 18 per cent increase on the previous year. 1229 referrals were made, a 12 per cent increase on the previous year.



	Reading	West Berkshire	Wokingham	Total
Alerts 13-14	654	543	577	1774
Alerts 14-15	702	601	868	2171



	Reading	West Berkshire	Wokingham	Total
Referrals 13-14	491	148	441	1080
Referrals14-15	527	203	499	1229

Referrals by Age and Primary Client Group

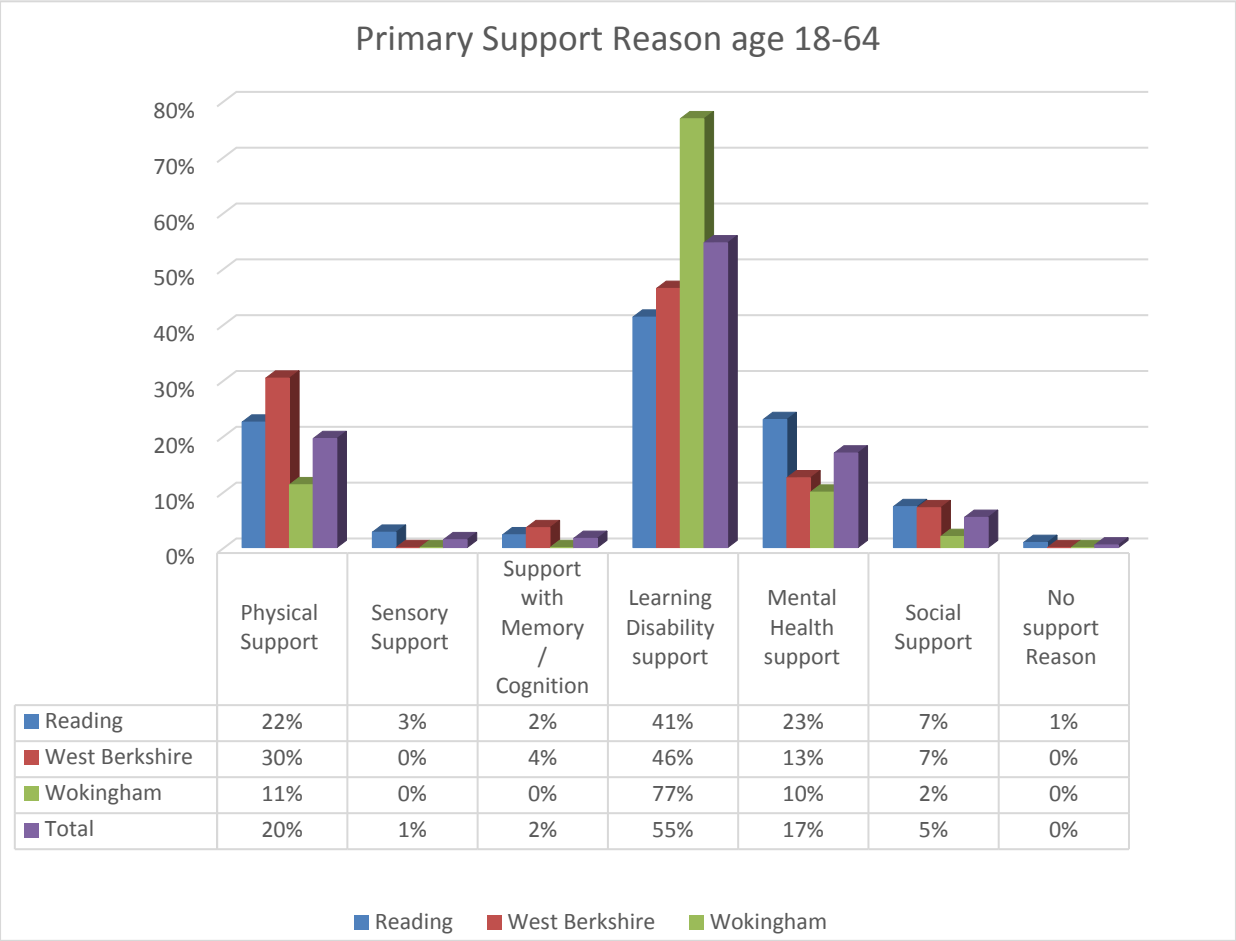
For the first time in 2014-15, data were collected on Primary Support Reason. This classification focusses on the main reason that a person requires social care services at any particular time and provides a better description of the impairment impacting on the

individual's quality of life and creating a need for support and assistive care. It may not be related to any underlying health conditions.

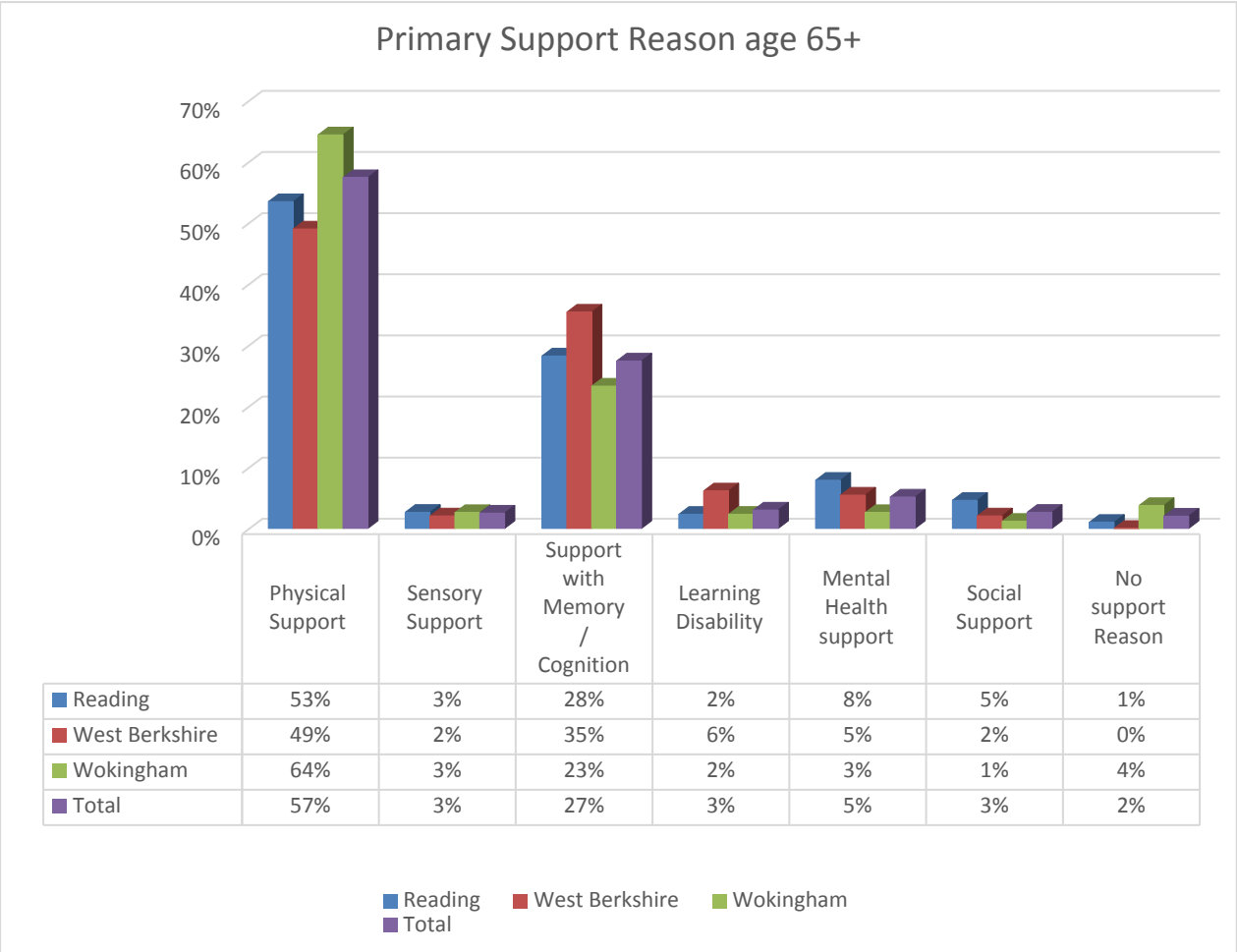
The tables below shows the breakdown of individuals with referrals by Primary Support Reason and Age.
At 55 per cent, Learning Disability accounts for the majority of cases involving individuals aged between 18 and 64, with Physical Support next at 20 per cent.

In the 65 plus age group, Physical Support accounts for the majority of cases with 37 per cent of individuals, and those with support needs for memory / cognition next at 18 per cent.

Trends are largely in line with last year, although additional categories have been included for 2014-15 making direct comparisons difficult especially for Mental Health data.



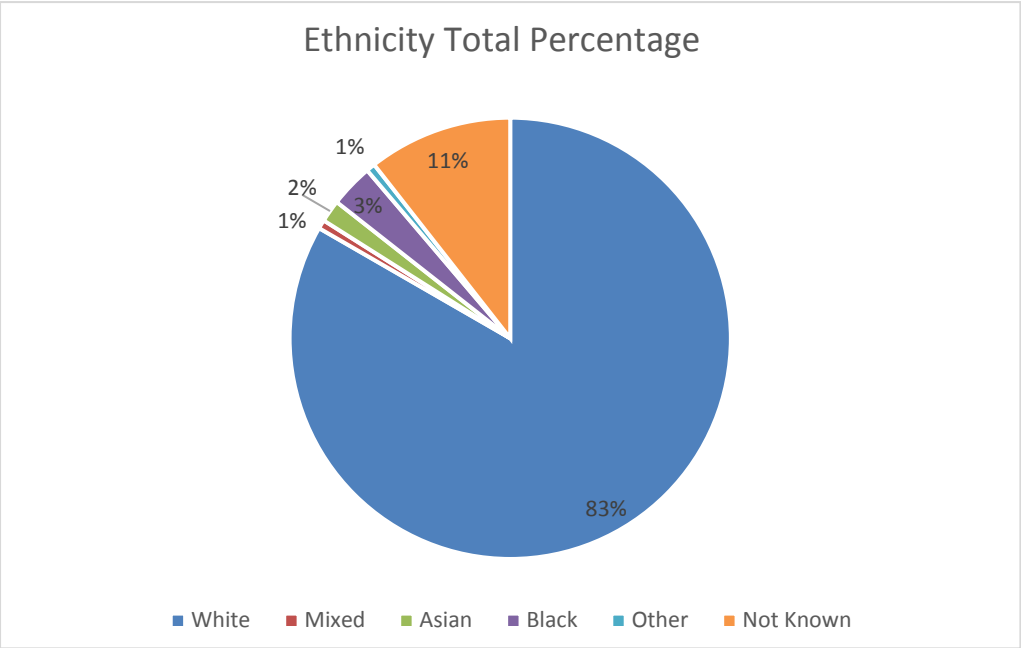
	Physical Support	Sensory Support	Support with Memory / Cognition	Learning Disability support	Mental Health support	Social Support	No support Reason
Reading	22%	3%	2%	41%	23%	7%	1%
West Berkshire	30%	0%	4%	46%	13%	7%	0%
Wokingham	11%	0%	0%	77%	10%	2%	0%
Total	20%	1%	2%	55%	17%	5%	0%

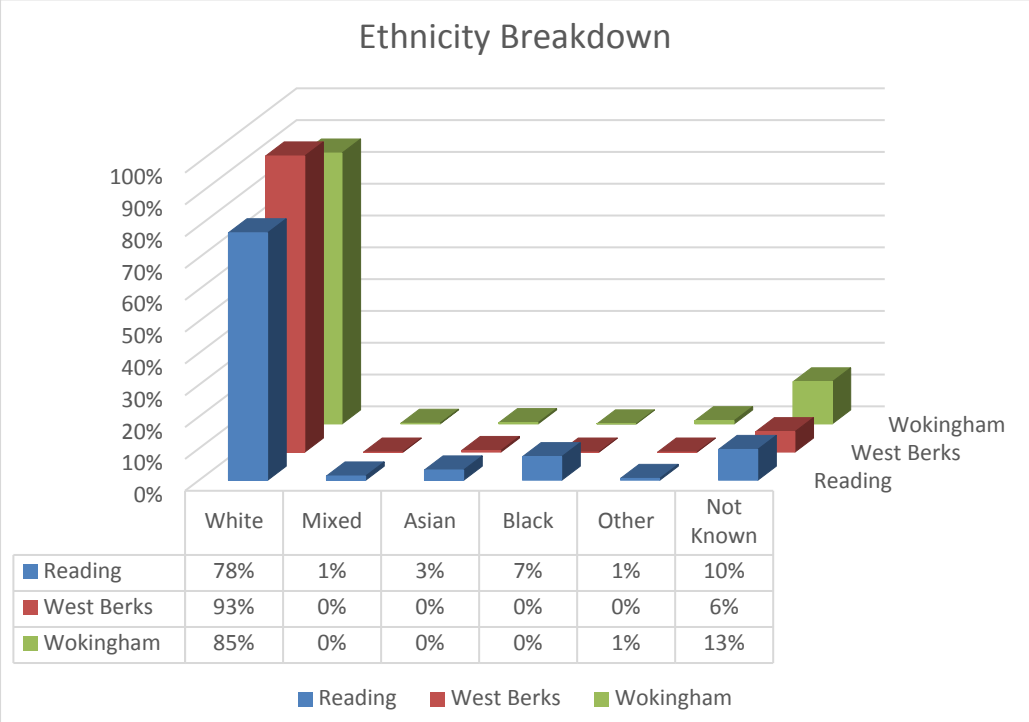


	Physical Support	Sensory Support	Support with Memory / Cognition	Learning Disability	Mental Health support	Social Support	No support Reason
Reading	53%	3%	28%	2%	8%	5%	1%
West Berkshire	49%	2%	35%	6%	5%	2%	0%
Wokingham	64%	3%	23%	2%	3%	1%	4%
Total	57%	3%	27%	3%	5%	3%	2%

Referrals by Ethnicity

The charts below show how many referrals there were for individuals from different demographic categories in 2014-15. We aim to reduce the number of cases where ethnicity is categorised as *Not Known* in future years.

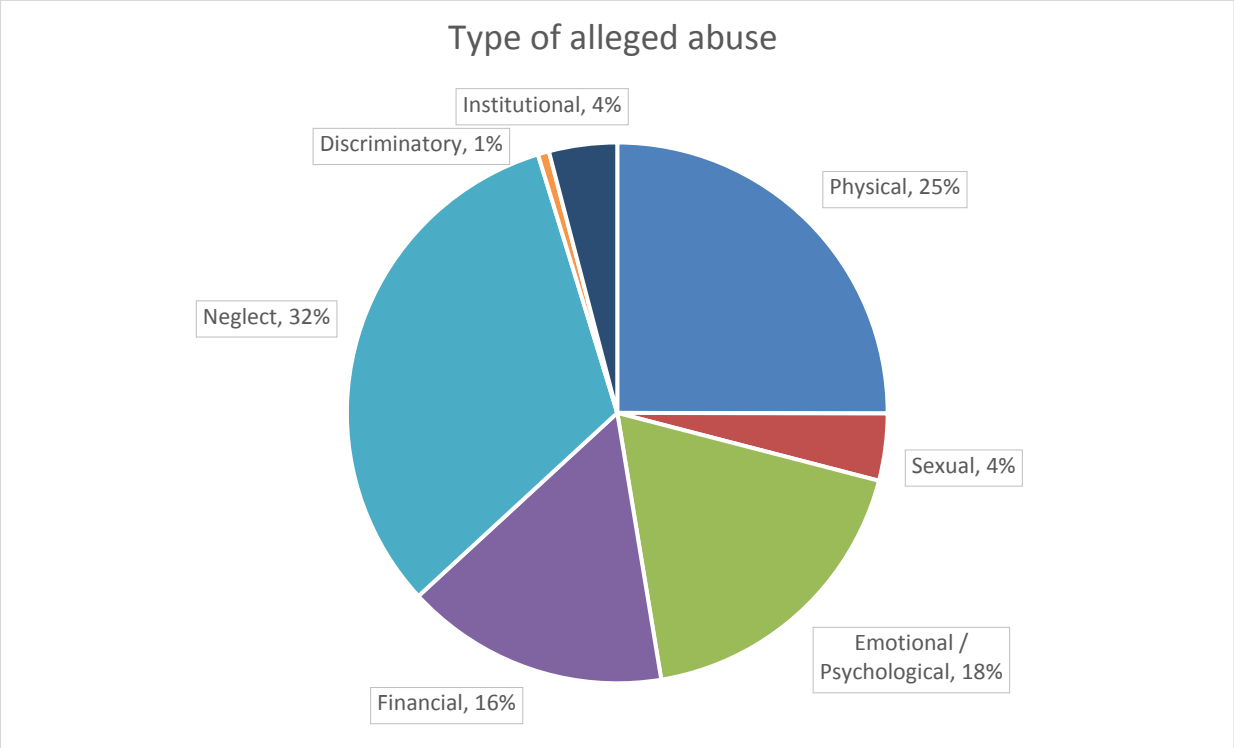


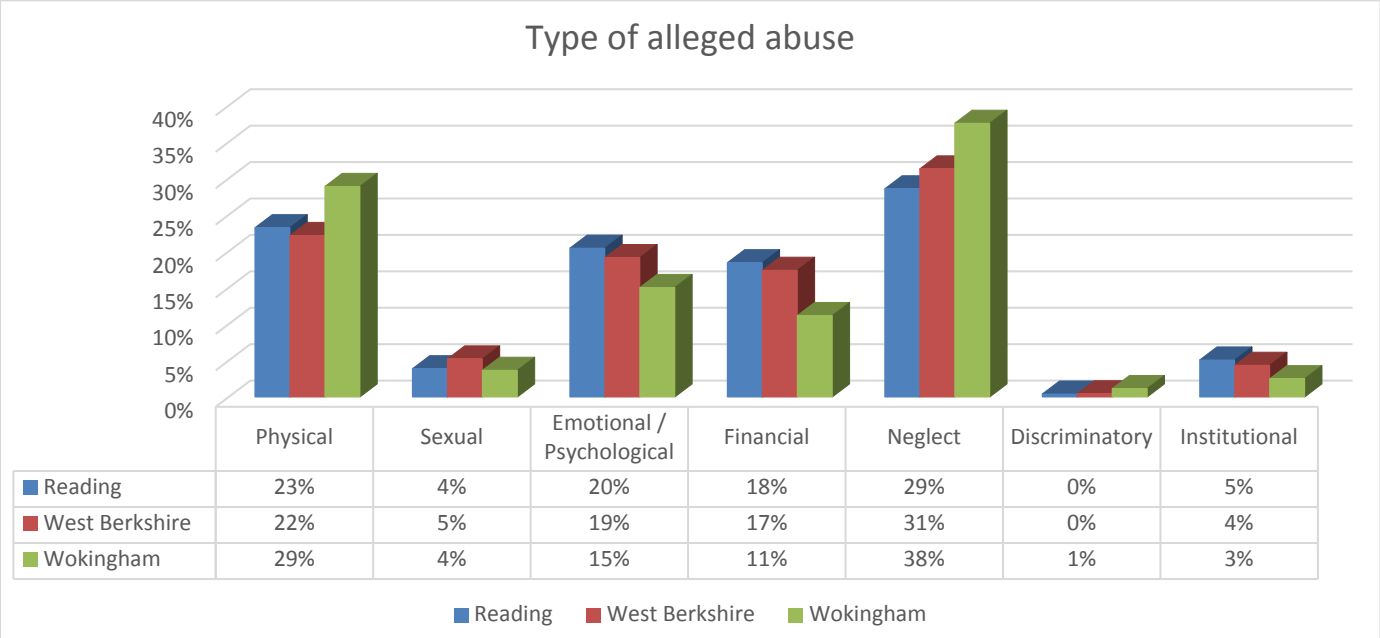


	White	Mixed	Asian	Black	Other	Not Known
Reading	78%	1%	3%	7%	1%	10%
West Berks	93%	0%	0%	0%	0%	6%
Wokingham	85%	0%	0%	0%	1%	13%

Type of Alleged Abuse

The most common type of alleged abuse was neglect and acts of omission, which accounted for 32 percent of allegations, followed by physical abuse with 25 percent. This is in line with national trends for the year. In the previous year the most common type of alleged abuse locally was physical abuse (27 per cent) followed by neglect (26 per cent.) Financial abuse has dropped by 3 per cent from last year and emotional and psychological has dropped by 2 per cent.





	Physical	Sexual	Emotional / Psychological	Financial	Neglect	Discriminatory	Institutional
Reading	23%	4%	20%	18%	29%	0%	5%
West Berkshire	22%	5%	19%	17%	31%	0%	4%
Wokingham	29%	4%	15%	11%	38%	1%	3%

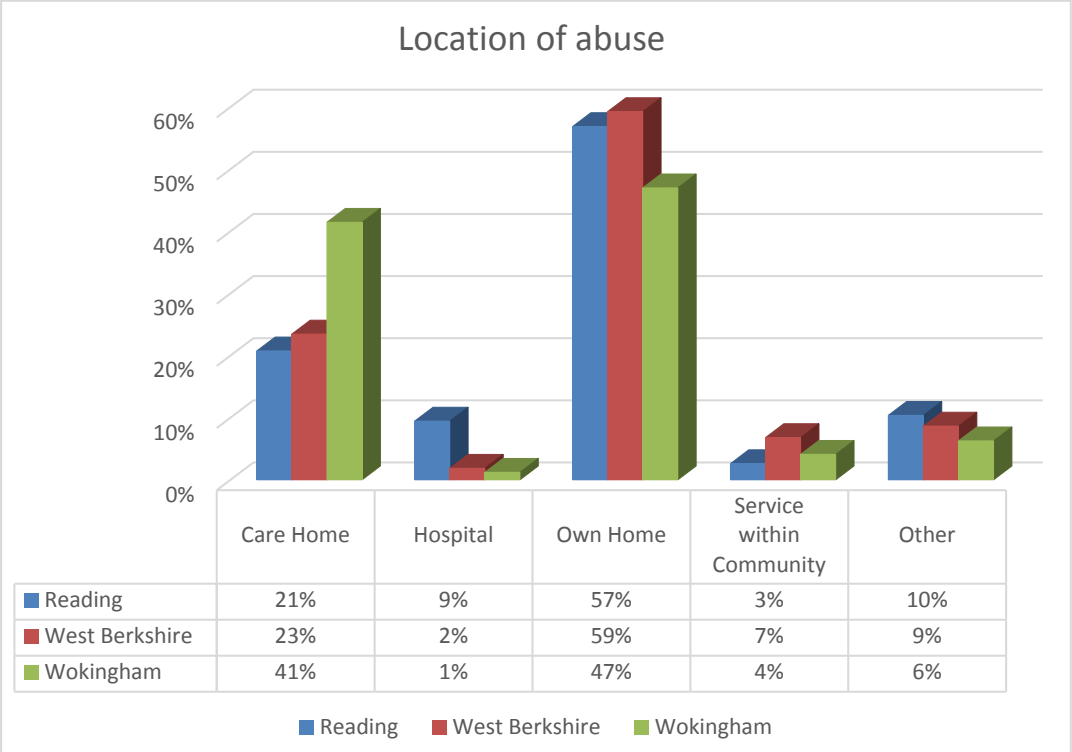
West Berkshire data in the table above includes 27% multiple types of abuse and Reading 27% multiple types of abuse. No examples of multiple types of abuse were recorded in Wokingham.

From 2015-16 four new voluntary categories will be added to this section of the national data collection (domestic abuse, sexual exploitation, modern slavery and self-neglect). Some

of these new categories may have been previously recorded under one of the other categories, so this is likely to impact on comparable data next year.

Location of Abuse

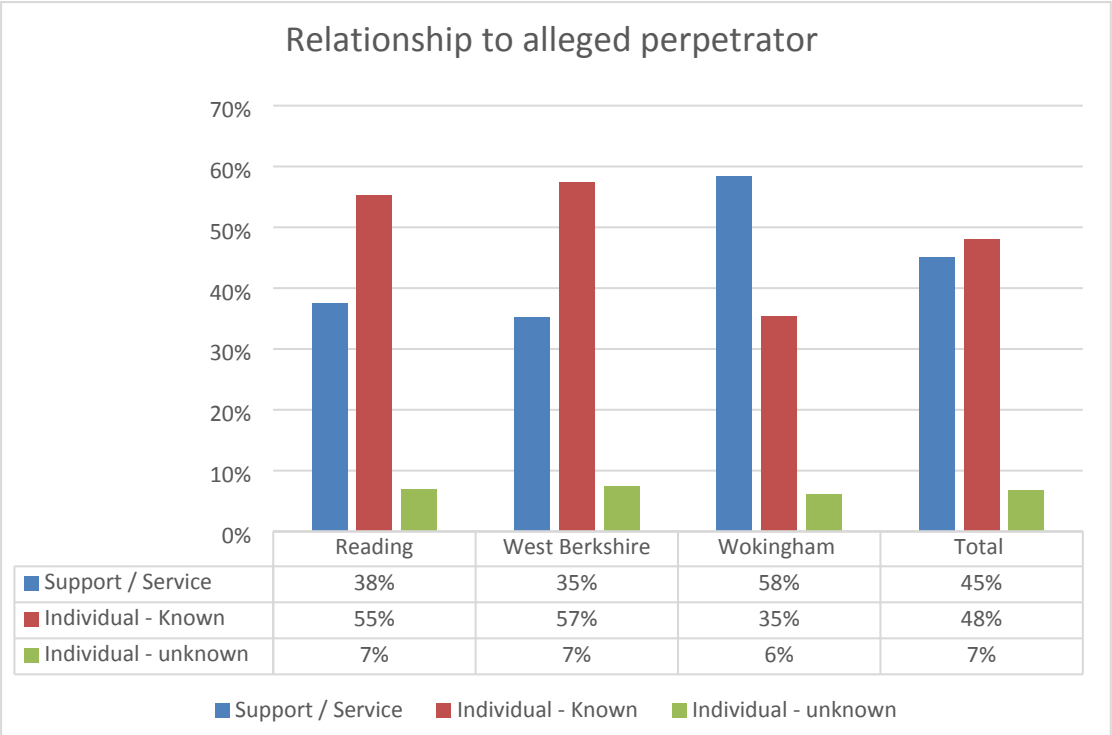
Data taken from completed referrals shows that the location of risk was most frequently the home of the adult at risk (54 per cent of allegations in total) or in a care home (29 per cent). Nationally, although the pattern is the same, the margin between these two locations is narrower, with the home of the adult at risk 43 per cent and care home 36 per cent.



	Care Home	Hospital	Own Home	Service within Community	Other
Reading	21%	9%	57%	3%	10%
West Berkshire	23%	2%	59%	7%	9%
Wokingham	41%	1%	47%	4%	6%

Relationship of Alleged Perpetrator to Vulnerable Adult

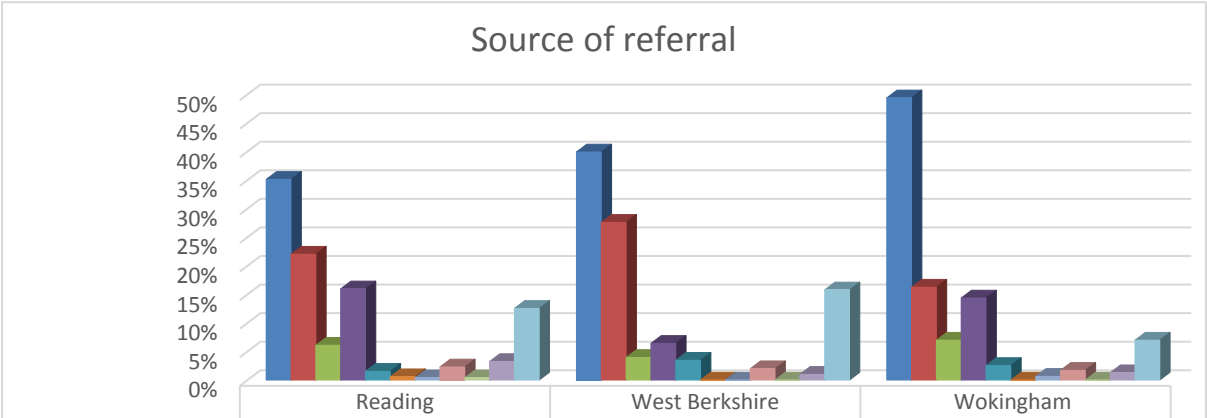
The source of risk was most commonly someone known to the adult but not providing a support service, accounting for 48 per cent of referrals. Someone providing support service was the source of risk in 45 per cent of referrals and for the remaining 7 per cent the source was someone unknown to the individual. This is largely in line with the national trend. The pattern in Wokingham is different to the other two areas.



	Reading	West Berkshire	Wokingham	Total
Support / Service	38%	35%	58%	45%
Individual - Known	55%	57%	35%	48%
Individual - unknown	7%	7%	6%	7%

Source of Referral

In 2014-15, 42 per cent of referrals were reported by social care staff (compared to 46 per cent in the previous year) and 21 per cent were from health care staff (compared to 17 per cent in the previous year.) Trends across all other sources are very stable.

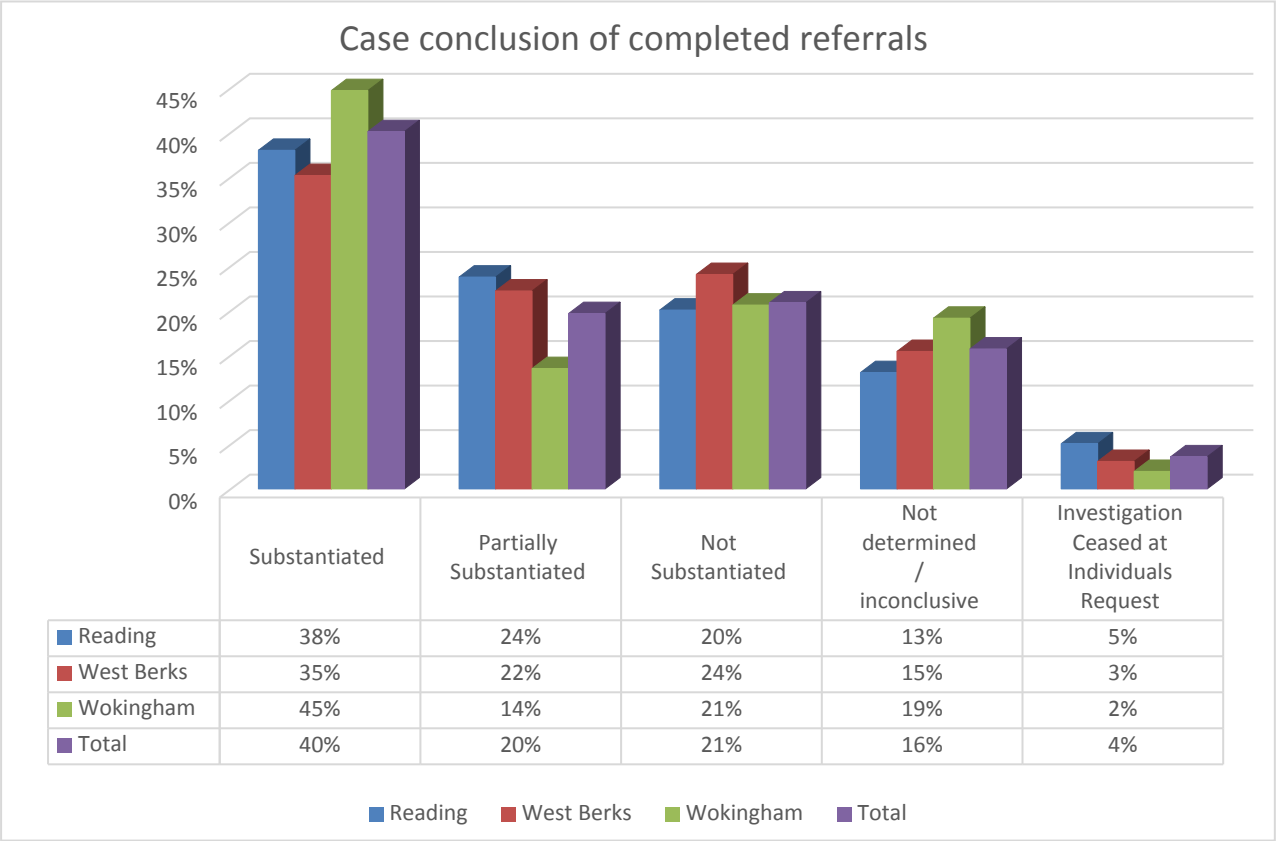


	Reading	West Berkshire	Wokingham
Social Care	35%	40%	49%
Health	22%	28%	16%
Self-referral	6%	4%	7%
Family Member	16%	6%	14%
Neighbour Friend	2%	3%	3%
Other service user	1%	0%	0%
CQC	0%	0%	1%
Housing	2%	2%	2%
Education training workplace	0%	0%	0%
Police	3%	1%	1%
Other	13%	16%	7%

Case Conclusion of Completed Referrals

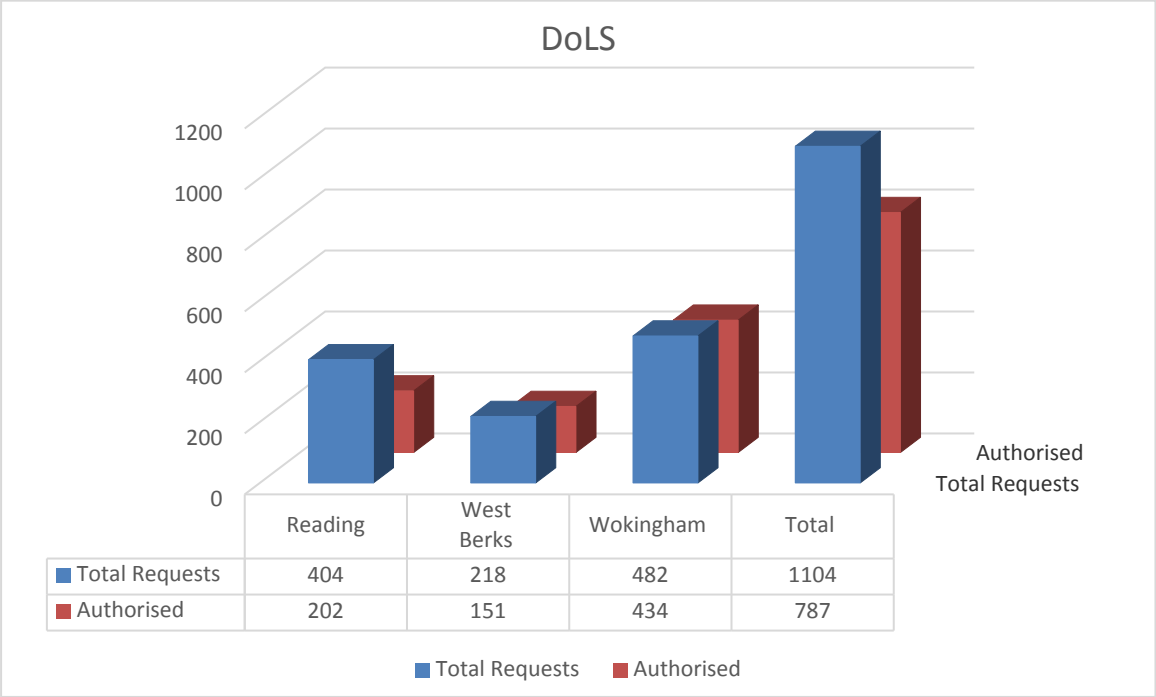
A case conclusion is the outcome of the investigation for a concluded referral and is categorised as Substantiated, Partly Substantiated, Inconclusive (or Not Determined) or Not Substantiated. The decision around substantiation is based on the 'balance of probabilities'. If an allegation of abuse can be proved on the balance of probabilities then it can be categorised as substantiated.

The table below shows the case conclusions for concluded referrals in 2014-15. There has been little change in the proportion of cases in each category from the previous year in the West of Berkshire. The allegations in over 40 per cent of cases were fully substantiated compared to 30 per cent nationally. 20 per cent of cases were partially substantiated compared to 10 per cent nationally and 21 per cent not substantiated, compared to 29 per cent nationally. Nationally, 22 per cent of cases were categorised as inconclusive, compared to 16 per cent locally.



	Substantiated	Partially Substantiated	Not Substantiated	Not determined / inconclusive	Investigation Ceased at Individuals Request
Reading	38%	24%	20%	13%	5%
West Berks	35%	22%	24%	15%	3%
Wokingham	45%	14%	21%	19%	2%
Total	40%	20%	21%	16%	4%

Deprivation of Liberty Safeguards (DoLS)



During 2013-14, the total number of requests across the three areas was 27, with 13 of these applications authorised. The dramatic rise in applications is as a result of the Supreme Court's judgement in March 2014 which suggests that the definition of a deprivation of liberty is wider than previously thought.

Safeguarding Adults Training Activity

From 1st April 2014 to 31st March 2015

	Number of staff attended training in 2012-13, per sector						
Reading Borough Council	**Own Staff**	**PVI**	**BHFT**	**RBH**	**Others**	**Your PVI Delivered**	
Level 1	75	253	0	0	0	134	
Level 1 Refresher N/A							
Level 1 E-learning							
Level 2	26	45	1	0	1	73	
Level 3	4	29	0	0	2	35	
Advanced refresher	11	3	0	0	0	14	
Level 1 Train the Trainer	1	13		0	0	14	
RBC Total	**117**	**343**	**1**	**0**	**3**	**270**	**734**
West Berkshire Council	**Own Staff**	**PVI**	**BHFT**	**RBH**	**Others**	**Your PVI Delivered**	
Level 1	55	80		0	6	188	
Level 1 Refresher	46	61	1	0	0	0	
Level 1 E-learning	65	88		0	0	0	
Level 2	8	5		0	0	0	
Level 3	3	2		0	0	0	
Level 1 Train the Trainer	0	0	0	0	0	0	
WeBC Total	**177**	**236**	**1**	**0**	**6**	**188**	**608**
Wokingham Borough Council	**Own Staff**	**PVI**	**BHFT**	**RBH**	**Others**	**Your PVI Delivered**	
Level 1	93	74	1	0	0	87	
Level 1 Refresher N/A					0	0	
Level1 E-learning N/A					0	0	
Level 2	60	24	3	0	6	0	
Level 3	12	0	1	0	0	0	
Level 1 Train the Trainer	0	0	0	0	0	0	
WoBC Total	**165**	**98**	**5**	**0**	**6**	**87**	**361**
Berkshire Healthcare NHS Foundation Trust	**Own Staff**	**PVI**	**BHFT**	**RBH**	**Others**		
Level 1	318	0	0		1		
Level1 E-learning	709	0	0	0	0		
Level 2	46	0	0	0	0		
BHFT Total	**1073**				**1**		**1074**
Royal Berkshire Hospital NHS Foundation Trust	**Staff**	**PVI**	**BHFT**	**RBH**	**Others**		
Level 1	0	0	0	0	0		
Level 1 E-learning	0	0	0	0	0		
Level 2	0	0	0	0	0		
RBH Total	**0**	**0**			**0**		
West Berkshire CCG	**Staff**	**PVI**	**BHFT**	**RBH**	**Others**		
Level 1	0	0	0	0	247	GPs	
Level 1 E-learning	18	0	0	0	0	CCG	
Level 2 (if deliver?)	0	0	0	0	0		
West Berks CCG Total	**18**	**0**	**0**	**0**	**247**		

6. Appendices

Appendix A

Strategy for Safeguarding Adults in the West of Berkshire 2015-2018

Commitment by the West of Berkshire Safeguarding Adults Board

The West of Berkshire Safeguarding Adults Board is a partnership committed to working together to ensure that adults who may be at risk are:

- Able to live independently by being supported to manage risk;
- Able to protect themselves from abuse and neglect;
- Treated with dignity and respect; and
- Properly supported by agencies when they need protection.

The Safeguarding Adults Board and its partners will achieve the above commitment through the delivery of the following strategic priorities and objectives:

Priority 1 - Establish effective governance structures, improve accountability and ensure the safeguarding adults agenda is embedded within relevant organisations, forums and Boards.

Objective 1.1 Develop oversight of the quality of safeguarding performance.

Outcomes for 2015-16 include:

a. Quality Assurance Audit used for cases across social care teams who carry out safeguarding investigations will assure staff, managers, elected members and the community that all investigations are carried out to a high standard and comply with legislation in terms of quality and timeliness.
b. Safeguarding Forums will encourage group conversation and reflective practice.
c. Royal Berkshire Hospital Foundation Trust multidisciplinary adult safeguarding clinical governance committee established with responsibility for oversight of clinical performance.
d. Quality performance measures developed by Protecting Vulnerable People Senior Managers in Thames Valley Police to review size of current investigations, workloads and themes.
e. Internal quality assurance framework will give direct feedback to staff and managers, inform on-going training and development needs, improve practice around standards in line with Berkshire safeguarding policy and improve staff recording.

Objective 1.2 Have in place an effective framework of policies, procedures and processes for safeguarding adults.

Outcomes for 2015-16 include:

a. Review of Adult Safeguarding Policy in response to the Care Act 2014 will provide assurance that compliant policies and processes are in place across agencies.
b. Review of the new operational process for Individual and Organisational safeguarding investigations and the Safeguarding Team duties in Reading Borough Council will allow amendments to be made based on real issues that have occurred.
c. Berkshire Healthcare Foundation Trust and Royal Berkshire Hospital Foundation Trust Mental Capacity Act Policies will provide clarity concerning the MCA, including training to support knowledge, audit of practice and interdependency with other policies.
d. Review of current practice and gap analysis report and action plan in response to report on *Jimmy Saville NHS investigations: Lessons Learnt, Feb 2015*, will provide additional assurance and clear lines of accountability concerning the lessons learnt in other organisations.

Priority 2 – Making Safeguarding Personal

Objective 2.1 The views of adults at risk, their family/carers are specifically taken into account concerning both individual decisions and the provision of services.

Outcomes for 2015-16 include:

a. Programme of external information and support planned for providers and service users in West Berkshire Council will ensure the Making Safeguarding Personal agenda is central to their understanding when raising safeguarding concerns.
b. The views of adults at risk and their family/carers will be reviewed as part of the Quality Assurance Audit in Reading Borough Council.
c. Achieve, as a minimum, bronze level compliance with the Making Safeguarding Personal programme in Reading Borough Council.
d. Safeguarding Forum meetings will provide service users and their representatives with an opportunity to share their views in a safe environment.
e. Audit of individual patient journeys by Royal Berkshire Hospital Foundation Trust will identify good practice and gaps, improve learning, and ensure patient focused actions.
f. Duty of Candour is applied to safeguarding investigations within Berkshire Healthcare Foundation Trust.
g. Feedback as a result of the implementation of the fire safety guide for adults used to identify good practice and gaps by Royal Berkshire Fire and Rescue Service.

Priority 3 - Raise awareness of safeguarding adults, the work of the Safeguarding Adults Board and improve engagement with a wider range of stakeholders

Objective 3.1 Raise awareness of safeguarding adults and the work of the Board within all organisations.

Outcomes for 2015-16 include:

a. Redeveloped Safeguarding Adults Forum in West Berkshire with renewed focus on membership and action planning to reflect the priorities of the Board, will increase awareness and understanding across the professional sector.

b. Links developed from staff intranets to Safeguarding Adults Board's website.
c. Awareness raising of safeguarding adults and improved communication to improve learning and practice.
d. Review of feedback systems within adult social care and joint health and social care teams in Wokingham to improve practice.

Objective 3.2 Increase public awareness of safeguarding adults and the work of the Board.

The Board has a Communication Strategy which outlines its aims and objectives for clear communication, its target audiences, the types of information it needs to share and the methods of communication. In addition, outcomes for 2015-16 include:

a. Launch of the Safeguarding Adults Board website.
b. Review and update safeguarding literature and promotional material to raise awareness amongst services users, families and the public.

Priority 4 - Ensure effective learning from good and bad practice is shared in order to improve the safeguarding experience and ultimate outcomes for service users.

Objective 4.1 Continue to ensure staff receive appropriate and effective level of safeguarding and other relevant training.

Outcomes for 2015-16 include:

a. Events to embed learning from reviews of significant incidents will ensure staff have various opportunities to access learning outside of the formal training programme.
b. Partners contribute to the work of the Learning and Development Subgroup and support peer observations and reviews of training across the area.
c. Improved safeguarding knowledge, competence and confidence within Royal Berkshire Hospital Foundation Trust workforce through a review of safeguarding training and a Strategy and Training Plan for 2015/16.
d. Training requirements for Berkshire Healthcare Foundation Trust reviewed in light of the Care Act.
e. Content and intentions of the Royal Berkshire Fire and Rescue Service's 'Adult At Risk' and associated 'Memorandum of Understanding' documents are understood by staff and partners.

Objective 4.2 Improve mechanisms to critique good and bad practice and share learning more widely.

Outcomes for 2015-16 include:

a. Maximise learning from reviews of significant incidents across the partnership using the Learning Together model.
b. Development of the operational Care Quality Intelligence Partnership Group and the strategic Care Quality Board in West Berkshire to identify good and bad practice and share

learning.

c. Quality Assurance Audits used in Reading to critique practice in order to ensure all investigations are carried out to a high standard which complies with legislation in terms of quality and timeliness.
d. Opportunities for sharing learning, concerns and best practice in a safe environment via Reading's Safeguarding Working Group and Forum will increase staff confidence in their practice.
e. Safeguarding practice included in Royal Berkshire Hospital Foundation Trust CQC peer review of wards/units will enable testing of knowledge and practice and targeted improvement.
f. Royal Berkshire Fire and Rescue Service embed 'Fatal Fires and Near Misses' process and associated communications for staff and partners.
g. Good and bad practice used to inform safeguarding training in Royal Berkshire Hospital Foundation Trust so that it is more relevant and supports staff development.

Priority 5 – Coordinate and ensure the effectiveness of what each agency does

Objective 5.1 Challenge staff and organisations where poor practice is identified.

Outcomes for 2015-16 include:

a. In West Berkshire, improved information sharing processes between teams, operational and strategic groups, to co-ordinate opportunities to challenge poor practice.
b. Improved information sharing between Safeguarding and Contract and Commissioning teams in Reading to support timely identification of potential organisational abuse and appropriate action.
c. Performance information collected and submitted by partners will be understood by Board members and used to inform planning.
d. Processes are reviewed to ensure pathways and responsibilities are clear and agreed by all parties in Wokingham.
e. Evidence from external reviews in Wokingham is used to improve service design.

Objective 5.2 Develop the role of the Forums to provide feedback on the effectiveness of what each agency does.

Outcomes for 2015-16 include:

a. Redeveloped and well-attended Safeguarding Adults Forums across all three localities, with functions and actions aligned with the Board's priorities.
b. Through the Forums, opportunities for feed-back by organisations and service users will ensure that practice is aligned to what works best for partners and service users.

Key actions in support of the strategy:

- Awareness raising and communication of key information to the public and professionals.
- Workforce planning by all member agencies to meet the demands of safeguarding work and develop the necessary knowledge and skills at all levels. Each organisation to have in place a training strategy.

- Collection and analysis of annual safeguarding performance data by the relevant agencies.
- Governance arrangements in place in each member organisation to monitor the standards of practice to safeguard vulnerable adults from abuse. These arrangements will include: formal links between the Board, senior managers and Local Authority Members; regular audits; clear responses to local and national incidents and inquiries; quality assurance process and data to inform forward planning and service development; information dissemination; prevention and intervention.
- Prevention is key: there is a clear programme of work to reduce the risk of abuse/neglect across the range of settings.
- The inclusion of safeguarding in commissioning strategies and in contracts.
- Continually updating policy and procedures in line with national and local developments both within safeguarding and in other key agendas.
- Carrying out Safeguarding Adults Reviews and acting on them.
- Development of services capable of responding to those who have been abused or are at risk of abuse or neglect, or those who are perpetrators of abuse or neglect.
- Engagement with the whole range of stakeholders including service users and carers.

Implementation and Monitoring

Implementation of this Strategic Plan will be achieved through the work of the Subgroups and through delivery of the actions in the Business Plan.

An annual Business Plan has been developed which gives detail about how the priorities of this Strategic Plan will be implemented. The Business Plan includes key actions that partner agencies have committed to delivering in the next year.

Progress against the Business Plan will be reported to the Safeguarding Adults Board at six monthly intervals and the Annual Report will provide an overview of achievements and any areas for further development.

Although the Strategic Plan is a three-year plan, it will be reviewed on an annual basis and updated where necessary.

Glossary:

BHFT – Berkshire Healthcare Foundation Trust

CQC – Care Quality Commission

MCA – Mental Capacity Act

RBFT – Royal Berkshire Foundation Trust

RBFRS – Royal Berkshire Fire and Rescue Service

SAB – Safeguarding Adults Board

SE ADASS – South East Association of Directors of Adult Social Services

Further information about how partner agencies will contribute to the delivery of this Strategic Plan can be found in the Business Plan 2015-16.

Appendix B

Learning from Safeguarding Adults Reviews - The Case of Ms F

1. Purpose of the Safeguarding Adult Review

Safeguarding Adult Reviews (SARs) are about learning lessons for the future. They will make sure that Safeguarding Adults' Boards get the full picture of what went wrong, so that all organisations involved can improve their practice.

Organisational systems are complex. Therefore findings are not presented as recommendations but as a series of problems and puzzles for consideration and local prioritisation.

A case review plays an important part in efforts to achieve safer and more effective systems. Consequently, it is necessary to understand what happened and why in the particular case, and go further to reflect on what this reveals about gaps and inadequacies. Case Review findings say something more about local agencies and their usual patterns of working. They exist in the present and potentially impact in the future. **The six findings are presented in section 4 below.**

It is important that local agencies review the findings from a Safeguarding Adult Review and consider what changes can be made in local processes and practices to prevent such a case reoccurring.

2. Succinct summary of case

Ms F was a woman of 22 at the time of her death. She had a baby removed and adopted in 2010 and she was not open to any service until just before her death, with the exception of her GP, when she was referred to Adult Social Care by the Police. She subsequently died of sepsis in May 2013. Other members of the household were well known to many services in Reading including Antisocial Behaviour and the Police, both as victims and perpetrators.

3. Appraisal of professional practice in this case – a synopsis

Various members of Ms F's household were well known separately as individuals to agencies for many years and many appropriate interventions were offered to them prior to the period under review and during it. The focus of these services was around the tenancy, in particular the state of the property and rent arrears, as well as the impact of anti-social behaviour on neighbours. **The differing drivers for services are explored further in Finding 2**.

This cycle of intervention and engagement is explored in Finding 2.

It is notable that for much of the review period, professional engagement was focused on other individuals in the family unit of which Ms F was a part, without specific interventions for her. It is also notable that the strong interdependency between members of the family went unrecognised, although this is not unexpected given that adult assessments are about individuals only. **This is explored in Finding 6.**

Prior to the period under review the case has some unique aspects. The treatment of another member of the family led to the first case that Reading Borough Council took to the Court of Protection on grounds of neglect, and one of the first Deprivation of Liberty Safeguards that was

carried out on another member. Neither of these people forms part of the family unit during the period under review but the historical background is significant. **The consequences of historical knowledge is explored further in Finding 6**

Ms F gave birth in 2010 but her baby was removed because of concerns of neglect and subsequently adopted in December 2011 and the case closed by Children's Services. Following this, Ms F had no subsequent support, with the exception of her GP who had prescribed anti-depressants. This was standard practice at the time. Since then the importance of support following removal and adoption of children has been recognised, and has led to the establishment of the Future Families Project.

In February 2012, the Police were called to the household after Ms F had reportedly attempted to cut her wrists with a knife. The Police response was compassionate and well-judged: they took Ms F to A&E away from the chaotic home situation.

After this event, no further services were requested or provided to Ms F in her own right until May 2013. Between February 2012 and March 2013 professionals from a number of different agencies attended the family home, largely as part of plans to implement an eviction on the grounds of antisocial behaviour and rent arrears. Ms F was present during all of these visits, but usually as a 'background' member of the household: most interventions were targeted at her mother, as she was the tenant, and mother's partner who had a diagnosed learning disability.

The Review Team has considered carefully whether any of these professionals could have picked up at any earlier stages that Ms F, or any other members of the family were at risk, and this is discussed below. However, in general it seems that there were no reasons why visiting professionals would have singled Ms F out within the family. Ms F appeared articulate and had a reasonable level of cognition compared to other individuals living in the household. **The impact that an individual's presentation can have on assessments of vulnerability is further discussed in Finding 5.**

The Police were called to the house on numerous occasions during the review period following alleged ASB or domestic abuse and drunken behaviour.

ASB visits were made at intervals during the Review period for the clear purpose of reducing anti-social behaviour. The ASB Officers were concerned about the vulnerability of the family as a whole, and in October 2012 contacted Safeguarding Adults to check if any household members were known to ASC because of concerns about their possible vulnerability. Whilst ASB were beginning to prepare the case for eviction, the Rents Section of Housing had already gained a possession order from the Courts for substantial arrears. This had been suspended as the household had undertaken to pay back arrears. The Neighbourhood Officer did not act effectively as the conduit between the Rents Team and ASB to pull the two eviction processes (via ASB and via rent arrears) together. This was in part due to the blurring of the role of Neighbourhood Officer and ASB Officer in terms of antisocial behaviour for Council tenants at the time. Roles have been subsequently defined.

It was not until ASB formally approached the Council's Legal Team to begin the Court process in June 2012 that they became aware that the tenant was already being taken through the eviction process due to substantial rent arrears. The current reorganisation of Housing to bring the Recovery Team into the Department rather than remain in Finance should prevent this dislocation occurring.

At the same time Recovery Officers continued to try to engage the tenant using a variety of methods including phone calls and visits as well as standard letters. There is a strange effect of the Court process that Council Officers have to repeat attempts to engage and support tenants time and again because they know that the Court will refuse the eviction unless they can prove over time that the actions have not been effective by citing non-payment of arrears, state of the property, or ASB. In order to evict, the ASB Team had to establish a large body of evidence of extreme behaviour as well as the poor state of the property. They also have to prove that they have tried to provide support to vulnerable tenants. **This is explored further in Finding 2**

In December ASB visited the house. They noticed that Ms F looked unwell and advised her to contact her GP. This was appropriate and above expected standards.

ASB contacted Safeguarding Adults again in December 2012 to discuss their concerns about family member's vulnerability as the eviction process was continuing. They were aware that a person with a Learning Disability (the tenant's partner) was living in the house but they were concerned about the tenant and her sister. They had no concerns about Ms F. This led directly to a series of joint visits between ASB and Community Learning Disability Team (CLDT).

The decision by CLDT to assess both the tenant and her partner was above expected standards. Historical knowledge indicated that only one household member was potentially eligible for community care support but consideration was given that the tenant's needs may have changed over the time. **See Finding 4 for further exploration of this.**

CLDT and ASB joint visits and attempts to engage were tenacious and beyond what would have been expected and were made as a genuine effort to support the family. During the visit when they were given entry, Ms F was sitting on the sofa, but it was the only furniture in the room. On that occasion in February Ms F's mother volunteered that she thought Ms F was unwell and she was advised to contact the GP and ask her to visit. This was appropriate given that both women had mobile phones, and from medication on the table it was clear that Ms F was in contact with her GP.

In February 2012, ASB took the case to the ASB Multi Agency Panel (MAP), a panel established in order to agree eviction of tenants who may have implications for other agencies. This was the only forum where there was a wider discussion of needs of the family as a group rather than individuals. The Review Team felt multi agency discussion would have been helpful much earlier. There is no structure to support this but a multi-agency strategy meeting could have been convened. MAP is not designed to take a holistic view of alternative actions, although this did in fact occur e.g. the decision to refer Ms F, her mother and aunt to the ASC Risk Enablement Panel (REP). REP is designed to examine 'stuck' cases and is used for individuals who don't necessarily reach community care criteria but who are high risk or resource intensive. In fact the referral did not take place and in any case was too late to impact on the subsequent eviction.

It is notable that the referrals to REP were INDIVIDUALS not as a family group. Ms F again does not feature as being of concern compared to others. **See Findings 1 and 2 where there is consideration of panel use, Finding 5 which explores innate bias and Finding 6 which explores the impact of assessment of individuals only**.

In May 2013 the Police were called to the house due to a neighbour dispute. During this visit, the Police Officer became concerned about Ms F because she appeared unwell. There was appropriate practice in recognition and referral of Ms F to ASC by the Police via the Protection of Vulnerable Adults Unit. It took almost 24 hours for the referral to be passed to Adult Social Care which was appropriate as the Police Officers attending had no reason to suspect the severity of Ms F's illness.

However, this meant that referral was sent late on a Friday afternoon prior to a Bank Holiday and was not picked up by the Single Point of Contact in ASC until the following Tuesday morning, below acceptable standards. The system for receipt of police referral has since been changed.

Once the referral had been triaged it was swiftly passed appropriately to CLDT as they knew the household. Because the referral was not marked as urgent, CLDT appropriately researched the household. It was appropriate to include a nurse as part of the joint visit that same afternoon given the nature of the referral. It was luck that the nurse was male and that Ms F's mother assumed he was a GP and allowed them access into the house. They chose not to insist on a physical examination due to the distress of Ms F but obtained permission to contact Ms F's GP.

The GP had Ms F flagged on the system as having LD which was incorrect but it meant she acted swiftly to make a home visit that evening, above appropriate standards. She called paramedics who took Ms F to hospital.

Safeguarding alerts made by paramedics and acute hospital staff, and the subsequent multi-agency safeguarding investigation adhered to the Berkshire Safeguarding Adults' Policy and Procedures.

Staff at RBH made every effort to understand Ms F's wishes and responded to these despite being understandably shocked at Ms F's physical condition. There was a strong multi-agency communication and joint working throughout the time period around the criminal investigation.

The efforts by Housing Needs to develop a supportive relationship and to ensure that the tenant understood the eviction process were above the expected standards particularly when the remaining family members were living in temporary accommodation.

What is notable was that the eviction process continued in parallel throughout the criminal investigation. To some extent officers were constrained by the statutory framework within which they operate but nevertheless the Review Team were surprised that the process continued. The death of her daughter coupled with the criminal investigation would have had a considerable impact on the tenant's ability to comply with the process.

Findings

FINDING 1

In Reading, the Multi-Agency Pathway for non-engagement is not consistently followed, with the consequence that multi-agency perspectives and resources are not brought to bear when previously-managed risk becomes less controllable.

SUMMARY

Reading has substantial numbers of adults who are either vulnerable or at risk, and who do not engage with services. Whilst this Safeguarding Adults Review was under way, the Safeguarding Adults' Partnership revised and re-launched an existing pathway to try and increase the likelihood of professionals, led by a senior practitioner, thinking collectively about possible new solutions in each instance of non-engaging adults where risk starts to increase. If practitioners and their managers are not familiar with the pathway, it cannot drive improvements.

Questions

- How do practitioners view the issue of non-engagement? How much of a block and a risk is it to the local safeguarding adults' system?
- What attempts have there been to tackle the safeguarding risks that can come with non-engagement?
- How can the development of the Multi-Agency Safeguarding Hub promote earlier professionals' meetings?
- How do we empower practitioners to make decisions about service users?

FINDING 2

Assessment tools cannot predict the impact of the eviction process, which results in years of preventative work being swept aside in response to a crisis

SUMMARY

Numbers of evictions are growing nationally and there is insufficient understanding of the impact of eviction on vulnerable adults. This is particularly concerning because despite recognition that the boundaries between antisocial behaviour and safeguarding are blurred, it is hard to find any analysis of existing assessment tools and how they can predict the effects of eviction on adults with vulnerabilities.

Questions

- Do Board members know of any examples of assessment tools that can help predict the impact of eviction on vulnerable adults?
- How will the Care Act 2014 be implemented, particularly around prevention?

What can be done to encourage multi-disciplinary assessments in line with the practice seen in the case at the centre of this Review?

FINDING 3

When agencies with different drivers are all working with a complex family, managerial panels do not always have their intended effect and vulnerabilities get lost

SUMMARY

The Review Team examined the role of the various managerial panels in Reading. For many cases these are working effectively to manage risk. However some agencies are either referring too late or not at all which means that safeguarding risks are not being anticipated and managed, and this is a heightened risk if certain panels receive the bulk of their referrals from the agency that convenes them.

Questions

- How can agencies ensure that workers refer early to panels?
- Are the criteria for referral clearly understood?
- Could referral sources to each of the panels listed above be explored, to see if the patterns mean that some cases are not being referred at all?

How can the use of panels improve joint working between agencies?

FINDING 4

Are chaotic childless families losing out because there are fewer tools or mechanisms such as the Troubled Families initiative for professionals to use compared to when a child is present, leading to less alternatives for those adults?

SUMMARY

The risk in the safeguarding system is that when professionals in adult services are focussed on individuals (as set out in Finding 6), and in addition, lack the resources that come with programmes like Troubled Families, those professionals are more likely to struggle with services and solutions for the chaotic childless families, who according to the Case Group, are becoming an ever larger cohort within their caseloads.

Questions

- What learning from the Turnaround Families programme can be transferred across to vulnerable adults without children, whose antisocial behaviour is problematic for all agencies?
- Do agencies think a 'think family' approach is important?
- How can we reconcile the tension between focus on the service user and consideration of their wider family's needs, particularly in complex situations?

FINDING 5

Young and assertive service users are less likely to be seen as vulnerable, even in the face of known risk factors, and this has the consequence that crises are missed.

SUMMARY

The way some individuals present may preclude their being judged as vulnerable. Ms F had particular vulnerabilities due to events in her life, and for professionals working with adult service users, it is a complex task to assess what different sorts of vulnerabilities lie behind the way in which young and assertive service users present. Understanding and responding to those vulnerabilities might reduce the risk of a distressing crisis for that young person in the future.

Questions

- When do you have to intervene?
- How can we ensure a shared understanding of what constitutes vulnerable?
- Do workers understand the impact of obesity on Mental and physical health?
- How can we skill staff up to allow them to differentiate between 'vulnerability' they perceive but cannot use to ensure support through Adult Social Care?
- Do practitioners understand the impact of situational incapacity?

FINDING 6

Assessment for adults is about individuals, without scope for focussing on co-dependent needs, which means services struggle to understand patterns of need and behaviour amongst co-dependent groups of adults.

SUMMARY

Assessment is a crucial opportunity to understand the world of an adult service user, and most families have interdependencies of some kind which it could be fruitful for assessment to explore. Doing this consistently, perhaps considering what approaches have been effective in children's services, enables professionals to understand risks that otherwise are not made transparent.

Questions

- How can we provide young people with a self-protection strategy when they live in chaotic household?
- How can staff balance being inquisitive about households and being driven by the process of individual assessment?
- Should agencies begin to map adult households with multiple needs in the same way as the troubled Families Programme has mapped households with children?

Appendix C

Membership of Board and Subgroups

The Safeguarding Board itself is made up of senior managers from a wide range of partners and agencies. As in previous years, attendance at the Board has been high. The Board is made up of representatives from the following agencies:

- Berkshire Healthcare Foundation Trust
- Berkshire West Clinical Commissioning Groups
- Emergency Duty Service
- HealthWatch Reading
- Joint Legal Services
- Reading Borough Council
- Royal Berkshire Fire and Rescue Service
- Royal Berkshire NHS Foundation Trust
- South Central Ambulance Trust
- Thames Valley Community Rehabilitation Company
- Thames Valley Police
- National Probation Service
- West Berkshire District Council
- Wokingham Borough Council

Membership of subgroups in 2014-15

Partnership and Best Practice Subgroup

The Partnership and Best Practice Subgroup assists the Board in promoting good quality safeguarding practice.

Sylvia Stone (Chair)	Kathy Kelly - CCG	Sarah O Connor - WBC
Natalie Madden (minutes)	Sue Brain - WBDC	Jo Wilkins – RBC
Elizabeth Rhodes – RBFRS	Elizabeth Porter – RBFT	Cathy Haynes - BHFT

Performance and Quality Subgroup

The Performance and Quality Subgroup oversees performance of adult safeguarding activity in the West of Berkshire, highlighting the effectiveness and risks of key processes and practices.

Natalie Madden (Chair and minutes)	Jessica Higson - RBFT	Nailah Mukhtar - WBDC
Debbie Ferguson – RBC	Kathy Kelly - CCG	Sairah Parkar - WBC
Sarah O'Connor - WBC	Michelle Tenreiro Perez – RBC	

Governance Subgroup

The purpose of the Governance Subgroup is to ensure the Board has robust governance arrangements, with clarity of purpose and public accountability.

June Graves – WBDC (Chair)	Michelle Tenreiro Perez – RBC	Natalie Madden (minutes)
Kathy Kelly – CCG	Patricia Pease – RBFT	Nancy Barber –BHFT
Suzanne Westhead - RBC	Sarah O'Connor – WBC	

Communication and Publicity Subgroup

The Communication and Publicity Subgroup supports the messages that safeguarding is everyone's business and that good communication is the responsibility of all partners sitting on the Safeguarding Adults Board.

Sylvia Stone - SAB (Chair)	Sarah O'Connor –WBC	Natalie Madden – SAB (minutes)
Nikki Malin – BHFT	Peta Stoddart- Compton - WBDC	Kathy Kelly – CCG

Learning and Development Subgroup

The purpose of the Learning and Development Subgroup is to develop, implement, review and update the multi-agency Workforce Development Strategy for the protection of adults at risk. The aim of this Strategy is to provide an effective, coordinated approach to learning in order to support all agencies to prevent abuse and respond to safeguarding concerns with timely, proportionate and appropriate action.

Eve McIlmoyle – RBC (Chair & minutes)	Kathy Kelly - CCG	Catherine Haynes - BHFT
Jo Wilkins – RBC	Natalie Madden – SAB	Edwin Fernandes – WBC
Neil Dewdney – WBDC	Sue Brain – West Berks Council	Elizabeth Porter – RBFT
Stefan McLaughlin - TVP	Johan Baker - Wokingham BC	Kathy Gonzalez-Atowo – BHFT
Joy Baker – Bracknell & Wokingham College (PVI rep)		

Reading Borough Council Safeguarding Adults Annual Summary 2014/15

Performance Data

This summary is based on the data used to collate the SAR (Safeguarding Adult Return) for 2014/15 and previous SAR/AVA (Abuse of Vulnerable Adults) returns for earlier years.

Please note this is provisional data as the final results have not yet been published (as at Sept 15).

The figures in this summary do not match the SAR submission but is based on the same data. The SAR looks at individuals rather than individual safeguarding incidents. In order to conduct a fair comparison to previous results, the data reported below is looking at incidents too.

From 2015/16 the SAR is changing to the SAC (Safeguarding Adults Concerns) and will be looking at slightly different things and the terminology will be changing, from Alerts and Referrals to Concerns and Enquiries.

Volumes

Reading only began recording "Alert only" cases from 2012/13 prior to this all safeguarding incidents were recorded as a Referral.

The figures below are looking at Alerts and Referrals started in period (1st April – 31st March) and Closed Referrals are referrals ended during the period regardless of when they started.

	2009/10	2010/11	2011/12	2012/13	2013/14	2014/15
Alerts only	-	-	-	87	163	175
Referrals	219	523	668	538	491	527
Total	219	523	668	625	654	702
Closed Referrals	225	532	662	539	451	513

- Alert Only -
    - Numbers have increased slightly on last year, but are almost double what was recorded in 2012/13. We think this increase is due to better recording and better understanding of what constitutes a safeguarding referral.
- Referrals -
    - Numbers of actual referrals have shown a slight increase this year (approx. 6%).

- The total of alert only's and referrals in period has shown a steady increase over the last 3 years - 625 in 12/13, 654 in 13/14 and 702 this year (approx. 6.8% increase on last year's total.

- These total figures work out at approx. 54 reports per month in 13/14 and 58 per month this year.

- The percentage of Alerts which go on to become referrals had reduced since 12/13 and this year remains at the same level - 86% in 12/13, 75% in 13/14 and 75% this year.

- Closed Referrals –

  - The percentage of completed referrals of all referrals is 91% for 13/14 and 97% for 14/15 indicating better use of documentation.

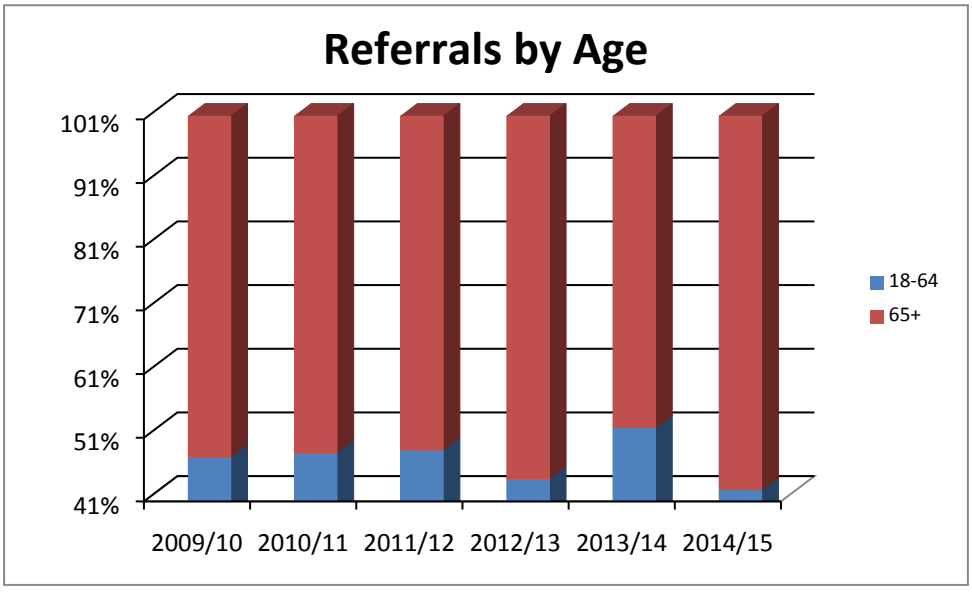
Referral Data

The next set of tables look at referrals received in the year broken down into different categorisations.

- Age Grouping

  - Last year was the first time the 18-64 group had more referrals than the 65+. This year it has reverted back to the norm.

Numbers by Age	2012/13		2013/14		2014/15	
	No's	%	No's	%	No's	%
18-64	232	43%	251	51%	218	41%
65+	306	57%	240	49%	309	59%
Total	**538**		**491**		**527**	



- Gender

    - The trend for this has remained the same – there is a higher proportion of referrals for females than males, with percentages this year matching last year's figures.

Percentages - Gender	2009/10	2010/11	2011/12	2012/13	2013/14	2014/15
M	-	44%	38%	40%	44%	44%
F	-	56%	62%	60%	56%	56%
Total	**0%**	**100%**	**100%**	**100%**	**100%**	**100%**

- Ethnicity

    - Again the continuing trend with ethnic origin is mostly white (78%) – percentages are not much different to previous years.

    - However the "not known" percentage is creeping up and may need to be monitored.

Percentages - Ethnicity	2009/10	2010/11	2011/12	2012/13	2013/14	2014/15	2001 Census (ONS)
White	78%	82%	77%	80%	79%	78%	75%
Mixed	3%	1%	1%	1%	2%	1%	4%
Asian	6%	7%	6%	5%	5%	3%	14%
Black	5%	5%	5%	7%	6%	7%	7%
Other	2%	1%	0%	1%	0%	1%	1%
Not Known	6%	4%	12%	6%	7%	10%	
Total	**100%**	**100%**	**100%**	**100%**	**100%**	**100%**	**100%**

    - We can see that Asian residents are under represented by 11% when compared to the data from 2011 Census, however the 10% of referrals whose ethnic identity is not known significantly hampers the reliability of performance information in this area.

- Client Group / Primary Support Reason

The categorisations for 14/15 have changed to previous years as the reports are now looking at Primary Support Reasons which makes direct comparison to previous returns much harder.

    - However we have seen that most remain in the Physical Support Category 41%.

Percentages - Support Reasons	2009/10	2010/11	2011/12	2012/13	2013/14	2014/15
PDFS (incl sensory **pre** 2014/15)	61%	46%	45%	57%	47%	41%

Sensory Support						3%
MH (incl Dementia **pre** 2014/15)	9%	24%	25%	20%	24%	15%
Support with Memory/Cognition (new 2014/15)						17%
LD	22%	23%	22%	19%	24%	19%
Subs Misuse	0%	3%	5%	1%	3%	
Social Support (New 2014/15)						6%
Other Vulnerable	7%	4%	3%	4%	1%	
No Support Reason (new 2014/15)						1%
Total	**100%**	**100%**	**100%**	**100%**	**100%**	**100%**

- Repeat Referrals

This looks at the number of repeat referrals as a percentage of all referrals received in the period.

Referrals are counted regardless of the incident so it could be the same incident being re-referred or different incidents involving the same safeguarding adult.

Percentages - Repeat Referrals	2010/11	2011/12	2012/13	2013/14	2014/15
Percentage	12.5%	15.4%	19.5%	16.5%	9.9%

  - The numbers of repeat referrals have been dropping which potentially demonstrates more effective resolution and risk management of issues reported.

- Source of Referral

The table below looks at the source of referrals i.e. who raised the concern.

Source of Referral	2010/11	2011/12	2012/13	2013/14	2014/15
Social Care	**34.8%**	**32.6%**	**33.5%**	**37.7%**	**35.1%**
Health	**12.6%**	**22.6%**	**16.5%**	**22.0%**	**22.0%**
Self Referral	15.3%	12.1%	10.2%	10.2%	6.1%
Family Member	17.8%	15.1%	16.4%	14.9%	15.9%
Friend/Neighbour	2.9%	3.9%	4.3%	1.8%	1.5%
Other Service User	0.8%	0.0%	0.2%	0.6%	0.6%
CQC	0.6%	0.4%	0.2%	0.8%	0.4%
Housing	4.2%	3.9%	5.8%	5.7%	2.3%
Education/Training/Workplace	0.0%	0.4%	0.2%	0.4%	0.4%
Police	3.1%	4.2%	5.8%	2.4%	3.2%
Other	8.0%	4.6%	7.1%	3.5%	12.5%
Total	**100.0%**	**100.0%**	**100.0%**	**100.0%**	**100.0%**

- Most years the figures have remained fairly settled although for this year we can see a slight dip in Self Referrals from 10% to 6%, and a significant rise in "Other" referrals from 3.5% to 12.5%, which may be a recording issue but may need monitoring.

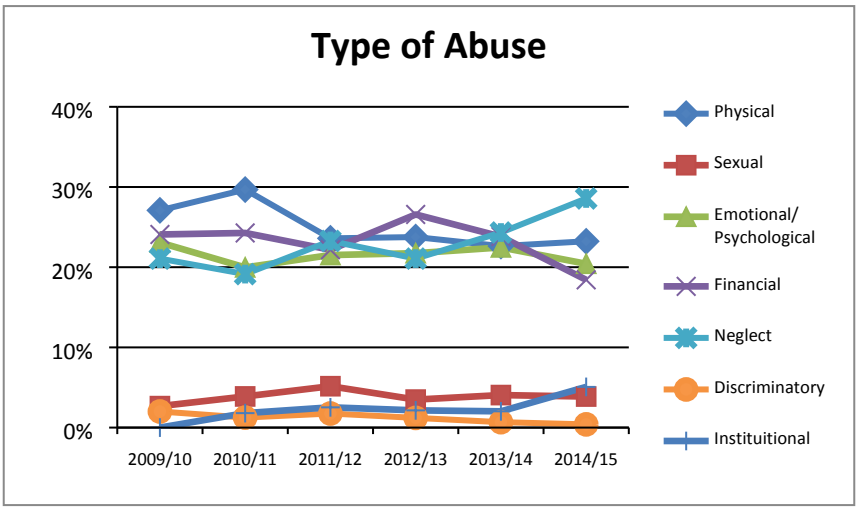
Closed Referral Data

The new SAR for 13/14 and 14/15 return looks at closed referrals during the period for the next tables (most of these would've come from cases opened in previous year's results which may skew the comparison a little.

- Abuse Types

Percentages - Abuse Types	2009/10	2010/11	2011/12	2012/13	2013/14	2014/15
Physical	27%	30%	24%	24%	23%	23%
Sexual	3%	4%	5%	3%	4%	4%
Emotional/ Psychological	23%	20%	22%	22%	22%	20%
Financial	24%	24%	22%	27%	24%	18%
Neglect	21%	19%	23%	21%	24%	29%
Discriminatory	2%	1%	2%	1%	1%	0%
Institutional	0%	2%	3%	2%	2%	5%
Total	**100%**	**100%**	**100%**	**100%**	**100%**	**100%**

- The top 4 remain the same. Last year however the top 4 had very similar percentages (22-24%) this year they cover a much larger range (19-29%):
  - Neglect (29%)
  - Physical (23%)
  - Emotional/Psychological (20%)
  - Financial (19%)
- Financial abuse has been declining over the last 3 years – from 27% in 2012/13 to 18% this year.
- Neglect has increased over the same 3 year period from 21% in 2012/13 to 29% this year.
- Organisational abuse has more than doubled from 2% to 5% from last year reflecting, we believe, an improved identification and investigation process. This increase is also reflected in Location of Abuse information which is also showing increases in Care Home (Res/Nurs) and Hospital location percentages and Alleged Perpetrator statistics showing an increase in abusers from Social Care Support.



- Location of Abuse

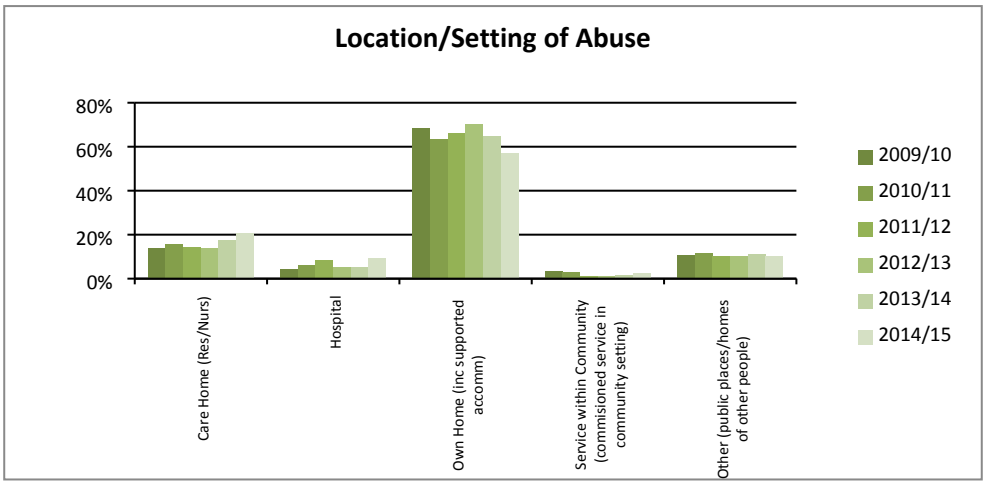
The categorisations for this option were reduced for SAR 13/14, so we have mapped previous year's options into the reduced options.

Percentages - Location/Setting	2009/10	2010/11	2011/12	2012/13	2013/14	2014/15
Care Home (Res/Nurs)	14%	16%	15%	14%	17%	21%
Hospital	4%	6%	8%	5%	5%	9%
Own Home (inc supported accomm)	68%	63%	66%	70%	65%	57%
Service within Community (commissioned service in community setting)	3%	3%	1%	1%	2%	3%
Other (public places/homes of other people)	11%	12%	10%	10%	11%	10%
Total	**100%**	**100%**	**100%**	**100%**	**100%**	**100%**

- Most alleged abuse occurred in "Own Home" (57%) although this is decreasing year on year since 2012/13.

- Alleged Abuse in Care Homes and Hospital locations has shown an increasing trend over the same period from 14% in 2012/13 to 21% this year in Care Homes and from 5% in 2012/13 to 9% this year for Hospitals.

This may not mean that more abuse is occurring within these institutions but may just be that recording/reporting of incidents has improved.



- Action under Safeguarding

This is a new question which was added to the SAR from 2013/14.

Percentages - Risk Action	2013/14	2014/15
No further action under Safeguarding	54%	21%
Action Taken - Risk Remains	8%	9%
Action Taken - Risk Reduced	32%	55%
Action Taken - Risk Removed	6%	15%
Total	**100%**	**100%**

- Last year we were concerned that 54% were recorded as “no further action” even though we were confident action would’ve been taken. We think this was a lack of understanding within the teams. This has decreased significantly to 21% this year, evidence of improved training and process changes therefore making more skilled staff.

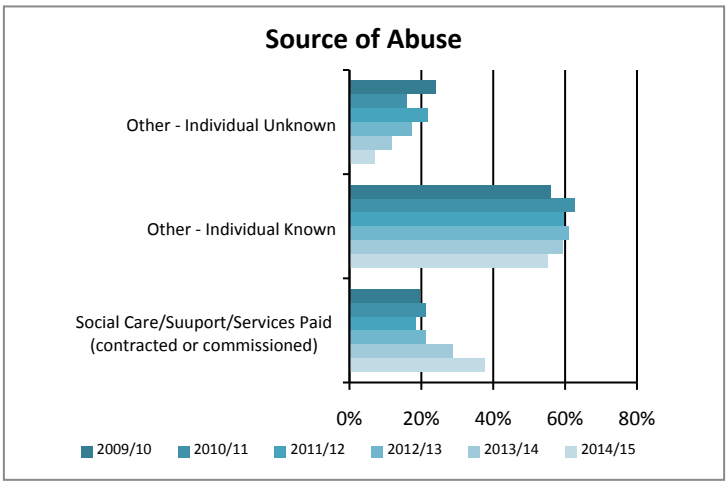
- “Risks Reduced” has increased significantly from 32% last year to 55% and “risk removed” has also increased from 6% to 15% this year.

- Source of Abuse

These options have been reduced for SAR (13/14) so we have mapped previous year’s options into the reduced listing for easier comparison. However there are 2 graphs at the end of this section looking at the options in a bit more detail.

Percentages - Source of Risk	2009/10	2010/11	2011/12	2012/13	2013/14	2014/15
Social Care/Support/Services Paid (contracted or commissioned)	20%	21%	19%	21%	29%	38%
Other - Individual Known	56%	63%	60%	61%	59%	55%
Other - Individual Unknown	24%	16%	22%	17%	12%	7%

Total	**100%**	**100%**	**100%**	**100%**	**100%**	**100%**

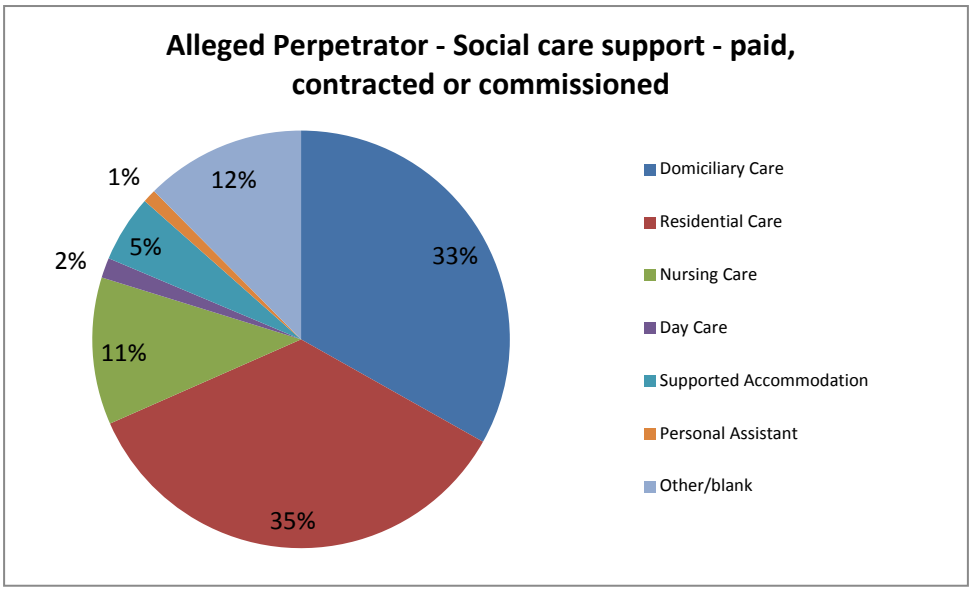


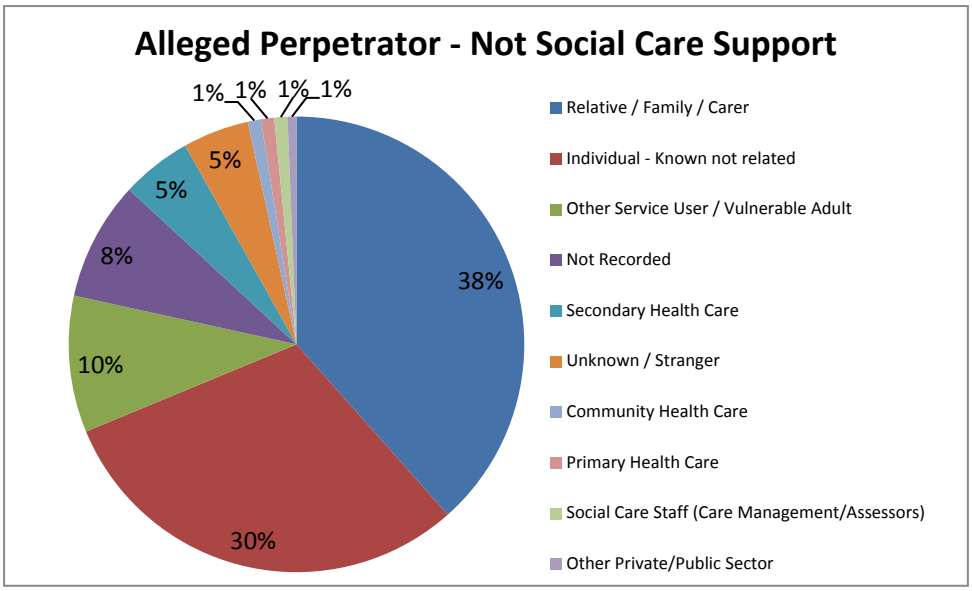
- The majority of alleged abusers are – known individual (55%) as in previous years, although this is showing a declining trend.

- Social Care/Support/Services Paid – has been increasing over the last 4 years from 19% in 2011/12 to 38% this year, which links in with the increase we have seen in care home abuse.

- Unknown Individual – has been decreasing over the last 4 years from 22% in 2011/12 to 7% this year. This is an improving picture which provides evidence of more consistent and tenacious work by our staff.

Below are two graphs breaking down the relationship of the alleged perpetrator in more detail.



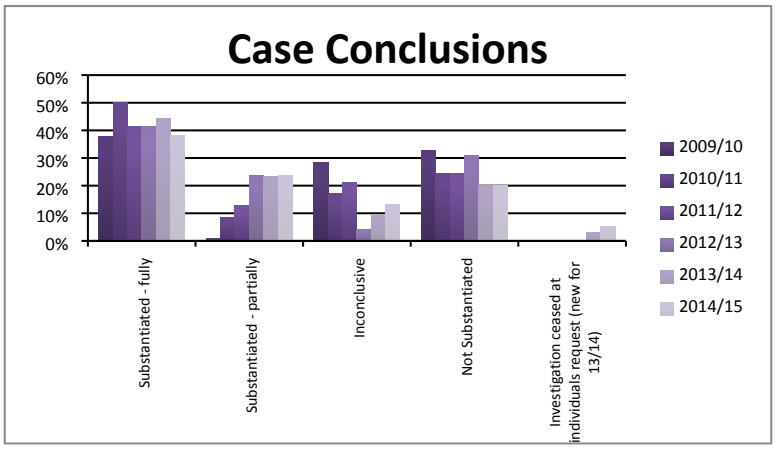


- Case Conclusion

This is no longer being counted in the return after this year. From next year we will be looking at Making Safeguarding Personal outcomes.

Percentages - Case Conclusions	2009/10	2010/11	2011/12	2012/13	2013/14	2014/15
Substantiated - fully	38%	50%	42%	42%	44%	38%
Substantiated - partially	1%	8%	13%	24%	23%	24%
Inconclusive	28%	17%	21%	4%	9%	13%
Not Substantiated	33%	24%	24%	31%	20%	20%
Investigation ceased at individuals request (new for 13/14)	0%	0%	0%	0%	3%	5%
Total	**100%**	**100%**	**100%**	**100%**	**100%**	**100%**

- Most cases were Substantiated fully (38%) although this is a decrease on last year's 44%.
- Inconclusive has increased over last 3 years from 4% in 2012/13 to 13% this year.

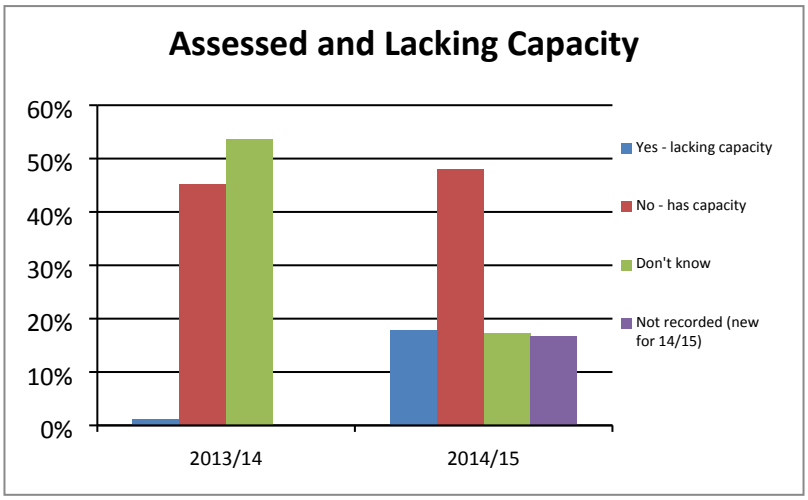


- Capacity

This is a new question added to the SAR from 2013/14. Not Recorded is a new categorisation added for this year (14/15).

Percentages - Capacity	2013/14	2014/15
Yes assessed and lacking capacity	1%	18%
No not assessed - has capacity	45%	48%
Don't know	54%	17%
Not recorded (new for 14/15)		17%
Total	**100%**	**100%**

- Most recorded as "Having Capacity" – 48%, similar to last year.
- Those lacking capacity has increased from 1% to 18% - we believe this to be better recording and understanding of this question from when it was introduced last year.
- "Don't knows" decreased significantly from 54% last year to 17% (although an additional 17% were not recorded at all this year).
- We expect this picture will continue to improve next year as renewed training on MCA takes effect.


Assessed and Lacking Capacity
60%
50%
40%
30%
20%
10%
0%
2013/14
2014/15
Yes - lacking capacity
No - has capacity
Don't know
Not recorded (new for 14/15)

West Berkshire Council Safeguarding Performance Executive Summary

1. Performance in 2014/2015 (based on SAR statutory reporting)

The data is sourced from the statutory SAR (Safeguarding Adults Return) for 2014/15. This is still provisional data as the DoH have not published the final cut and includes all episodes of alerts and referrals.

It should be noted that the data provided below for SAPB reports on safeguarding episodes to allow comparison with previous years reporting.

The data published in the SAR only reports on client numbers and can therefore not be directly compared.

With the introduction of the new SAC (Safeguarding Adults Collection) for 2015/16, and the SAB dashboard there will be greater consistency.

1.1 Volume of Episodes for Safeguarding Adults

The overall number of alerts and referral episodes has increased by 12% (707 in 2013/14 to 804 in 2014/15).

Alerts saw an increase in volume of 10% on the previous year (601 compared to 543 in 2013/14)

Referrals have increased by 19% in 2014/15; this is as a result of a higher number of alerts but also a higher conversion rate of alert to referral (34%). A higher alert to referral conversion rate suggests improved recording of alerts requiring referral stage 2 investigations.

Completed referrals as a percentage of all referrals was 82% this year compared to 76% last year.

Number of alerts, referrals and completed referrals over past 3 years

(includes repeat referrals)

	Alerts	Referrals	Total	Concluded Referrals	% Alerts leading to Referral
2012-13	630	202	832	176	***32%***
2013-14	543	164	707	125	***30%***
2014-15	601	203	804	167	***34%***
% increase from previous year	***10%***	***19%***	***12%***	***25%***	

Completed referrals are the number of referral and strategy meeting forms that have been closed within the reporting period. The completed referral total is often different from the total number of referrals because it can include those referrals opened in the previous reporting year that then end in the current reporting year.

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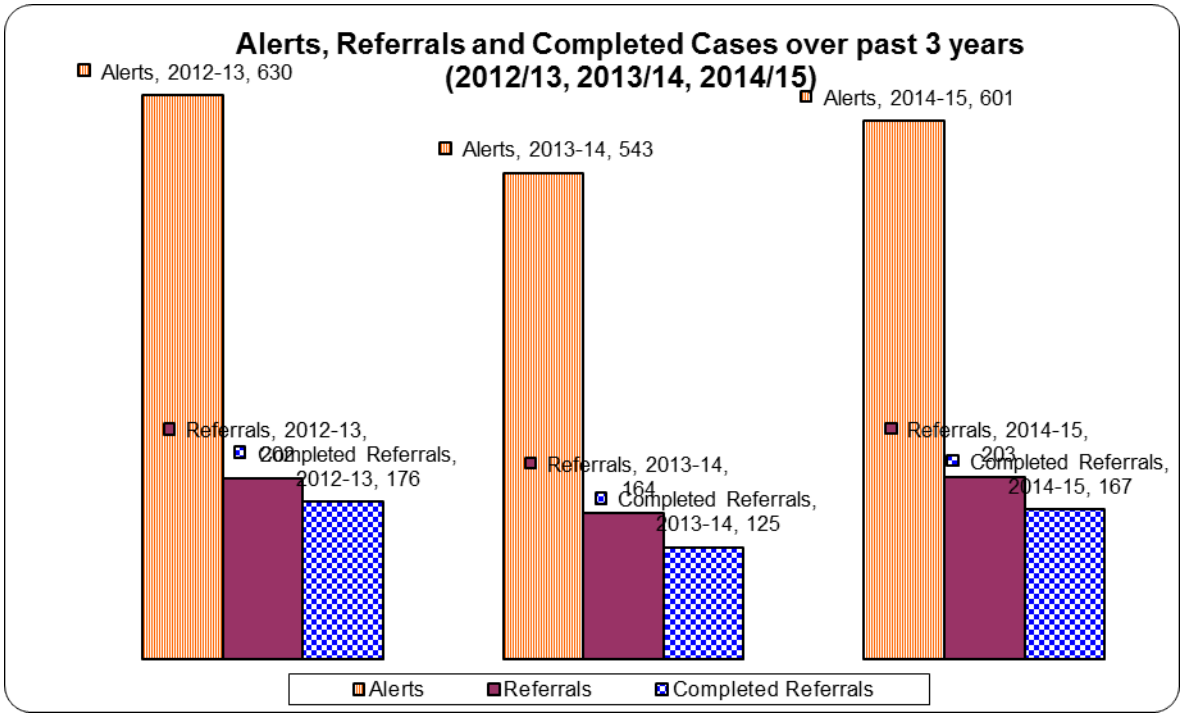


1.2 Alerts and Referrals by Age, Client Group and Gender

	2013/14			
Alerts and Referrals	18 - 64	65 and over	Total	%
Physical Disability	41	255	**296**	***42%***
Mental Health (excluding dementia)	50	35	**85**	***12%***
Dementia	4	161	**165**	***23%***
Learning Disability	83	5	**88**	***12%***
Other (inc Vul People and Substance Misuse)	30	43	**73**	***10%***
Total	**208**	**499**	**707**	
	29%	**71%**		

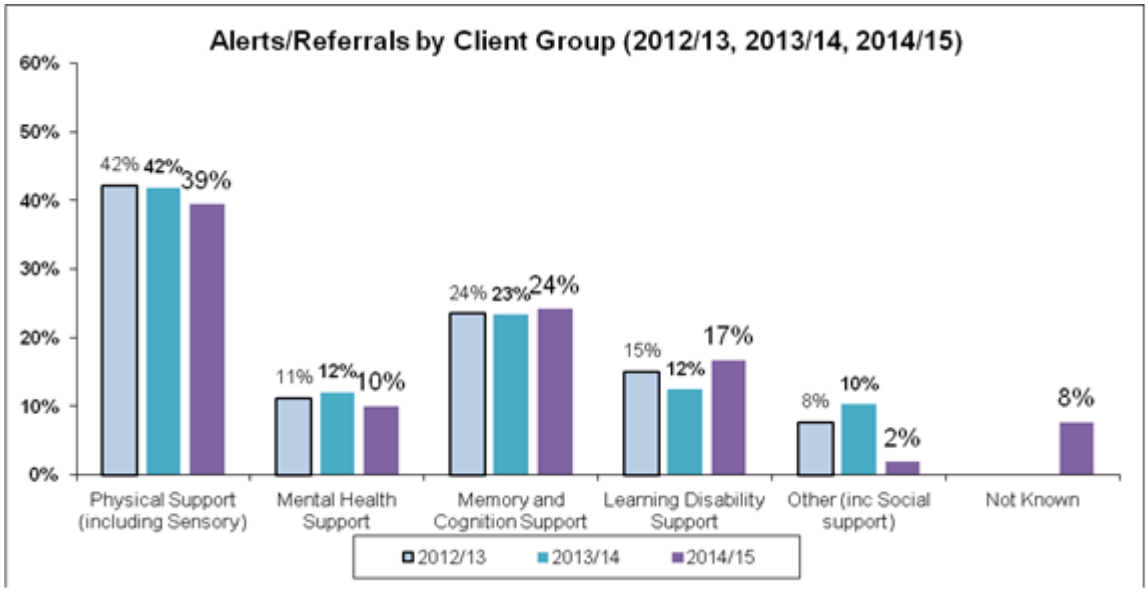
	2014/15			
Alerts and Referrals	18 - 64	65 and over	Total	%
Physical Support (including Sensory)	52	257	**309**	***39%***
Mental Health Support	38	41	**79**	***10%***
Memory and Cognition Support	5	185	**190**	***24%***
Learning Disability Support	109	22	**131**	***17%***
Other (inc Social support)	8	7	**15**	***2%***
Not Known	6	54	**60**	***8%***
Total	**218**	**566**	**784**	
	28%	**72%**		

Changes in statutory reporting means that we no longer report on 'Client group' and now report in relation to 'Primary Support Reason'. This distinction can be seen in the tables above.

In 2014/15:

Client Primary Support reason

- The highest percentage of alerts and referrals were in the physical support category which remains static compared to the previous year category of 'physical disability'.
- There has been an increase in the percentage of alerts / referrals from learning disability clients this year (17% compared to 12% in the previous year).
- The number of alerts/referrals by clients with a PSR of Memory and Cognition (previously under dementia) has increased – the proportion increased from 23% to 24%)



Age Group

- The number of alerts/referrals by age group 18-64 (28%) and 65+ (72%) has remained relatively static this year.

Gender

- The overall number of alerts/referrals by gender remains static, 40% male and 60% female.

	2013/14		
Alerts and Referrals	**Female**	**Male**	**Total**
18 - 64	111	97	**208**
65+	316	183	**499**
Total	**427**	**280**	**707**
	60%	40%	

	2014/15		
Alerts and Referrals	**Female**	**Male**	**Total**
18 - 64	121	101	**222**
65+	360	222	**582**
Total	**481**	**323**	**804**
	60%	40%	

1.3 Repeat Referrals

Referrals are classed as repeat referrals when they involve a separate incident about the same vulnerable adult within the same reporting period. A low level of repeat referrals can demonstrate effective resolution and risk management of issues.

The repeat referral rate this year was 11.3% compared to 9.8% in the previous year. A target of 8% or below was set for 2014/15 and although this has not been achieved, there is continued monitoring around the numbers of repeat referrals.

Further analysis of the repeat safeguarding referrals shows that this relates to a small number of individual that fall into three broad categories.

1. Chronic, multiple allegations where, for example a person with capacity continues to act unwisely with their finances and they prove difficult to engage / help or where a carer and cared for person continue to live together by choice but the carer has their own health or other problems that generate multiple expressions of concern.

2. Repeat referrals for the same incident are being reported by different agencies

3. Repeat referrals that are entirely unrelated, for example, the behaviour of a daughter towards her mother when visiting her in her care home and a minor assault on the mother by another resident of the care home.

Number of repeat referrals by age band of vulnerable adult

	18 - 64	65 - 74	75 - 84	85 and over	Total	% Referrals that are Repeats
2012/13	5	0	5	10	**20**	***9.9%***
2013/14	5	2	6	3	**16**	***9.8%***
2014/15	4	5	8	6	**23**	***11.3%***

Analysis of those repeat referrals on a monthly basis ensures patterns and trends are identified and acted upon at the earliest opportunity. However, it is recognised this is not a particularly useful measure of overall performance because of the uncontrollable nature of the client group. As a result, the Department of Health has decided this measure is no longer required from April 2015 and therefore it will not feature in future reports.

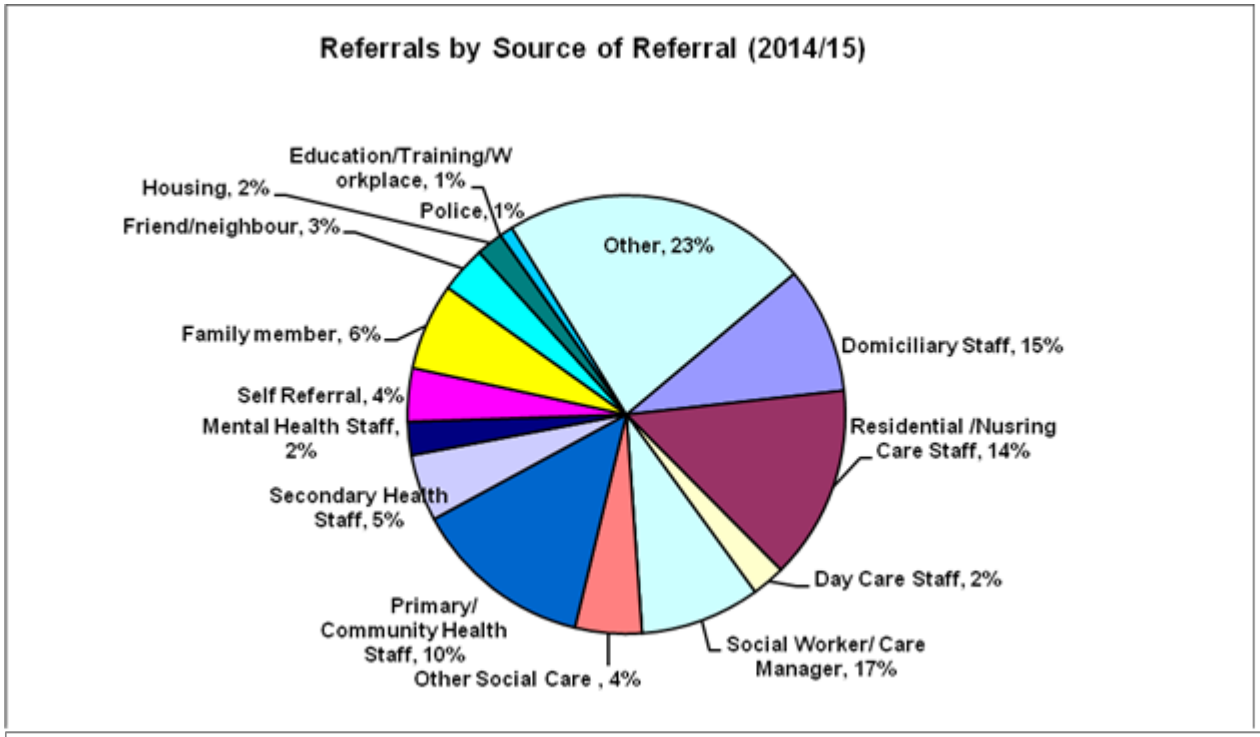
1.4 Referrals by Referrers/Source of Referral (who reported the concern)

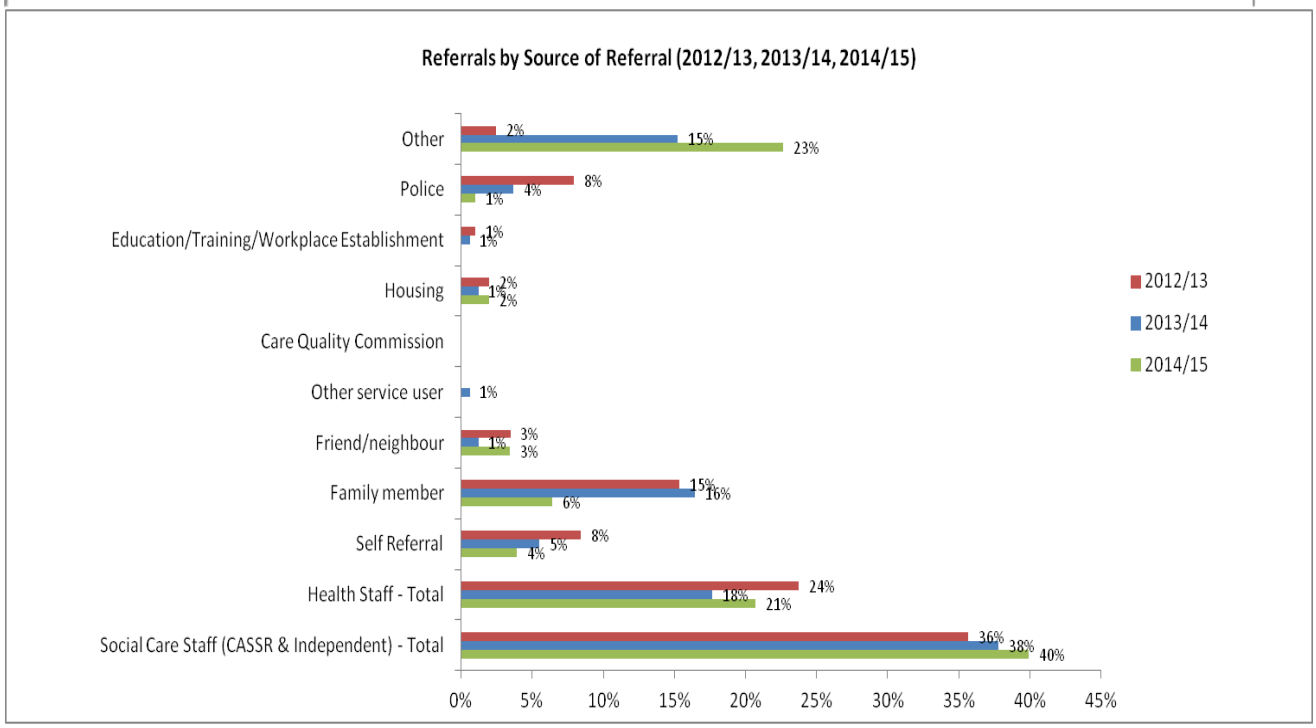
This year, there has been an increase in the number of referrals where the abuse was reported by Social Care staff (40% compared to 38% in the previous year) and a significant increase in the number of referrals reported by other sources (23% compared to 15% in the previous year). This increase may indicate that there is a wider awareness of safeguarding within the community.

The number reported by self, family, friends and neighbours has decreased this year (14% compared to 23% last year) and our referrals from the Police

have also decreased from 4% to 1% this year. The referrals from Housing have increased to 2% from 1% last year.

	Referrals	2012/13	2013/14	2014/15	*2012/13*	*2013/14*	*2014/15*
Social care staff	**Social Care Staff (CASSR & Independent) - Total**	**72**	**62**	**81**	***36%***	***38%***	***40%***
	of which: Domiciliary Staff	**15**	*21*	*19*	***7%***	***13%***	***9%***
	Residential /Nusring Care Staff	**35**	*14*	*29*	***17%***	***9%***	***14%***
	Day Care Staff	**5**	*5*	*5*	***2%***	***3%***	***2%***
	Social Worker/Care Manager	**9**	*18*	*18*	***4%***	***11%***	***9%***
	Self -Directed Care Staff	**0**	*2*	*0*	***0%***	***1%***	***0%***
	Other	**8**	*2*	*10*	***4%***	***1%***	***5%***
Health staff	**Health Staff - Total**	**48**	**29**	**42**	***24%***	***18%***	***21%***
	of which: Primary/Community Health Staff	**23**	*18*	*27*	***11%***	***11%***	***13%***
	Secondary Health Staff	**19**	*6*	*10*	***9%***	***4%***	***5%***
	Mental Health Staff	**6**	*5*	*5*	***3%***	***3%***	***2%***
Other sources of referral	**Self Referral**	**17**	**9**	**8**	***8%***	***5%***	***4%***
	Family member	**31**	**27**	**13**	***15%***	***16%***	***6%***
	Friend/neighbour	**7**	**2**	**7**	***3%***	***1%***	***3%***
	Other service user	**0**	**1**	**0**	***0%***	***1%***	***0%***
	Care Quality Commission	**0**	**0**	**0**	***0%***	***0%***	***0%***
	Housing	**4**	**2**	**4**	***2%***	***1%***	***2%***
	Education/Training/Workplace Establishment	**2**	**1**	**0**	***1%***	***1%***	***0%***
	Police	**16**	**6**	**2**	***8%***	***4%***	***1%***
	Other	**5**	**25**	**46**	***2%***	***15%***	***23%***
	Total	**202**	**164**	**203**			





1.5 Referrals by Alleged Abuse Type and Multiple Abuse

- Referrals reporting neglect has increased (31% this year compared to 25% in the previous year)
- Alleged psychological abuse has increased (19% psychological compared to 18% last year).
- Financial abuse has remained static at 17%

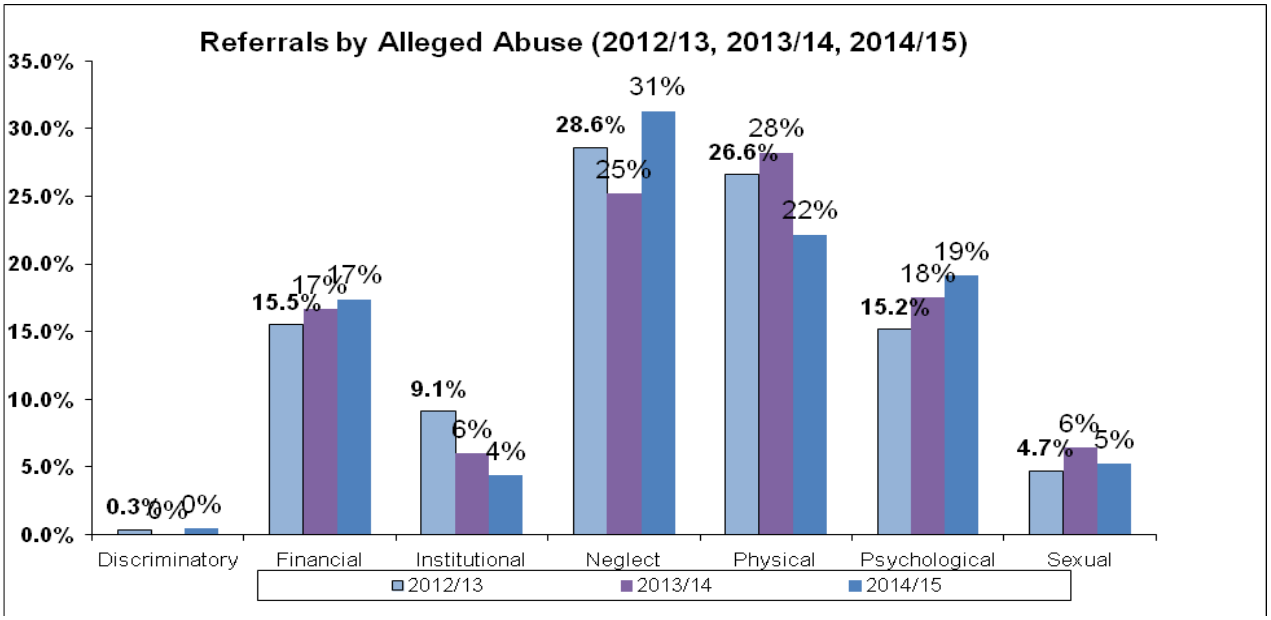
- Referrals reporting alleged institutional abuse has decreased this year (4% institutional compared to 6% last year)
- Physical abuse has also decreased from 28% to 22% in 2014/15

The two most prevalent types of abuse are **neglect** and **physical abuse,** closely followed by financial and psychological abuse. This is the same as the trend indicated in previous years.

Cases which recorded multiple abuses increased from 30% to 31% in 2014/15, indicating that there are a high number of referrals received by safeguarding which have an increased complexity (% calculated as a proportion of referrals started in the reporting period).

Number of Referrals by alleged abuse type

Referrals	**2012/13**	**2013/14**	**2014/15**	*% 2012/13*	*% 2013/14*	*% 2014/15*
Discriminatory	1	0	1	***0.3%***	***0%***	***0%***
Financial	46	39	40	***15.5%***	***17%***	***17%***
Institutional	27	14	10	***9.1%***	***6%***	***4%***
Neglect	85	59	72	***28.6%***	***25%***	***31%***
Physical	79	66	51	***26.6%***	***28%***	***22%***
Psychological	45	41	44	***15.2%***	***18%***	***19%***
Sexual	14	15	12	***4.7%***	***6%***	***5%***
Total Abuse	297	234	230			
Of which:- Multiple	69	50	63			

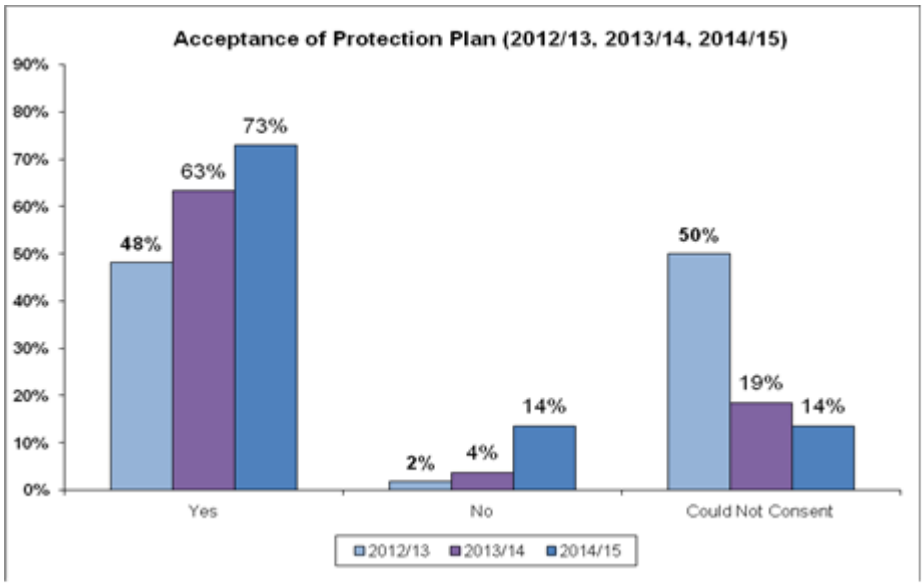


1.6 Acceptance of Protection Plans

The percentage of protection plans accepted by those with the capacity to consent is shown below. This demonstrates the level to which the adult at risk engages with the safeguarding process.

Acceptance of Protection Plan (completed referrals where plan offered)

Acceptance of Protection Plan?	*2014/15*	2013/14	2012/13
Yes	86	62	78
No	16	6	3
Could Not Consent	16	30	81
Total Plans	**118**	**98**	**162**
84.31% of protection plans offered where there was capacity to consent were accepted			



Theoretically, a high percentage indicates a high level of service user involvement in the risk management and decision making process in line with best practice for service user engagement. However, it is important to note that the numbers are small and so therefore can have a significant impact on the overall % figure. It is also important to note that not all successful safeguarding interventions result in a protection plan being offered and accepted.

With the new SAC return, protection plans will no longer be reported on and there is a move towards reporting on outcomes

Wokingham Annual Performance Report 2014-15

Executive Summary

Annual Performance Report 2014-15 Safeguarding Adults At Risk

Performance in 2014/2015 is based on SAR statutory reporting.

The data provided within this report is sourced from the Safeguarding Adults Return (SAR) for 2014/2015. The data is currently provisional pending Department of Health release of final publication.

Data provided within this report is for the purpose of the Safeguarding Adults Board to enable comparison with previous years reporting. Direct comparison cannot be achieved due to changes in reporting requirements however it is envisaged with the introduction of new Safeguarding Adults Collection requirements for 2015/2016 greater consistency will be achieved.

Volume of episodes for Safeguarding-Alerts and referrals

(Alerts are safeguarding concerns received by the Local Authority; Referrals are episodes which progressed into a Safeguarding investigation.)

Alerts and referrals

There were 868 alerts received by Wokingham Borough Council in 2014-15. 57% of these alerts progressed on to a referral (499 out of 868 alerts progressed to a part 2 investigation). There were 408 individuals who received a safeguarding referral in 2014-15.

Referrals increased by 13% in 2014-15 (499 compared to 441 referrals in 2013-14). The number of repeat referrals increased from 15% in 2013-14 to 18% this year.

	2012-13	2013-14	2014-15
Alerts		577	868
Referrals	812	441	499
Individuals who had referral	558	373	408
% of repeats	31%	15%	18%

Gender

61% of referrals started in the year were for females and 39% were for males. As with the previous year there were more referrals for females than males.

Age groups

The table below shows age groups for individuals referred in 2014-15 and the previous year. Following last year's trend there were more referrals from individuals aged 65 years or over than 18-64.

In 2014-15, 71% of referrals were from people aged 65 years or over. This is an increase from the previous year where 62% of referrals were from the 65+ age group.

Age band	2013-14	*% of total*	2014-15	% of total
18-64	143	38%	117	29%
65-74	31	8%	36	9%
75-84	81	22%	98	24%
85-94	106	28%	131	32%
95+	12	3%	23	6%
Age unknown	0	0%	3	1%
Grand total	373		408	

Ethnicity

85% of all individuals with referrals started in period were of white ethnicity and 2% were of other ethnic groups. 13% did not have any ethnicity recorded.

Primary support reason

For 2014-15 we have changed from the previous categorisation of primary client group (PCG) to primary support reason (PSR) so there are no direct comparisons with last year. The majority of people who had a referral in 2014-15 had a primary support reason of physical support or learning disability support. 48% of referrals were for individuals who had a primary support reason of physical support.

Primary support reason	Individuals	% of total
Physical support	197	48%
Sensory support	8	2%
Support with memory and cognition	69	17%
Learning disability support	99	24%
Mental health support	17	4%
Social support	6	1%
No support reason	12	3%
	408	

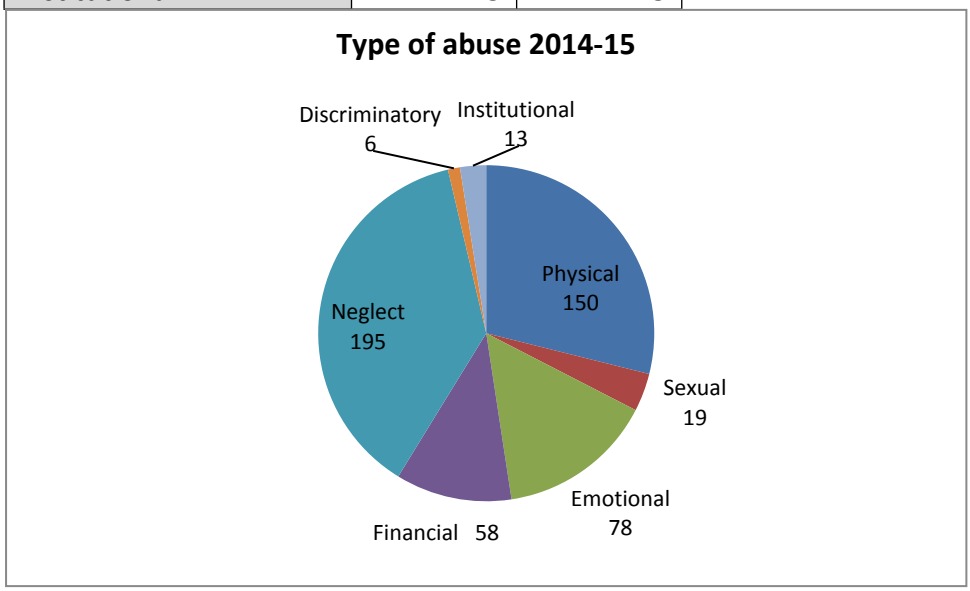
Reported health conditions

There were 11 people who had a safeguarding referral in 2014-15 with a reported health condition of Autism or Asperger's syndrome.

Type of alleged abuse

Referrals	2013-14	2014-15

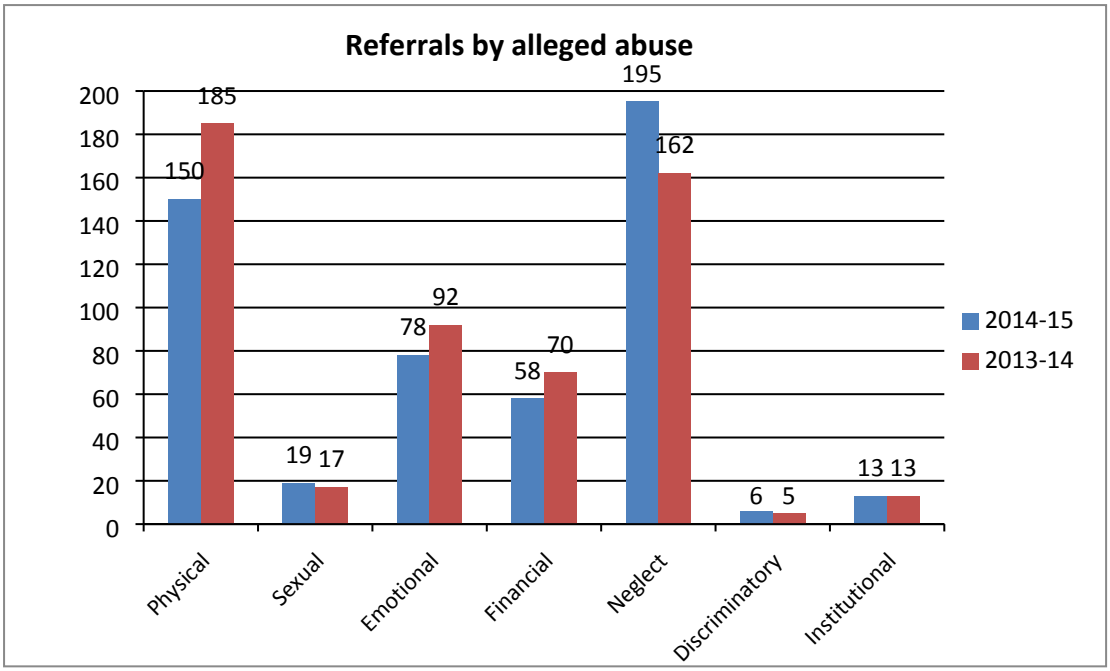
Physical	185	150
Sexual	17	19
Emotional/Psychological	92	78
Financial	70	58
Neglect	162	195
Discriminatory	5	6
Institutional	13	13



As with previous years the highest levels of alleged abuse remain in the physical and neglect categories.

- Referrals for physical abuse have decreased by 19% from previous year.
- Referrals for neglect have increased by 20% from previous year.

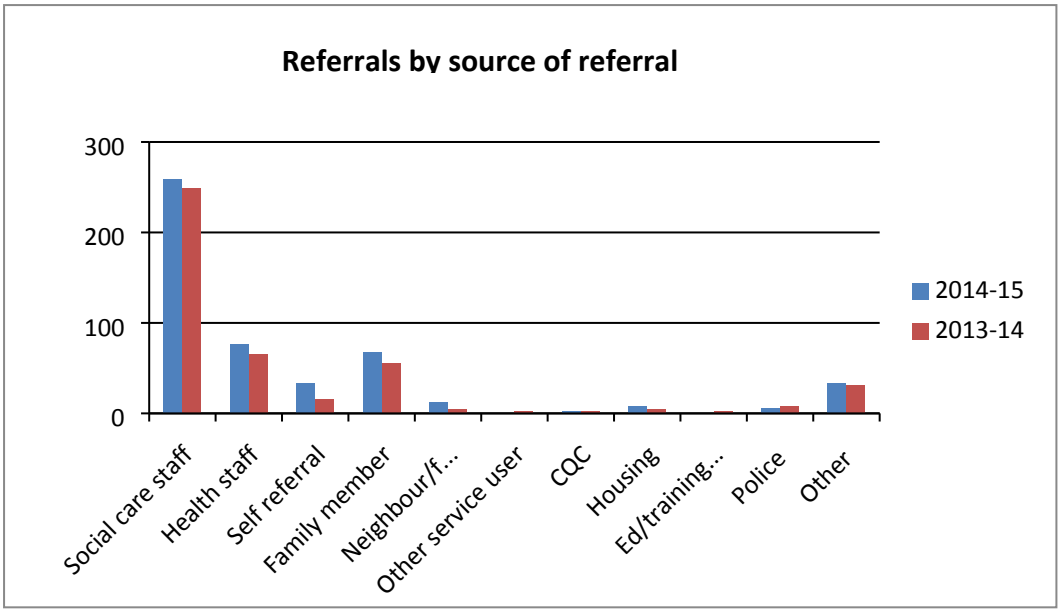
From 2015-16 four new voluntary categories will be added which will be domestic abuse, sexual exploitation, modern slavery and self-neglect. This may impact comparable data as some of these new categories may have been previously recorded under one of the other categories.



Referral Source

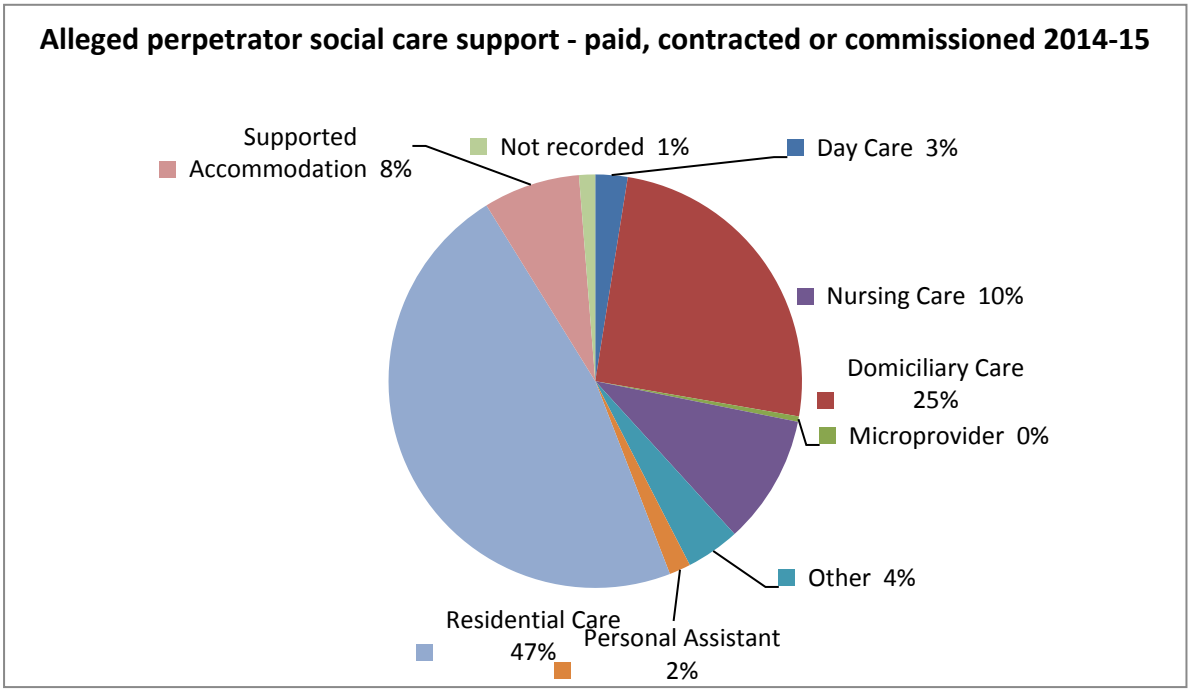
In 2014-15 52% of referrals were reported by social care staff and 15% were from health care staff. The number of self-referrals has increased this year (7% compared to 4% in 2013-14) showing an increasing awareness and leading to self-reporting of perceived abuse.

	Referrals	2013/14	2014/15
Social Care Staff	Social Care Staff total (CASSR & Independent)	249	259
	Of which: Domiciliary Staff	37	48
	Residential/ Nursing Care Staff	155	139
	Day Care Staff	12	21
	Social Worker/ Care Manager	25	25
	Self-Directed Care Staff	2	3
	Other	18	23
Health Staff	Health Staff - Total	65	77
	Of which: Primary/ Community Health Staff	41	38
	Secondary Health Staff	10	21
	Mental Health Staff	14	18
Other sources of referral	Self-Referral	16	33
	Family member	56	68
	Friend/ Neighbour	5	12
	Other service user	2	0
	Care Quality Commission	2	3
	Housing	5	8
	Education/ Training/ Workplace Establishment	2	0
	Police	8	6
	Other	31	33
	Total	**441**	**499**

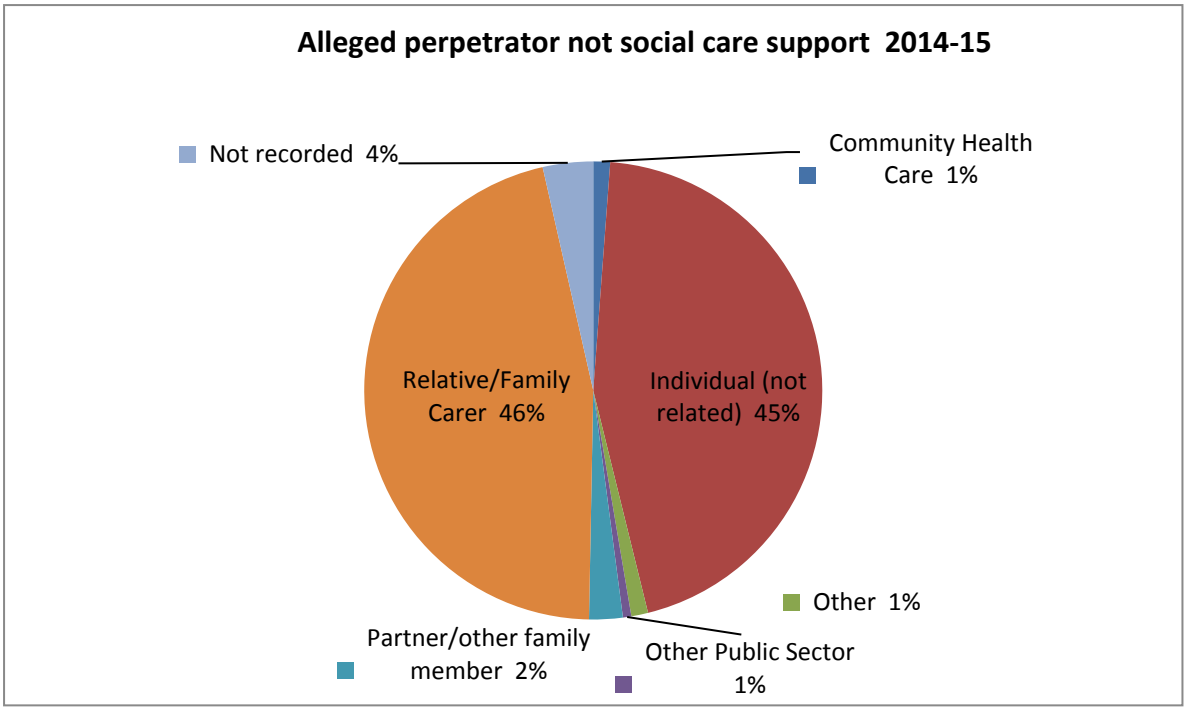


Alleged perpetrator

The chart below shows the service type where the alleged perpetrator was social care support and refers to any individual or organisation paid, contracted or commissioned to provide social care support.



The following chart shows where the alleged perpetrator was not paid, contracted or commissioned social care support.



Location of alleged abuse

The table below shows the location the alleged abuse was reported to have taken place for 2014-15. As with previous years the main locations where the alleged abuse took place was in the persons own home and care home.

Location of abuse	2013/14	2014/15
Care home	195	172
Hospital	6	5
Own home	166	195
Community service	38	17
Other	40	26

Case conclusions and outcomes

There were 407 concluded referrals in 2014-15.

The table below shows case conclusions for 2014-15 by result.

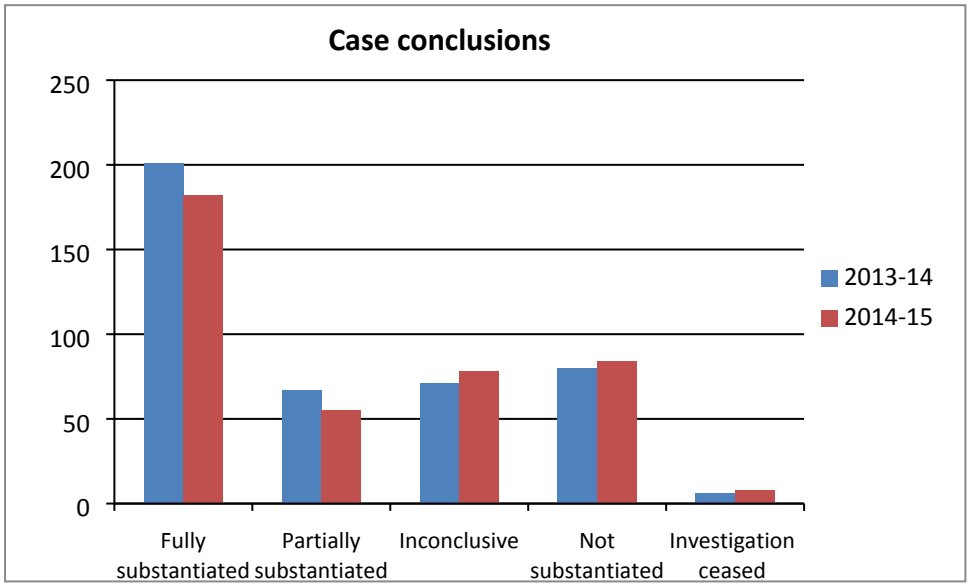
Result	2013/14	2014/15
Action Under Safeguarding: Risk Reduced	333	265
Action Under Safeguarding: Risk Removed	40	46
Action Under Safeguarding: Risk Unchanged	14	20
No Further Action Under Safeguarding	38	76
Total	425	407

In 2014-15, in 65% of referrals risk to the individual was reduced as a result of action taken.

The majority of cases in 2014-15 were fully substantiated. However this is a decrease from last year's figures (45% of cases were fully substantiated in 2014-15 compared to 47% last year).

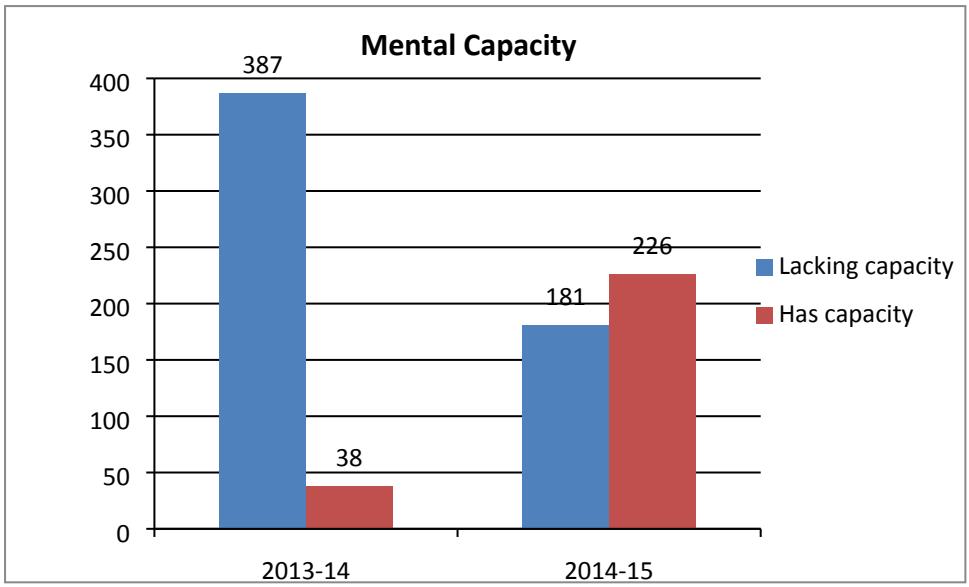
Conclusion	2013-14	2014-15
Fully substantiated	201	182
Partially substantiated	67	55
Inconclusive	71	78
Not substantiated	80	84
Investigation ceased	6	8

The chart below shows that the number of cases not substantiated has increased slightly from 19% last year to 21% in 2014-15.



Mental capacity

Of the 407 concluded referrals in 2014-15, there were 181 referrals where the individual lacked capacity.



Of those lacking capacity in 2014-15, 76% of individuals were provided support by an independent advocate, friend or family member. This is an increase from 32% last year, it is likely that is a result of focused training and awareness raising of requirements under the Mental Capacity Act 2005.