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Notice of Meeting

Health and Wellbeing Board

Thursday, 24th March, 2016 at 9.30 am

in Council Chamber Council Offices
Market Street Newbury

Date of despatch of Agenda: Wednesday, 16 March 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 or e-mail: joanna.reeves@westberks.gov.uk

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

West Berkshire COUNCIL

To: Dr Bal Bahia (Newbury and District CCG), 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 (Policy Officer) and Councillor Gordon Lundie (Council Member)

Agenda

Part I

Page No.

1 **Apologies for Absence**
To receive apologies for inability to attend the meeting (if any).

2 **Minutes** 7 - 16
To approve as a correct record the Minutes of the meeting of the Board held on 28 January 2016.

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

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

5 **Declarations of Interest**
To remind Members of the need to record the existence and nature of any Personal, Disclosable Pecuniary or other interests in items on the agenda, in accordance with the Members' Code of Conduct.

6 **Public Questions**
Members of the 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

8 **Annual Report of the Director of Public Health (Lise Llewellyn)** 21 - 50
Purpose: To present the Annual Report from the Director of Public Health

Systems Resilience

9 **Health and Social Care Dashboard (Tandra Forster/Shairoz Claridge/Rachael Wardell)** 51 - 54
Purpose: To present the Dashboard and highlight any emerging issues.

10 **Mental Health Street Triage Briefing Report (Shairoz Claridge/Jason Jongali)** 55 - 58
Purpose: To provide an update for the Board.

Integration Programme

11 **Better Care Fund: Guidance and process for 2016/17 and wider integration programme (Tandra Forster/ Shairoz Claridge)** 59 - 66
Purpose: to keep the Board up to date on the BCF and wider integration programme and to inform the Board of the process for 2016.

Health and Wellbeing Strategy/Joint Strategic Needs Assessment

12 **Joint Strategic Needs Assessment and the District Needs Assessment (Lesley Wyman)** 67 - 104
Purpose: To present a snapshot of the JSNA, which includes any changes the Board needs to be aware of.

Commissioning Plans

13 **Alignment of Commissioning Plans and Local Account (Tandra Forster/Shairoz Claridge/Lesley Wyman)** 105 - 116
Purpose: To inform the Board where commissioning alignment is already taking place; what plans are for the coming year; where efforts could be improved; what the challenges are and how the Health and Wellbeing Board can help influence this work.

Public Engagement

14 **Community Engagement Event (Dr Bal Bahia)** 117 - 130
Purpose: To update the Board on the community engagement event with the voluntary sector that took place in December.

Other information not for discussion

15 **Joint Agreement in respect of operational arrangements for children and young people with Special Educational Needs and Disabilities (SEND) aged 0 to 25 years (Jane Seymour)**

16 **Beat the Street (Maureen McCartney)**

17 **BHFT Quality Account Q3 2015/16**

18 **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.

a **Question to be answered by the Executive Member for Health and Wellbeing submitted by Councillor Gordon Lundie**
"Is there any assessment of the demand and the suitability of West Berkshire Community Hospital to provide expanded oncology services that would allow patients currently treated in the Royal Berkshire Hospital to be cared for close to home?"

b **Question to be answered by the Executive Member for Health and Wellbeing submitted by Councillor Gordon Lundie**

"Was there a plan to use the upper floor of West Berkshire Community Hospital (I understand it has been recently refurbished) to provide extra remote oncology care for patients normally treated at the Royal Berkshire Hospital?"

c **Question to be answered by the Executive Member for Health and Wellbeing submitted by Councillor Gordon Lundie**

"Who would own the commissioning of additional remote oncology service if we wanted to further investigate this development?"

19 **Future meeting dates**

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

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, 28 JANUARY 2016

Present: Dr Bal Bahia (Newbury and District CCG), Dr Barbara Barrie (North and West Reading CCG), 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) and Shelly Hambrecht (Empowering West Berkshire) (Substitute in place of Leila Ferguson)

Also Present: Lesley Wyman (WBC - Public Health & Wellbeing), Tandra Forster (WBC - Adult Social Care), Shairoz Claridge (Newbury and District CCG) and Dr Angus Tallini (GP Clinical Lead NDCCG)

Apologies for inability to attend the meeting: Leila Ferguson

PART I

67 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.

Councillor Graham Jones declared an interest in all agenda items by virtue of the fact that he was a Pharmaceutical Director in Lambourn but reported that, as his interest was personal and not prejudicial or a disclosable pecuniary interest, he determined to remain to take part in the debate and vote on the matters where appropriate.

Andrew Sharp declared an interest in any items that might refer to South Central Ambulance Service due to the fact that he was the Chair of Trustees of the West Berks Rapid Response Cars (WBRRC), a local charity that supplied blue light cars for ambulance drivers to use in their spare time to help SCAS respond with 999 calls in West Berkshire, and reported that, as his interest was personal and not prejudicial or a disclosable pecuniary interest, he determined to remain to take part in the debate and vote on the matters where appropriate.

68 Minutes

The Minutes of the meeting held on 26th November 2015 were approved as a true and correct record and signed by the Chairman subject to the following amendments:

- Jo Karasinski be included in the list of attendees.
- References to ‘Jo Karsinski’ on page 11 of the agenda that were misspelt be corrected to read ‘Jo Karasinski’.

69 Health and Wellbeing Board Forward Plan

The Health and Wellbeing Board noted the forward plan.

Lise Llewellyn asked that the Director of Public Health's Annual Report be added to the forward plan for the next meeting on 24th March 2016.

70 Actions arising from previous meeting(s)

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

71 Public Questions

There were no public questions received.

72 Petitions

There were no petitions presented to the Board.

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

The Board considered Agenda Item 8, concerning the Health and Social Care dashboard, designed to demonstrate system resilience, 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 had since been updated 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 although performance was reported as 88%, there had been a slight improvement since the data was provided for the dashboard and performance was now at 89%. Tandra Forster explained that the indicator referred to a small cohort of people, this meant that even a small change could impact the ability to meet the target.

(Hilary Cole joined the meeting at 9.09am)

(Councillor Roger Croft joined the meeting at 9.10am)

AS3: Average number of Delayed Transfers of Care which are attributable to social care per 100,000 population (18+): Tandra Forster reported the Delayed Transfers of Care (DToC) information referred to the previous quarter, more recent data showed that performance had improved and this should show in Q3.

(Cathy Winfield joined the meeting at 9.11am)

Tandra Forster advised that nationally, the number of patients attending hospitals was increasing, placing all hospitals under pressure. The Council's performance with Royal Berkshire Hospital (RBH) was strong, benefitting from implementation of the Joint Care Provider and seven day working. DToC information showed that there were particular issues with delay at North Hants Hospital. Analysis of the data highlighted the primary reasons for delays were lack of capacity in both homecare and nursing/residential.

Shairoz Claridge introduced the acute section of the dashboard.

AS1: 4-hour A&E target – total time spent in the A&E department: Shairoz Claridge reported that the figures from October 2015 had been presented to the Board. Performance over the Christmas and New Year period had been better than expected with good patient flow. The year-to-date figure was 95.6%. The Royal Berkshire Hospital (RBH) had achieved the target in the last quarter and efforts were being made to ensure the RBH maintained it.

A remedial action plan was in place to address under performance at North Hants and Great Western Hospital, with Great Western Hospitals NHS Foundation Trust achieving 93.3% against the 95% target. In line with the contractual process, Clinical

Commissioning Groups (CCG) were to withhold 2% of the contract value (from December 2015 onwards). Cathy Winfield added that she hoped the impact of the action plan would soon be realised.

AS2: Average number of Delayed Transfers of Care (all delays) per 100,000 population (18+): Shairoz Claridge reiterated that the system was working well. Cathy Winfield commended the system for its performance against this measure and agreed that the issue was being caused by the outsourced parts.

Councillor Hilary Cole enquired how the other hospitals might be brought up to the same level as the Royal Berkshire Hospital and questioned the effectiveness of a fine rather than increased support. Tandra Forster replied that only one hospital had used fines and discussions were being held to resolve this. She added that if those discussions were not successful, a letter from the Health and Wellbeing Board might be required.

Tandra Forster advised that the delays in general related to a very small cohort of people living in border areas of the district who the local authority struggled to get the appropriate care for. She identified that improvements were needed with North Hants, whose system resilience group was not a strong as West Berkshire's. Shairoz Claridge added that 40% of Newbury patients were admitted to North Hants hospital but Delayed Transfers of Care was in single figures.

Dr Barbara Barrie enquired whether the matter could be escalated to the Thames Valley level; Tandra Forster replied that the Health and Wellbeing Board could address the issue with the hospital, however the other networks might be helpful.

AS5: Ambulance Clinical Quality – Category A 8 Minute Response Time – Red 2: Shairoz Claridge reported that that performance was green against target for the first time However 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 had been agreed with South Central Ambulance Service (SCAS)as a result of the contract performance notice and this forecasted recovery in performance from March onwards. The Trust had started the National Ambulance Response Programme (NARP) pilot in October which allowed 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 would review the impact on performance and re-profile the trajectory as necessary.

AS6: A&E Attendances: Shairoz Claridge explained that these figures were not RAG rated and since providing the data for the dashboard, the Royal Berkshire Hospital had received 300 further admissions. She reported that the RBH had coped well with these extra admissions.

Shairoz Claridge, in introducing the Primary Care indicators, explained that full delegation would be in place from 1st April 2016. On-demand General Practitioner (GP) appointments were still a work in progress.

Councillor Roger Croft asked that the fines from North Hampshire be considered at a future meeting of the Board in order to consider a way forward. Councillor Cole agreed that a letter from the Board should be sent to express its concerns.

It was agreed that the Children's Social Care section would be discussed once Rachael Wardell had joined the meeting.

RESOLVED that

- the Health and Wellbeing Board noted the dashboard.

- Tandra Forster to write a letter to be sent to Hampshire Hospital Foundation Trust and to be signed by the Chairman on behalf of the Health Wellbeing Board regarding the fines imposed by north Hants CCG in respect of the DToC target.

74 Primary Care Strategies (Cathy Winfield/Angus Tallini/Rupert Woolley)

(Councillor Mollie Lock joined the meeting at 9.25am)

Cathy Winfield introduced the report (Agenda Item 9) which presented the Berkshire West Primary Care Strategy for 2015-2019.

An engagement report would also be published which would describe how the strategy had been informed by extensive discussion with patients through public meetings, dissemination of information about its vision and an 18 week online consultation.

The Clinical Commissioning Groups (CCGs) also wanted to highlight that they had applied to move to a fully delegated co-commissioning arrangement with effect from 1st April 2016. It was believed that this would have a positive impact on the development of local primary care services, and put CCGs in a stronger position to implement the vision described in the strategy.

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

There was an emerging consensus locally that a clinically and financially sustainable health economy could best be delivered through the creation of an Accountable Care System (ACS), ultimately functioning 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.

The strategic context mirrored the national picture, essentially being an ageing population and an increase in consultation rates.

Other key pressures related to General Practitioner (GP) recruitment and retention. Although training places were full, Primary Care was struggling to retain GPs as they increasingly applied to work abroad or move to a part of the country where living cots were lower. There were also trends for increased part-time working among female members of staff and trainees, in addition to an ageing workforce who would be reaching retirement age in five to ten years.

Patients had been consulted on their views and they had contributed that they would welcome online services and would like Saturday morning appointments.

The strategic objectives were to address pressures in the system, work with specialists usually in the secondary sector (such as with diabetes), taking a more preventative role, using technology to allow information sharing and mobile working and finally, consistently referring to other services where required.

Angus Tallini echoed the positive approach to resolving some of the issues that had been identified and outlined four strands of action being taken locally.

(Rachael Wardell joined the meeting at 9.32am)

Firstly, motivated patients with long-term health conditions would be enabled to mange their own care. Patients with such conditions often had a better understanding of their needs than their GP so lessons would be learnt from the approach to diabetes and

ownership of care would be shifted onto patients. The result would be that GPs had more time for undiagnosed and acute issues.

Secondly, a wider workforce would be developed to support primary care staff. It had been identified that other healthcare professionals were not utilised as much as they could be .For example, a pilot had been undertaken where a pharmacist had been utilised in a GP surgery to handle enquiries about medication, explain side effects and monitor those on high risk medications. It was also thought that physiotherapists could be integrated into the practice.

Thirdly, collaboration among smaller clusters of practices would link into the Accountable Care System.

Finally, a Training Hub was proposed to Health Education England to address local recruitment and retention problems across many areas of health care. A new Healthcare Coordinator Level 3 NVQ would be developed to ensure clerical staff had organisational and healthcare knowledge. Steps would also need to be taken to raise the profile of the area.

Councillor Jones thanked Cathy Winfield and Angus Tallini for clear data presentation in the report. He agreed that for too long there had been an emphasis on giving care but not explaining care. Councillor Jones added that he would be pleased to see the involvement of the pharmacist in a GP practice be developed and welcomed the proposals regarding the training hub.

Councillor Cole advised that she would like to see West Berkshire's social work academies be involved in the training hub as social workers had a role in healthcare and she would not want to see duplication. She added that the CCGs should engage with the Director of Communities to see whether there was any synergy between the two and whether economies of scale could be achieved.

Councillor Cole expressed the view that the proposed Level 3 NVQ should include an element of customer care because patients expected a level of service and in order to get patients out of the habit of seeing their GP, that service had to be consistently high across the practice.

Additionally, Councillor Cole asked if there was any scope to contractually oblige GPs to remain in service for a period of time following the completion of their training. Cathy Winfield advised that Health Education England funded the training so such a requirement would not be legally enforceable. Dr Barbara Barrie commented that there was a national problem of second and third year doctors leaving the NHS, with 600 applications per week to work abroad, although she noted that this was in part due to the national debate regarding junior doctors' contracts. Dr Bal Bahia observed that in order to achieve a happy and motivated workforce, there needed to be incentive rather than deterrent. Lise Llewellyn concurred that doctors were trained under a national process and budget and they could not be 'tied in' under Human Resources law.

Andrew Sharp noted that the workforce retention issue was reminiscent of the teacher recruitment and retention problem, and asked whether giving doctors key worker status might assist with their costs of living. He also outlined that the communication to the public of the different way of work would need to be clear as they might not understand the role, for example, or the pharmacist other than dispensing medication. Councillor Lynne Doherty agreed that a communications exercise on the integration of health and social care would be required to support the strategy.

Cathy Winfield informed the Board that while face-to-face communication would be the richest way to communicate the message, a short film was in production which would

include interviews with different healthcare professionals explaining their roles. Councillor Doherty proposed that these films be played in GP surgeries.

Dr Bahia expressed his excitement in the idea of a training hub which extended to back office roles because it would enrich understanding of the roles of other healthcare professionals.

Dr Barrie offered a perspective from the North and West Reading CCG. She reported that there were similar problems with training and recruitment, drawing particular attention to Physician's Assistants which was not well funded and required a large time commitment. There had been successful programmes such as the Living Well project and Beat the Street which has achieved positive outcomes including sustained levels of exercise. There was a concern that many GPs would be retiring over the next five to ten years so alongside measures to persuade them to keep working, GP surgeries would be asked to alert the Lead Commissioner in order for remedial action to be taken.

Dr Barrie continued that a GP in Reading had spent some time in Newcastle to gain an understanding of their new transformed care model which included patients receiving longer appointments. A generic model for care plans had been developed and the project had seen increased job satisfaction among GPs.

Rachael Wardell identified that a connection between this work and the frail and elderly pathway was essential in order to combat increasing consultation rates from the older population.

RESOLVED that the report be noted.

75 Urgent and Emergency Care Review 'Safer, Better, Faster' (Maureen McCartney)

The Board considered a report (Agenda Item 10) concerning "The Urgent and Emergency Care Review" (referred to as the Review*)* which proposed a fundamental shift in the way urgent and emergency care services were provided, and would be the first major practical demonstration of these new models of care. Cathy Winfield explained that the public were confused about what services they should be accessing; an issue which the Review sought to clarify.

The vision was:

- 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.

The Strategy set the expectation that the NHS 111 Service would be the 'front-door' to accessing urgent and emergency care however it would have an increased input from a range of clinicians.

Connected records would also be essential to connected care as patients progressed to different professionals. A better link between A&E and the Out-of-hours service would make a difference.

It was also proposed that the NHS 111 service could directly book an appointment with a patient's GP in order to improve confidence in the system.

There was due to be re-procurement of the Thames Valley NHS 111 service. Following publication of the new commissioning standards for integrated urgent care in October 2015 it was agreed that this work should move to the commissioning of an integrated NHS 111/Urgent Care Service for Thames Valley. This would offer patients who required

it immediate access to a wide range of clinicians, both experienced generalists and specialists. The procurement would be undertaken using the most capable provider model, with phase two of the procurement engaging in a dialogue about how the system would be shaped.

RESOLVED that the Board noted the report.

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

Rachael Wardell introduced the Children's Social Care section of the Dashboard. She outlined that although the data reported on the dashboard was from quarter two (and therefore the same as had been reported at the previous meeting) there had been change in the measures.

CSC1: The number of looked after children per 10,000 population: Rachael Wardell reported that latest figures had indicated that there were now 46 looked after children per 10,000 populations which was a move in the right direction.

CSC2: The number of child protection plans per 10,000 population: Child Protection enquiries had increased; concurrently the number of child protection plans per 10,000 population had increased from 37 to 41.

CSC3: The number of Section 47 enquiries per 10,000 population: Rachael Wardell reported that there remained a high volume of Section 47 enquiries per 10,000 but a review of Section 47 thresholds had given assurance that the appropriate threshold was applied.

CSC4: To maintain a high percentage of (single) assessments being completed within 45 working days: Performance against this indicator was now recorded as being 83%.

CSC7: Percentage of LAC with Health Assessments completed on time: Rachael Wardell announced that latest data had revealed that performance was now at 93% against the indicator which represented a great improvement. Work would continue to pursue getting this figure to 100% and the service was now turning its attention to the percentage of dental assessments completed on time.

Councillor Jones commented that the improvements were a good step forward.

RESOLVED that the Children's Social Care section of the dashboard be noted.

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

The Board considered a report (Agenda Item 11) which provided an update on the Better Care Fund (BCF) and wider integration programme.

Tandra Forster reported that work was underway on all of the schemes in the West Berkshire BCF programme. Although the two locality projects were currently rated as amber, only one required remedial actions and these had been agreed.

Tandra Forster drew attention to Personal Recovery Guides which were being piloted in the voluntary sector 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 had staff and volunteers in place to deliver this service and had 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. Take up of the service during this short pilot phase had been gradual as it was taking time for it to become known about. It was felt that the delay in project implementation would mean there would be insufficient data on which to confidently

design a service going forward. For this reason the West Berkshire Locality Board had taken a decision in principle to extend the pilot for a further three months, subject to successful negotiations with the providers regarding the terms of the extension.

Tandra Forster went on to report that the Department of Health had confirmed that there would be a BCF for 2016/17. The timetable was proving to be very challenging with the outline financial planning needing to be submitted by the 8th February 2016; however the technical guidance had not yet been received. Shairoz Claridge added that two new national conditions had been applied regarding Delayed Transfers of Care and integrated working. Tandra Forster reported that the Integrated Health and Social Care Hub was being successfully utilised by professionals.

Shairoz Claridge reported that the Rapid Response and Treatment team had received 15 referrals and conducted between six and eight reviews per session.

In response to a question from Councillor Cole, Tandra Forster advised that analysis had been undertaken to identify care homes responsible for the highest numbers of non-elective admissions. Five had been selected in West Berkshire and the impact of project was being monitored closely. Councillor Cole requested that monitoring reports come to the Board, Shairoz Claridge advised that the data was captured in the Highlight Reports.

Dr Barrie offered an example of the value of the Rapid Response team when called to a care home between Christmas and New Year. She advised that they had excelled in compiling comprehensive notes, working with the patient's family in order to enable swift decision making. Dr Barrie commented that the care home manager's main concern in that situation was the staffing pressures that might be caused in order to care for the patient in the care home.

Lise Llewellyn commended the progress that had been reported and commented that the papers provided were confusing as they included projects under Wokingham Borough Council. Tandra Forster advised that historically the Board had requested these to be reported but in the future the high level report and the two locality reports could be presented to the Board.

RESOLVED that the progress report be approved.

78 Governance for the Health and Wellbeing Board (Nick Carter)

The Board considered a report (Agenda Item 12) which 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.

Nick Carter noted that the first proposal was to merge the West Berkshire Locality Board and the Health and Wellbeing Management Group, offering the view that there was shared membership so in addition to some time savings, there could be benefit to the integration agenda. The chairing arrangements of the Locality Group would be maintained.

The second proposal was to alternate between public and private meetings of the Board from April 2016 in order to encourage a less inhibited discourse. The forward plan would need to be shaped in order to accommodate the alternation of meetings.

Councillor Doherty commented that the report accurately reflected the development session.

Dr Bahia enquired whether the steering group chairing arrangements could alternate or be shared with the Clinical Commissioning Groups (CCGs) operational director. Tandra Forster responded that it was felt there needed to be representation of the Council and the delivery groups. Shairoz Claridge contributed that she suggested a Co-Chairing arrangement; the amendment of the terms of reference had been deferred. Cathy Winfield reported that Reading and Wokingham's Locality Boards were Co-Chaired, which she thought would be an acceptable arrangement for West Berkshire.

RESOLVED that

- **As from April 2016 the current West Berkshire Locality Board and Health and Wellbeing Management Group be disbanded and replaced by a single West Berkshire Health and Wellbeing Steering Group.**
- **That the Terms of Reference for the new group reflect those of the two extant groups and that membership of the new group was drawn from the two current groups. The new group would meet monthly and be chaired by the current chair of the West Berkshire Locality Board.**
- **A more detailed governance paper be prepared by the Policy Officer supporting the Board and that this be considered at the first meeting of the new Steering Group.**
- **As from April 2016 meetings of the Board be 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.**

79 New Health and Wellbeing Priorities (Tandra Forster/Lesley Wyman/Mac Heath/Shairoz Claridge)

The Board considered a report (Agenda item 13) which recommended that the Board agree 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.

Lesley Wyman advised that these proposals had come out of the development session held in November 2015, where it was identified that there were a large number of priorities that could be grouped in order to focus the work around them.

The priorities for 2016/17 would be:

1. Mental health and wellbeing in children and young people and adults (including social isolation)
2. Older people living independently (including Long term conditions, falls prevention and dementia)

The priorities for 2017/18 would be:

1. Cardiovascular disease and cancer pathways (incluings all preventative work in the current priorities: healthy eating, weight management, physical activity, smoking and alcohol).
2. Health and wellbeing of carers including young carers.

Lesley Wyman reported that she had seen the position statement of Milton Keynes' Health and Wellbeing Board which put forward its priorities as:

1. Starting Well
2. Living Well
3. Ageing Well

Councillor Jones commented that these principles would be common to all Health and Wellbeing Boards and by focussing on certain aspects, there was likely to be greater impact.

Cathy Winfield sought to reiterate the appropriateness of the priorities for 2016/17 as they connected to the work of the frail elderly pathway for older people and the 'Future in Mind' programme for Children and Young People's mental health.

Rachael Wardell concurred that a few sharp priorities would be more effective than an umbrella statement.

RESOLVED that the new set of priorities for the remaining two years of the current H&WB Strategy, 2016-2018, be approved.

80 Local Safeguarding Children's Board Annual Report (Rachael Wardell)

The Board considered the Local Children's Safeguarding Board (LSCB) Annual Report 2014-15 (Agenda Item 14). Rachael Wardell advised that she was introducing the report on the behalf of the LSCB Chair.

Rachael Wardell advised the report had previously considered each agency in isolation, whereas now a multi-agency approach had been taken. Success against the strategic priorities were reported and the report contained many examples of children's voices. Pupils at Mary Hare were converting the report to a children's version.

Partners in the Board financially contributed specifically to the LSCB to enable it to operate and undertake work against the priorities. The Local Authority was the largest financial partner in the LSCB and the proportion of funding was out of line with national averages so some work was being undertaken to balance this. Councillor Lynne Doherty noted that it was a detailed and accurate report.

RESOLVED that the report be noted.

81 Syrian Refugee Resettlement Programme

This report had been provided for information only and was not discussed.

82 Safeguarding Adult's Board Annual Report

This report had been provided for information only and was not discussed.

83 Members' Question(s)

There were no questions received from Members.

84 Future meeting dates

It was confirmed that the next meeting of the Health and Wellbeing Board would take place on 24th March 2016 at the slightly later time of 9.30am.

Lesley Wyman reminded the Board that there would be a Hot Focus Session on child and adolescent emotional health and wellbeing services on 11th February 2016 at 9.30am in Shaw House.

(The meeting commenced at 9.05am and closed at 10:40am)

CHAIRMAN …….

Date of Signature …….

Health and Wellbeing Board Forward Plan 2016/17

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?
14th April 2016 (Special)						
Items for Decision						
Better Care Fund 2016/17 (HWB3109)	To agree the Better Care Fund arrangements for 2016/17	Decision	7th April	Tandra Forster/ Shairoz Claridge	Health and Wellbeing Steering Group	Part 1
28th April 2016 - half day hot focus session - Strategy (Shaw House)						
26th May 2016 (Development Session - PRIVATE)						
Items for Discussion						
Berkshire West Peer Review Feedback	To discuss the feedback from the LGA following the Peer Review in March	Discussion				
7th June 2016 - PARTNERSHIP CONFERENCE (this is a follow up event to that which took place on 5th November 2015)						
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 Steering 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 Steering Group	Part I
Health and Wellbeing Strategy / Joint Strategic Needs Assessment						
Health and Wellbeing Strategy Refresh (C3114)	To present the refreshed Joint Health and Wellbeing Strategy to the Board	Decision	8th June	Lesley Wyman	Health and Wellbeing Steering Group, Operations Board, Corporate Board	
Feedback on the Health and Wellbeing Strategy Hot Focus: Children and Adolescent Mental Health Service & Falls Prevention	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/ April peberdy	Health and Wellbeing Steering 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 Steering Group	Part I
Development Plan						
Health and Wellbeing Board's Development Plan	To present the development Plan for the Board	For information and discussion	8th June	Nick Carter/Graham Jones	Health and Wellbeing Steering Group	Part I
Other Issues for discussion						
Sustainability and Transformation Plan	?	*For information and discussion*		?	*Health and Wellbeing Steering Group*	
Other information not for discussion						
End of Life Care	tbc	For information	8th June	Dr Jane Baywater	Health and Wellbeing Steering Group	Part I
29th September 2016 (Development Session - PRIVATE)						
2016/17 Strategic Priority: Mental Health in Children, Young People and Adults	*To review the work achieved against the strategic priority for 2016/17 and to suggest further ways in which to promote work against this priority.*					
Delivery Groups	To review the effectiveness of the Delivery Groups at achieving outcomes against the HWB strategic priorities	Discussion				
2016/17 Strategic Priority: Older People	*To review the work achieved against the strategic priority for 2016/17 and to suggest further ways in which to promote work against this priority.*					

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 Steering 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 Steering Group	Part I
Health and Wellbeing Strategy / Joint Strategic Needs Assessment						
Feedback on the Health and Wellbeing Strategy Hot Focus Sessions : Obesity and TBC	To feedback on activity that has taken place over the last three months.	For information and discussion	26th October	TBC	Health and Wellbeing Steering 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 Steering Group	Part I
26th January 2017 (Development Session - PRIVATE)						
2016/17 Strategic Priority: Mental Health in Children, Young People and Adults	*To review the work achieved against the strategic priority for 2016/17 and to suggest further ways in which to promote work against this priority.*					
2016/17 Strategic Priority: Older People	*To review the work achieved against the strategic priority for 2016/17 and to suggest further ways in which to promote work against this priority.*					
23rd February - half day hot focus session, topic tbc (Shaw House)						
30th March 2017						
Items for Discussion						
System Resilience						
Health and Social Care Dashboard	To present the Dashboard and highlight any emerging issues	For information and discussion	1st March	Tandra Forster/Shairoz Claridge/Jessica Bailiss	Health and Wellbeing Steering Group	Part I
Integration Programme						
An update report on the Better Care Fund and wider integration programme	To keep the Board up to date on progression with the BCF and wider integration programme.	For information and discussion	1st March	Tandra Forster/Shairoz Claridge	Health and Wellbeing Steering 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	1st March	TBC	Health and Wellbeing Steering Group	Part I
Governance and Performance						
Delivery Plan Performance Report	To provide exception reports from each of the delivery groups.	For information and discussion	1st March	Lesley Wyman	Health and Wellbeing Steering Group	Part I
25th May 2017 (Development Session - PRIVATE)						
2017/18 Strategic Priority: Cardiovascular Disease and Cancer Pathways	*To suggest way in which to promote and achieve outcomes against the strategic priorities for 2017/18*					
2017/18 Strategic Priority: Carers	*To suggest way in which to promote and achieve outcomes against the strategic priorities for 2017/19*					

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	Completed.
73	28-Jan-16	Terms of Reference be drafted for the new Steering group to 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.	Shairoz Claridge/ Jo Reeves	WBC	Governance review of health and social care integration arrangements across West Berkshire	New ToRs drafted.
74		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.	Jo Reeves	WBC	Governance review of health and social care integration arrangements across West Berkshire	To be presented at the new Steering Group meeting in April
75		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.	Jo Reeves	WBC	Governance review of health and social care integration arrangements across West Berkshire	Completed..

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Title of Report:	**Annual Report of the Director of Public Health**
Report to be considered by:	Health and Wellbeing Board
Date of Meeting:	24th March 2016

Purpose of Report: **To present the Director of Public Health's annual report to the Health and Wellbeing Board.**

Recommended Action: **To note the report.**

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:	Dr Lise Llewellyn
Job Title:	Strategic Director of Public Health
Tel. No.:	
E-mail Address:	Lise.Llewellyn@bracknell-forest.gov.uk

Executive Summary

1. Introduction

1.1 The attached paper presents the DPH annual report to the Health and Wellbeing board .

2. Context

2.1 In general the statutory responsibilities of the DPH are designed to match exactly the corporate public health duties of their local authority. The exception is the annual report on the health of the local population – the DPH has a duty to write a report, whereas the authority's duty is to publish it (section 31 of the 2012 Act).

2.2 The role of the Director of Public Health is to be an independent advocate for the health of the residents in this authority. The annual report is an independent review of the health of the residents intended to inform and support the local organisations in addressing health needs. As previously the local report is not a summary of the needs of the local population since the JSNA is available which gives the key health issues , the report focuses on one area of our population in more detail to highlight key issues and stimulate debate and development.

2.3 The aim of the report is to raise issues with a sense of curiosity and to surface evidence that is available to shape our collective approach to service and health improvement.

3. DPH annual report 2014/15

3.1 Last years annual report raised and described the issue of Mental Health within our population and described in both childhood and adulthood the widespread impact and inequality that this major health issue caused locally.

3.2 This publication of the report was coupled with a new sense of priority around mental health services in the national NHS guidance and positively this year (2015/6) has seen significant investments in this major area of health burden and inequality. Moreover it has been a major area of work in the Health and Well being Board arena and joint work between the NHS and local government. Developments that have occurred include street triage services for residents in crisis, improved capacity and access to services and improvement in mental health prevention and promotion services .

3.3 Whilst we are just seeing the impact on service experience for our residents this is the start of a long journey to achieve parity of esteem and understandably yet to be translated into improved outcomes for residents . We will review the indices around mental health as part of the JSNA annually and continue to review the trends on outcomes over the coming years.

4. 2015/16 Annual report

4.1 This years annual report focuses on Childrens health in its broader sense. Each organisation is charged with improving the health of our local residents and to reduce health inequalities. If we look to the evidence then the priority area to

address if we are serious about reducing health inequalities is giving children the best start in life. This report highlights some of the issues that challenge our children and highlights some of the inequalities that work within this group. Services can be too focussed on clinical conditions and not recognise the huge impact that other issues contribute to outcomes. Education and health are intertwined. And many of us know that where you live will have a significant impact on your chances of a healthy life and your use of, or access to support. However too often we simply think that inequalities are only about where you live, whilst this does have a huge impact on life chances there are other factors that are also at work.

5. Summary

5.1 The report is presented to stimulate discussion and debate and inform the work of the HWB board.

Appendices

Appendix A – Draft Annual Report of the Director of Public Health

Consultees

Local Stakeholders: *

Officers Consulted: *

Trade Union: *

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Draft
Public Health
Annual Report
West Berkshire Council

Dr Lise Llewellyn

Strategic Director of Public Health

Public Health Services across Berkshire

Why children?

The Public Health role of local government is to improve the life expectancy of its residents and reduce health inequalities.

Across Berkshire, Wokingham, West Berkshire, Bracknell Forest and Windsor and Maidenhead have high levels of affluence and in line with this affluence have good life expectancy. Whereas Reading and Slough are less affluent and see more premature deaths (deaths before the age of 75 years).

Additionally within each LA we can see that life expectancy varies according to the affluence of the ward – 6.4 years for men and 6.9 years for women within West Berkshire.

Throughout the 20th century, infant mortality rates in England and Wales have steadily declined, largely due to 'improved living conditions, diet and sanitation, birth control, advances in medical science and the availability of healthcare'. [1] The reduction in infant mortality has been cited as the single greatest factor contributing to increased life expectancy over the past 100 years.

In his key report on health inequalities, Professor Marmot identified six policy priorities that would have an impact on reducing health inequalities in England. Two of these priorities focused on children:

"Give every child the best start in life"

and

"Enable all children, young people and adults to maximise their capabilities and have control over their lives" [2]

The report clearly shows that disadvantage starts before birth and accumulates throughout life. Action to reduce health inequalities therefore must start before birth and be followed through the life of the child. Only then can the close links between early disadvantage and poor outcomes throughout life be broken.

For this reason, giving every child the best start in life is the highest priority recommendation given in the report to address inequalities.

This Annual Report presents some of examples across England and Berkshire of how health and other experiences of our children varies according to where they live. It also summarises some of the reasons for this pattern, and touches on other circumstances that alter the outcomes for children.

This year the commissioning responsibility of health visiting services has transferred into local government and this is an additional opportunity to support better outcomes for our children through fully integrating health and other early help services to support families and children.

I hope this report shows the importance of addressing children's health in relation to the public health duties in local government, and illustrates that whilst all families need support at some time, services should recognise that specific children and families need greater support. The evidence shows that if we give this support early we can make major improvements to the life chances of these families.

Infant Mortality

One of the most obvious measures of inequality is the rate of deaths in childhood. The level of childhood mortality can also be seen as a major indicator of the nation's heath as a whole. On a personal level, the death of a child is also probably the most difficult time in any family.

Death in childhood is measured in a number of ways.

Still births *- children born after 24 weeks gestation where the child showed no signs of life*

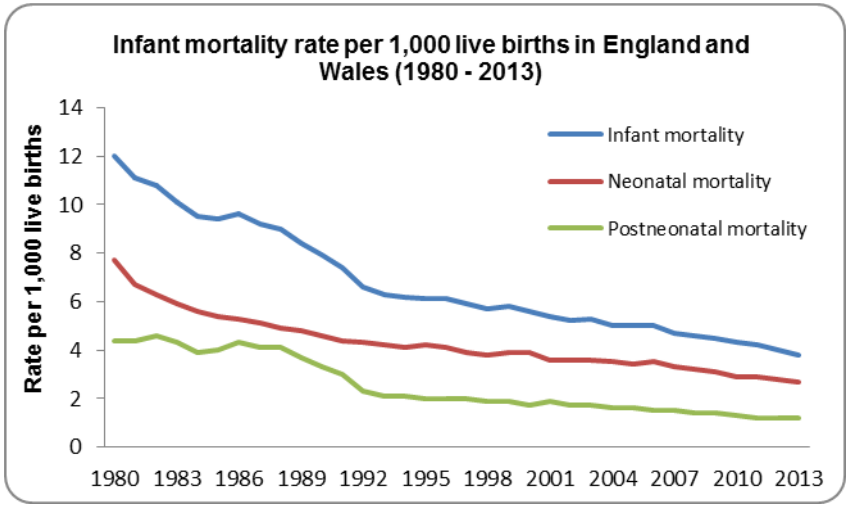
Neonatal mortality *- deaths before age of 28 days per 1,000 live births*

Infant mortality *- deaths between birth and one year per 1,000 live births*

Child mortality *- deaths before age of 5 years*

Infant mortality in England and Wales has decreased over the last 20 years.

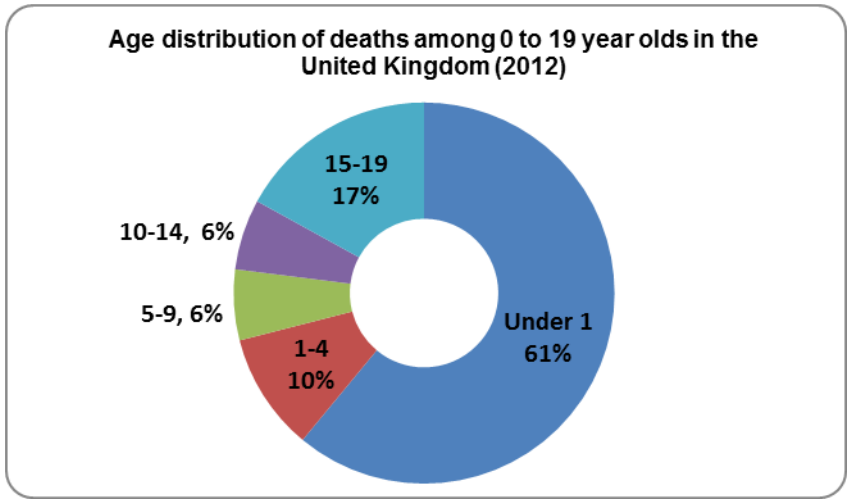
In 1980, there were 12.0 deaths per 1,000 live births and in 2013 there were 3.8 deaths per 1,000 live births. This was the lowest level recorded in England and Wales .[3]

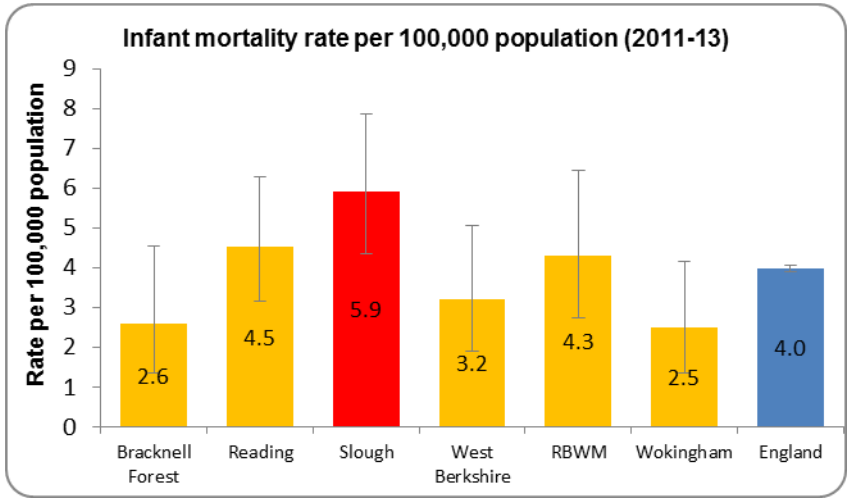


In contrast, 20 years ago mortality in the UK for under 19 years compared favourably with the rest of Europe. However, now we have one of the highest rates. If we compare ourselves against Sweden then **every day 5 extra children under the age of 14 die in the UK.** [4, 5]

Additionally there is considerable variation across the regions in the UK with deaths between the ages of 1 to 17 having a three fold variation (7 to 23 deaths per 100,000 population), similarly infant mortality (2.2 to 8 per 1,000 live births) and perinatal mortality (4.2 – 12.2 per 1,000 live births).[5]

Most childhood deaths in England occur under 1 year of age, with the next highest rate being between 15-19 years. [5]





Causes of childhood deaths

Child death overview panels (CDOPs) are responsible for reviewing information on all unexpected child deaths.[6] They record preventable child deaths and make recommendations to ensure that similar deaths are prevented in the future. Within Berkshire there is a CDOP that reviews cases across he county and reports into each Local Safeguarding Board.

CDOPs main functions are to collect and review details of children's deaths to identify :

- any matters of concern affecting the safety and welfare of children in the area of the authority
- any wider public health or safety concerns arising from a particular death or from a pattern of deaths in that area; and
- 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

Within West Berkshire the main causes of children's deaths in 2015 were chromosomal, genetic and congenital anomalies perinatal and neonatal.

In older age groups accidents and injuries becoming increasingly important as causes of deaths and disability. Within this group road traffic accidents account for over a third of all incidents.

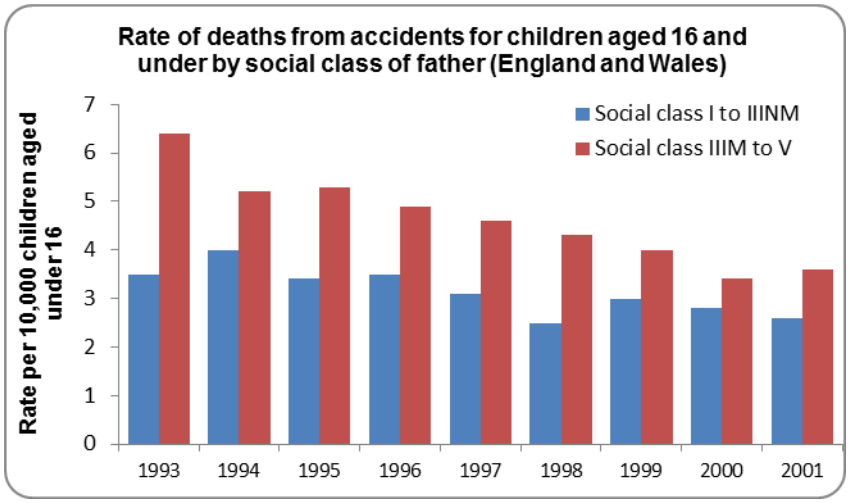
In 2011-13, 75 children were killed or seriously injured in road traffic accidents in Berkshire. The rate in England was 19 per 100,000 children (aged under 16). West Berkshire's rates were similar to the national rate.

Childhood mortality

All children are exposed to injury as part of their everyday lives, but the burden is not evenly spread. Injuries disproportionately affect some children more than others.

Patterns of injuries vary by age, gender and also socio-economic class. The latter is complex, but key factors underpinning this relationship include :

- Lack of money (ability to buy safety equipment)
- Exposure to hazardous environments inside and outside the home (facilities for safe play; smoking parents; older wiring; lack of garden; small, cramped accommodation)
- Ability of parents/carers to supervise children (single parent families; parents' maturity, awareness and experience; depression and family illness; large family size)
- Children's attitudes and behaviour (risk taking)[7]



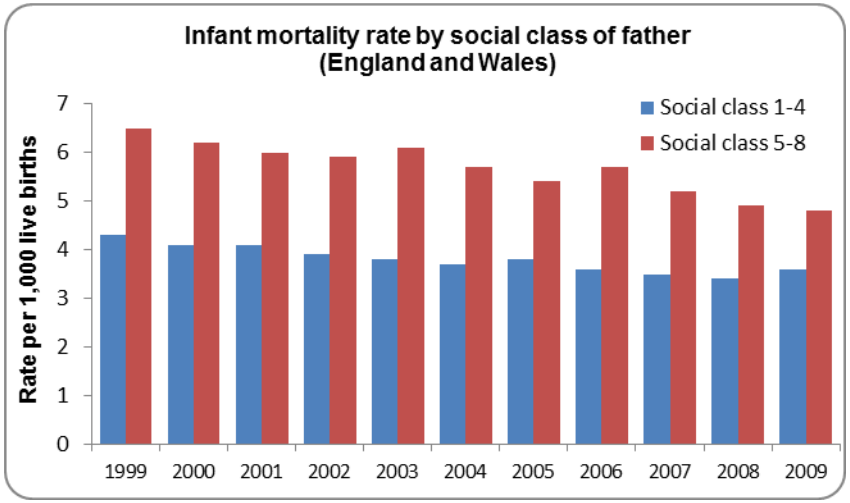
Deaths from accidents and injuries are reducing, but at rates comparable to European countries that already have lower childhood mortality. This does not, therefore, explain our worsening relative position in childhood death rates within Europe.

The key areas where the UK rates appear to be relatively high are infant deaths and deaths among children and young people who have chronic conditions.[8] The rate of improvement is relatively low in these key areas.

Wider influences

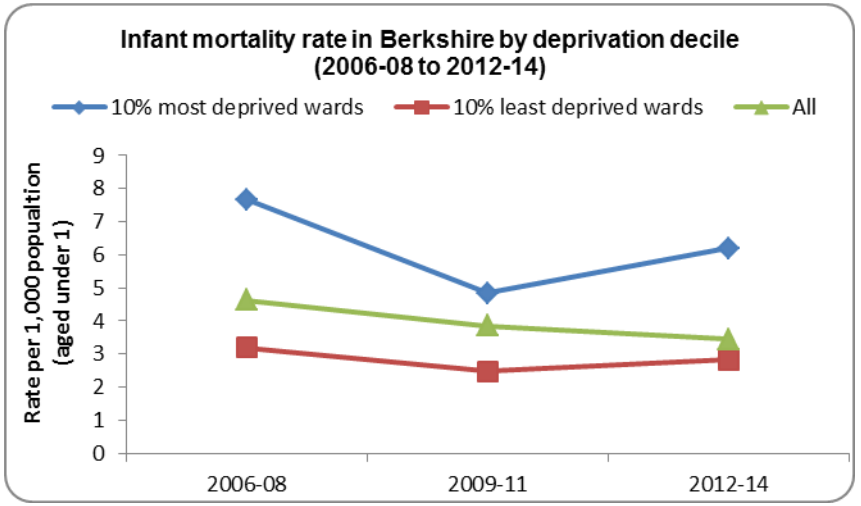
The link between deprivation and death rates are seen in infant deaths.

Infant mortality rates are highest for routine and manual occupations in England and Wales. In 2013, there were 5.4 deaths per 1,000 live births for these occupations, compared to 2.2 deaths per 1,000 live births for higher managerial, administrative and professional occupations and 3.2 deaths per 1,000 live births for intermediate occupations. [9]



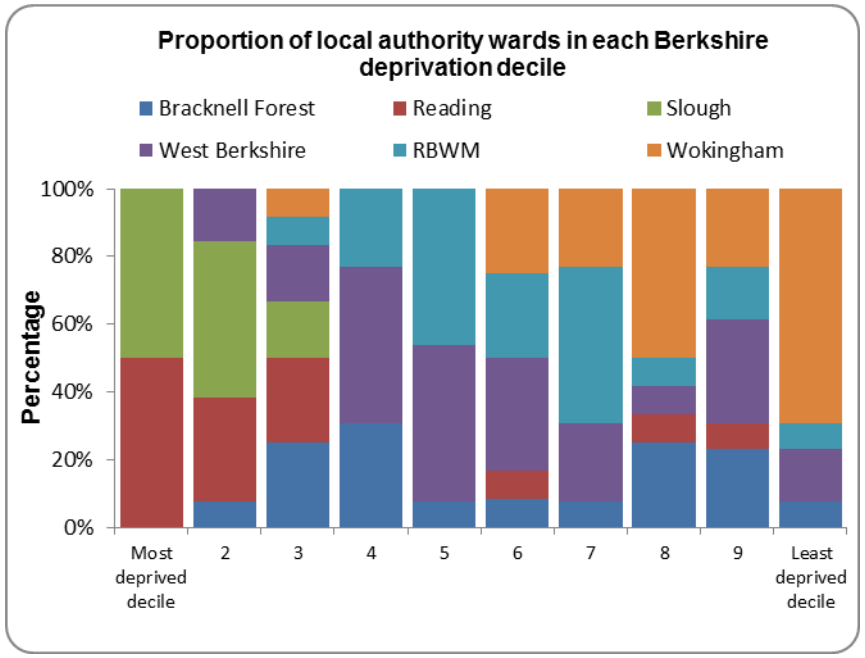
When the improvement in infant mortality is reviewed by ward, it is possible to see that wards that were relatively less deprived experienced a greater reduction in infant mortality rates compared to the national rates in England and Wales [1, 8].

Likewise when one looks at infant mortality across Berkshire, the differences in infant mortality according to deprivation can be seen.



West Berkshire is one of the most affluent areas in the country and we would therefore expect infant mortality to be lower than the England average. This is the case, as in 2011-13 there were 3.2 infant deaths per 1,000 live births compared to the England average of 4.0 per 1,000 live births.

In 2014, 10.2% (3,040) of our children in West Berkshire lived in poverty (defined as 'children living in families in receipt of out of work benefits or tax credits where their reported income was <60% median income').[10] 9% of children (3,184) lived in the 10% most deprived wards in the Borough.



The UK's higher infant mortality rates are partly explained by the high numbers - nearly two thirds - of deaths that occur before a child's first birthday that were born preterm and/or with low birth weight. UK rates of low birth weight and preterm births are higher than some other European countries, including the Nordic countries.

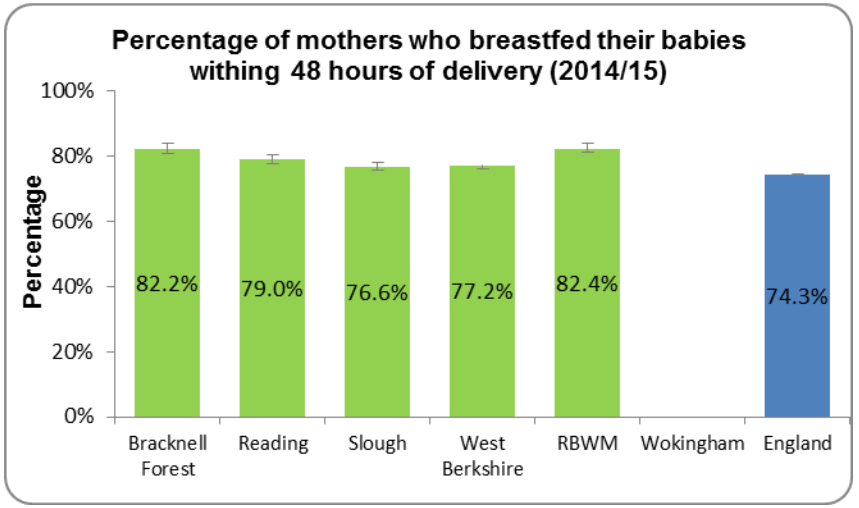
Rates of low birth weight are higher in less advantaged socio-economic groups[11] and are particularly linked to a number of negative health behaviours such as poor prenatal care, substance abuse, poor nutrition during pregnancy and smoking which are more common in these groups. [7]

Breastfeeding

Studies have shown that babies who are breastfed have a 21% lower risk of death in their first year, compared with babies never breastfed. The reduction in risk rises to 38% if babies are breastfed for 3 months or more.[12]

There is a clear association between reduced rates of breastfeeding and deprivation. The Infant Feeding Survey (2012) reported that in 2010 the prevalence of breastfeeding at all ages of babies up to nine months was highest among the highest Socio-Economic Classification group, whilst the incidence of breastfeeding decreased as deprivation levels increased. [13]

In 2014/15, 74.3% of women giving birth initiated breastfeeding within the first 48 hours after delivery in England.[10] Bracknell Forest, Reading, Slough, West Berkshire and RBWM all had significantly higher levels of breastfeeding initiation. Data for Wokingham was not published for data quality reasons.



Other inequalities

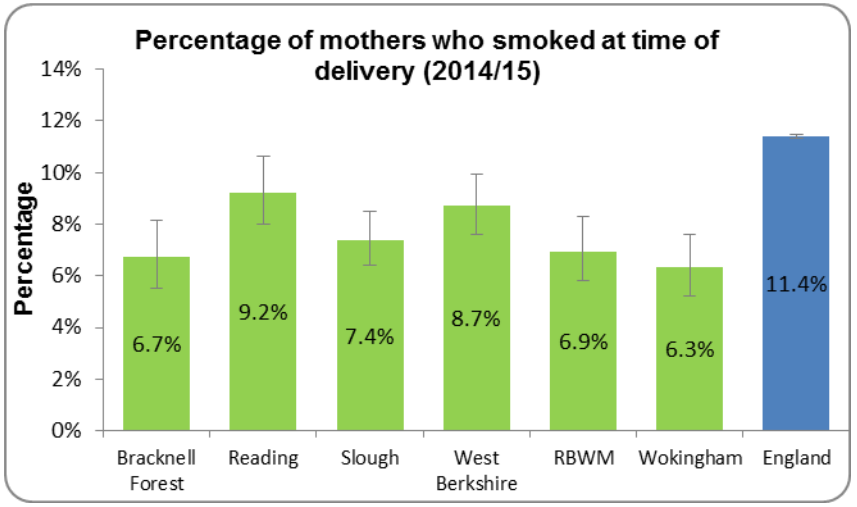
Smoking

Smoking reduces the amount of oxygen available to the foetus during pregnancy and increases the risk of low birth weight, a key risk for infant mortality.[14] It has been shown that for first pregnancies smoking 20 cigarettes a day leads to a 56% increase in risk of infant death. [15]

In the USA it was estimated that if all pregnant women stopped smoking, the number of foetal and infant deaths would be reduced by approximately 10%.

Smoking also has implications for the long term physical growth and intellectual development of a child. In 1999 the World Health Organisation concluded, *"Parental smoking is associated with learning difficulties, behavioural problems and language impairment in children".* Studies consistently report that high social class is linked to low smoking rates before pregnancy and high rates of smoking cessation during pregnancy. [14]

In 2014/15, 11.4% of mothers in England were smokers at the time of delivery. All of the Berkshire local authorities had a significantly lower level of smokers, from 6.3% in Wokingham to 9.2% in Reading. [10]



Obesity

Maternal obesity is a significant risk to both the mothers' health and that of the child.

The Confidential Enquiry in maternal and Child Health CEMACH report for the period 2003-2005 identified the risks of maternal obesity to the child as:

- stillbirth
- neonatal death
- congenital anomalies
- prematurity [16]

National statistics for the prevalence of maternal obesity are not collected routinely in the UK. A national audit of extreme obesity during pregnancy between March 2007 and August 2008 identified that nearly one in every thousand women giving birth in the UK had a body mass index (BMI) of at least 50kg/m2 or weighs more than 140kg, whilst a later audit showed that 5% of women had a BMI of over 35 or weighed at least 100kg (a higher threshold than usually used for obesity). 2% had BMIs of over 40, which is morbidly obese. [17]

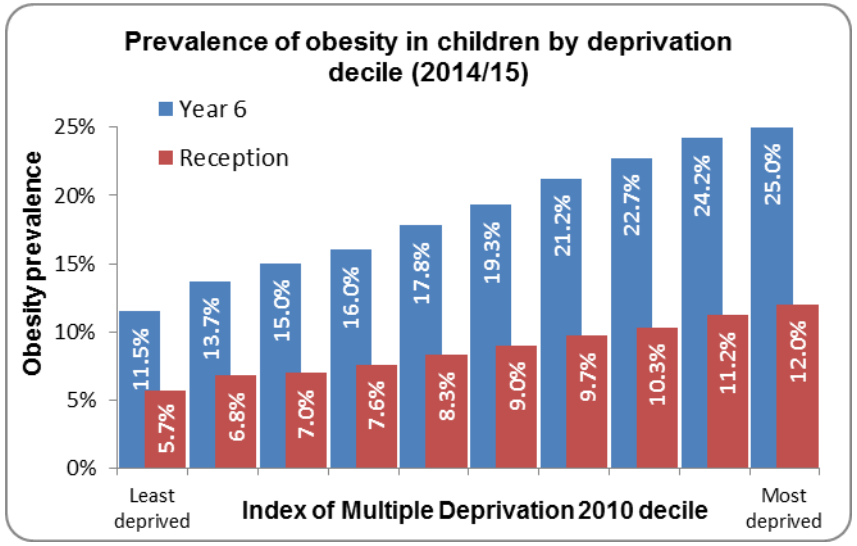
UK studies within the last five years have shown an increase in the prevalence of obesity amongst pregnant women presenting to hospital for booking. [17]

The impact of obesity on infant mortality and pregnancy complications is short term, but the impacts continue through the life of the child. There is a significant relationship between maternal obesity, large birth weight babies and the subsequent development of childhood and subsequent adult obesity.

A systematic review of the childhood predictors of adult obesity showed that maternal obesity and weight gain during pregnancy are related to higher BMI in childhood and subsequent obesity in adulthood. Children who are obese are more likely to have parents who are obese. [17]

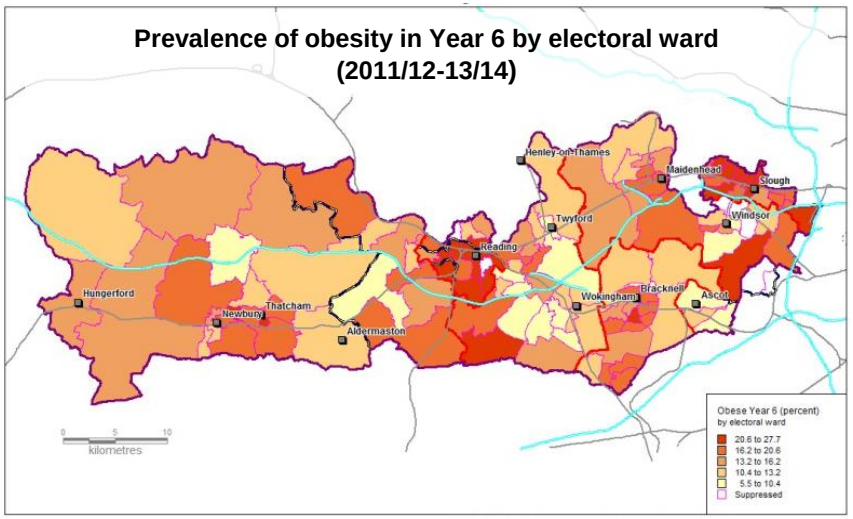
We have tried to describe in this report a 'social gradient' in health – that is a pattern in outcomes that show how outcomes get worse as the level of deprivation increases, such as infant mortality.

Sadly in the UK, socioeconomic inequalities have increased since the 1960s and this has led to wider inequalities in both child and adult obesity, with rates increasing most among those from poorer backgrounds. This worsening of health inequalities in relation to obesity is more marked for women. This pattern is repeated in children, with the socioeconomic inequalities in obesity being stronger in girls than boys. [18]

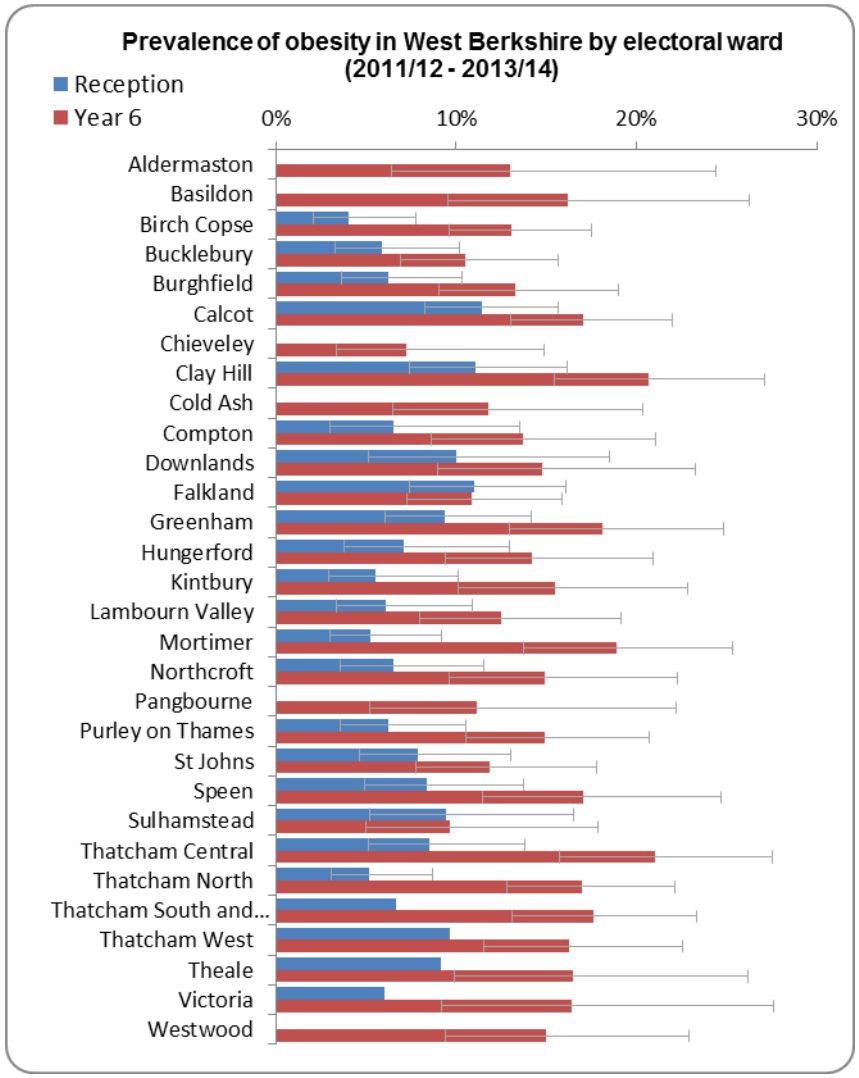


The well described national picture that children in deprived areas are more obese is also mirrored in Berkshire. The more affluent local authority areas have lower levels of obesity in Berkshire, as shown in the table and map below. [18]

Prevalence of childhood obesity in Berkshire based on National Child Measurement Programme (2014/15)			
	Local Authority	**Reception**	**Year 6**
Most deprived	Slough	10.0%	24.5%
	Reading	10.0%	19.8%
	West Berkshire	7.2%	14.9%
	Bracknell Forest	7.2%	14.6%
	RBWM	5.6%	16.6%
Least deprived	Wokingham	6.7%	13.8%



Locally within West Berkshire the pattern is shown across the wards and, as can be seen, the rate of obesity almost doubles between reception and year 6. [18]



Obese children are more likely to have long terms health and other issues, such as being absent from school due to illness, experience health-related limitations and require more medical care than children of a normal weight. [19]

Type 2 diabetes - Usually an adult illness, children as young as 7 are now being diagnosed with Type 2 diabetes in the UK. 95% of children diagnosed are overweight and 83% are obese. The rate of increase is higher in children from minority ethnic groups.

Asthma - a recent study has quantified that overweight and obese children are at a 40-50% increased risk of asthma compared to children of a normal weight.

Cardiovascular (CVD) - In the Netherlands, 62% of severely obese children aged under 12 years old have one or more CVD risk factors. Whilst in the USA, childhood obesity is associated with a quadrupled risk of adult hypertension.

Obesity not only increases cardiovascular risk in adulthood, but it is also associated with cardiovascular damage during childhood.

Mental Health - Strong evidence to suggest that by adolescence, there is increased risk of low self-regard and impaired quality of life .

Education and health

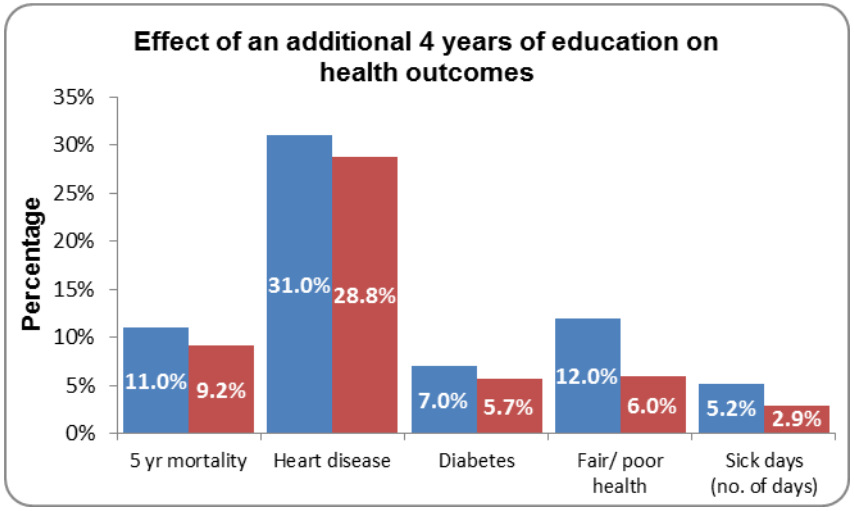
The relationship between health and education is complex. It is widely evidenced that in general those with higher educational attainment earn higher salaries. This may be the basis of the government policy which encourages more children to go to university as a route to promote economic growth.

Educational attainment is the most important of the factors examined in explaining poverty in both the UK and other EU countries studied. In the UK, those with a low level of educational attainment are almost five times as likely to be in poverty now as those with a high level of education. [20]

However, the effect of education is not simply an increase in income. The association between education and health remains substantial and significant even after controls for income, job characteristics and family background are taken into account. The relationships of health and differences in valuing the future, access to health information, general cognitive skills, individual characteristics, rank in society, and social networks have also been tested. No single factor explains the relationship seen between education and improved health, however undoubtedly education has the potential to substantially improve health.

International and UK evidence shows that education is strongly linked to better health . Those with more years of schooling tend to have better health and well-being and healthier behaviours. [21]

A substantial body of international evidence clearly shows that those with lower levels of education are more likely to die at a younger age and are at increased risk of poorer health throughout life than those with more education. [22]



Cross country comparisons in Europe have produced similar findings. People with low education were more likely to report poor general health and functional limitations. Low education level has been associated with increased risk of death from lung cancer, stroke, cardiovascular disease and infectious diseases.

Associations have also been found between education and a range of illnesses including back pain, diabetes, asthma, dementia and depression.

Evidence suggests that those who achieve a higher level of educational attainment are more likely to engage in healthy behaviours and less likely to adopt unhealthy habits. For women in the United States, college education for a minimum of two years decreases the probability of smoking during pregnancy by 5.8% points. This is a large effect given that on average only 7.8% of the women in the sample smoked during pregnancy. [23]

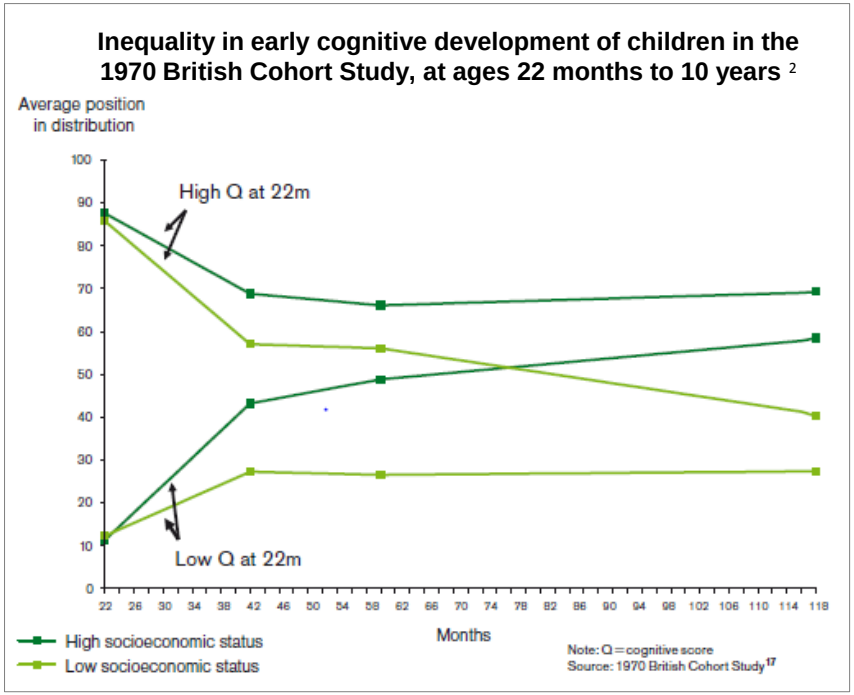
What influences education?

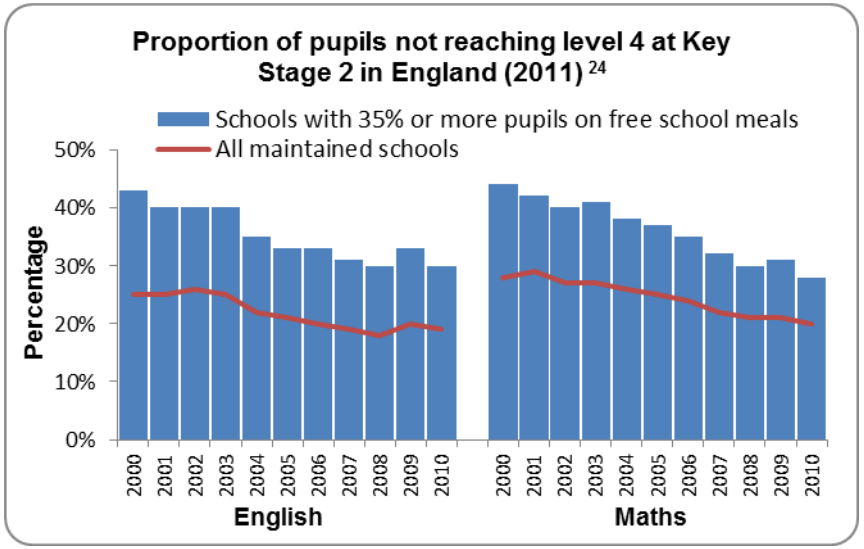
So if education has such a powerful impact on health, do all our children have the same educational success or the same chances of this success?

In the UK, the largest influence on a child's success at school is their father's education level. Young people are 7.5 times more likely to have a low educational outcome if their father has a low level of education, compared with a highly educated father. [19]

The UK has a low level of earnings mobility across the generations, meaning that there is a strong ongoing relationship between the economic position of parents and that of their children. It could be inferred that improving educational attainment will have a lasting impact on the community in many aspects including health.

Lower income and social class does have a marked impact on educational attainment. Social class has a rapid impact on a child's attainment . Children with higher cognitive ability but from lower socio economic class in testing are overtaken in test results by children of lower ability but higher social background by the age of 7. [2]

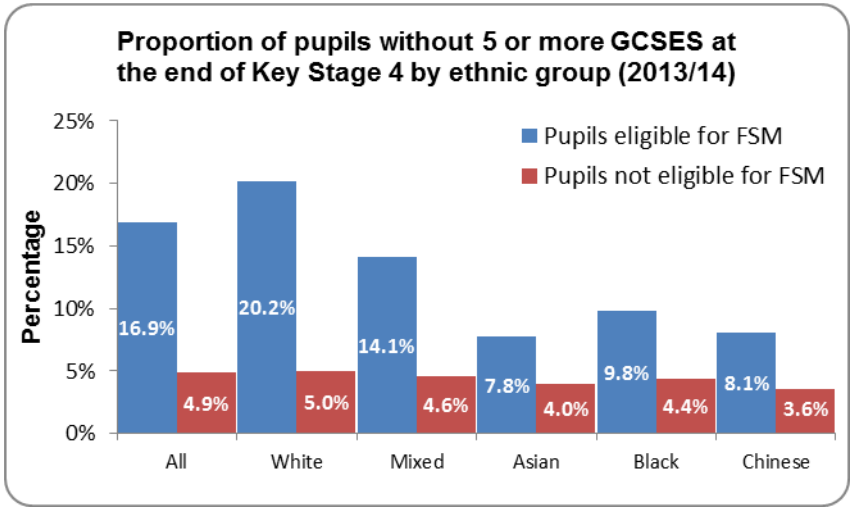




In the UK, children eligible for free school meals (FSM) are used as a proxy measure for families with lower incomes. To be eligible for FSM, the family must receive one of a series of income support mechanisms.

Pupils eligible for FSM are more likely to be absent from school than non-FSM pupils. In secondary schools the absence rate of FSM pupils is around double that of non- FSM pupils between Years 8 and 11. [23]

20% of boys eligible for free school meals did not obtain 5 or more GCSEs in 2013/14. This compares with 14% for girls eligible for free school meals and 6% for boys not eligible for free school meals. 10% of White British pupils eligible for free school meals did not obtain 5 or more GCSEs. This is a much higher proportion than that for any other ethnic group. [25]



Interestingly , children eligible for FSM in cities generally enjoy a significant advantage over their peers who grow up in similar backgrounds, but in smaller cities and market towns. This reverses assumptions that educational inequality is an inner city burden.

In 2013/14, over 60% of pupils in Inner London who were eligible for Free School Meals achieved 5 A*-C grades at GCSE, which was almost 20% above the national average. [25]

There has been good progress over the last decade across the UK, with more pupils from disadvantaged backgrounds achieving 5 A*-C grades at GCSE. However, the gap between these pupils and their wealthier classmates has remained the same or widened. In 2013/14, 71% of children in the South East who were not eligible for FSM achieved 5 A*-C grades at GCSE, but for poorer children this shockingly drops by 25% and even in in inner London there is a 20% gap. [25]

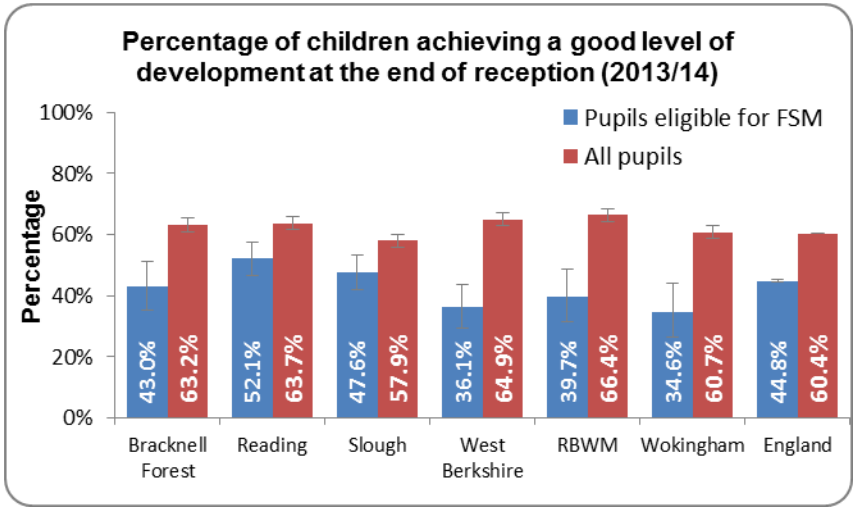
This 'narrowing the gap' issue is replicated in each of the local authorities in Berkshire. Bracknell Forest has the largest gap and, together with West Berkshire, is under the South East average attainment. In Slough we see the greatest success with exams in children eligible for FSM , where success is approaching the inner London achievement rates. In all are authorities we must persist in tackling this enduring inequality.

Percentage of students achieving 5 A*-C grades at GCSE (2013/14) [25]

Area	Pupils eligible for Free School Meals	All other pupils
Bracknell Forest	27%	71%
Reading	38%	74%
Slough	50%	79%
West Berkshire	34%	75%
RBWM	43%	72%
Wokingham	44%	77%
London	56%	75%
South East	35%	71%

The difference in school attainment for children who receive Free School Meals is also evident in primary school. The Public Health Outcomes Framework includes 2 measurements of school readiness for children who are in Reception and Year 1 (ages 4 to 6). Evidence shows that gaps in attainment emerge early in life for children from different social backgrounds. [10]

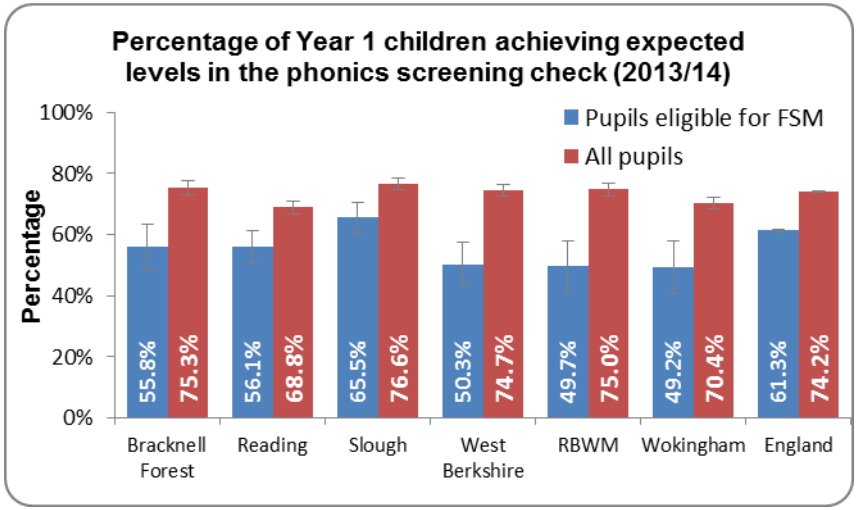
Children are defined as having reached a good level of development at the end of Reception if they achieve the expected level in the early learning goals of personal, social and emotional development, physical development, communication and language and specific areas of maths and literacy. In 2013/14, 60.4% of children achieved a good level of development by the end of reception in England. This compared with 44.8% of children who were eligible for Free School Meals and was a gap of 15.6% points.



West Berkshire's achievement gap was notably higher at 28.8% points and this was significantly worse than the England average.

In 2013/14, only 36.1% of children eligible for free school meals in West Berkshire achieved a good level of development at the end of reception. While the cohort of eligible children in West Berkshire was low (169 children in Reception), this was one of the lowest achievement rates in England.

Children complete a phonics screening check at the end of Year 1. In 2013/14, 74.2% of pupils achieved the expected level in England. This compared to 61.3% of pupils who were eligible for Free School Meals, which was a 12.9% point gap.



West Berkshire's gap between pupils eligible for Free School Meals and all children was significantly worse than England's at 24.4% points. Again the cohort in West Berkshire was quite small (185 children in Year 1), however this remains one of the lowest rates in England.

Looked after children

As we have described in this report, affluence and deprivation are key factors that influence health. Improving the education of all our children should therefore improve the health of our children, by reducing the impact of low wages and poverty.

Only one or two studies have expressed these types of impacts in quantitative and costed terms. These have shown that the health benefit of education is equivalent to 15-60% of the wage effect. This is a substantial additional benefit that may indicate a major under-investment in education. [21]

In a specific health area, an assessment of the monetary impact on the benefits of education for reducing depression were undertaken. This found that by taking women without qualifications to Level 2 (GCSE or equivalent) would reduce their risk of adult depression from 26% to 22% at the age of 42. It is estimated that this would reduce the total cost of depression for the population of interest by £200 million a year in the UK. [21]

Inequalities in education and health drive a similar divide in the world of employment and later adult outcomes. The educational attainment gap often carries over into poor adult outcomes. For example, - children on Free School Meals in Year 11 were more likely than those not eligible FSM to become NEET (Not in Employment, Education or Training) in the following three years. NEETs are more likely to have grown up in social disadvantaged households including low levels of employment, single parent families and parents with low educational qualifications.

Children eligible for free school meals are not the only children that do less well in terms of educational attainment and health outcomes. A child who is being looked after by the local authority is known as a child in care. They might be living:

- with foster parents
- at home with their parents under supervision of social services
- in residential children's homes
- other residential settings like schools or secure units

The rate of looked after children in Berkshire is below the England average. This is to be expected, since the risk of becoming a looked after child is related strongly to deprivation – overcrowding, single parent families, reliance on income support. However, there are still 850 children in this vulnerable group.

	Number and rate of Looked After Children on 31-Mar-2015 [26]	
Area	**Number**	**Rate per 10,000 population**
Bracknell Forest	105	37.0
Reading	205	57.0
Slough	195	49.0
West Berkshire	170	47.0
RBWM	100	30.0
Wokingham	75	20.0
Berkshire	850	40.3
England	69,540	60.0

The educational achievement of looked after children as a group remains low and the Children Act 1989 places a duty on local authorities to promote their educational achievement. Worryingly, only 15% of looked after children in the South East achieved 5 GCSEs graded A*-C in 2014 (Local numbers cannot be shown as they are too small to publish.) [27]

Whilst each looked after child must have a personal educational plan that promotes the quality of support and personal achievement, attendance at school in this vulnerable group of children is often worse than their counterparts and has been so for a significant period.

Locally we can seen that absence rates fluctuate quite markedly across the years, which reflect the small and changing numbers of children in each Local Authority.

	Percentage of sessions lost due to unauthorised absences for looked after children [27]				
Area	**2010**	**2011**	**2012**	**2013**	**2014**
Bracknell Forest	1.0	1.1	0.5	1.7	1.0
Reading	0.6	0.8	1.6	1.8	0.7
Slough	2.6	0.7	0.5	0.5	0.6
West Berkshire	0.4	1.0	0.2	1.6	0.8
RBWM	0.8	1.7	0.7	0.0	0.3
Wokingham	1.4	1.3	0.3	1.2	1.1
South East	1.5	1.4	1.2	1.1	1.2
England	1.5	1.5	1.2	1.1	1.0

Looked after children and young people share many of the same health risks and problems as their peers, but often to a greater degree. Children often enter the care system with a worse level of health than their peers, in part due to the impact of poverty, poor parenting, chaotic lifestyles and abuse or neglect. Longer term outcomes for looked after children remain worse than their peers. [28]

Mental health disorders are more common in looked after children

- 50% of boys and 33% of girls aged 5-10 have an identifiable mental disorder.
- 55% of boys and 43% of girls aged 11-15 have an identifiable mental disorder.
- This compares to around 10% of the general population aged 5 to 15

A major survey of looked after children found that two thirds had at least one physical health complaint. Problems with speech and language, bedwetting, co-ordination difficulties and eye or sight problems were more common.

Young people leaving care are particularly vulnerable. Both young women and young men are more likely than their peers to be teenage parents. Studies have shown that 25-50% of young women leaving care become pregnant within 18 to 24 months of leaving care.

The health of care leavers also worsens in the first year after leaving care. They are almost twice as likely to have problems with drugs or alcohol and report mental health problems. 'Other health problems' such as asthma, weight loss, allergies and flu are also far more likely. [28]

One of the key duties of the Children's Act requires the local authority to assess the health of all their looked after children annually. This includes arrangements for mental and dental care, such as immunisations and dental check-ups, as well as a short behavioural screening questionnaire (SDQ).

The SDQ should be completed for each looked after child between the ages of 4 and 16 and is completed by the main carer. It assesses:

- emotional symptoms
- conduct problems
- hyperactivity/inattention
- peer relationship problems
- prosocial behaviour

The SDQ is an important measure of emotional distress in this vulnerable group. In 2014, 68% of looked after children had an SDQ score submitted in England, but the submission rate across Berkshire did vary significantly from 29% in West Berkshire to 93% in Bracknell Forest.

Higher SDQ scores highlight concerns with the emotional and behavioural health of children. The average score for all 5 to 15 year olds in England is 8.4, however the scores for looked after children are higher at 13.9 in 2014. This is as the research findings would suggest. Higher scores are associated with poorer health experiences and highlight the particular and consistent health needs of this group.

Area	Number of LAC at 31-Mar-15 who had been looked after for at least 12 months	Percentage of LAC at 31-Mar-15: [27]		
		whose immunisations were up to date	who had their teeth checked by a dentist	who had their annual health assessment
Bracknell Forest	75	93.3%	86.7%	93.3%
Reading	160	93.8%	84.4%	87.5%
Slough	120	100.0%	95.8%	95.8%
West Berkshire	105	100.0%	71.4%	85.7%
RBWM	70	85.7%	92.9%	100.0%
Wokingham	55	81.8%	81.8%	81.8%
South East	**6,030**	**84.4%**	**83.4%**	**85.2%**
England	47,670	87.1%	84.4%	88.4%

Area	Average Strengths and Difficulties (SDQ) scores for looked after children [27]			
	2011	2012	2013	2014
Bracknell Forest	11.8	15.5	15.3	14.6
Reading	17.8	19.6	17.9	17.1
Slough	14.4	15.7	14.2	14.9
West Berkshire	15.7	15.8	16.4	16.8
RBWM	13.5	15.4	13.9	14.8
Wokingham	x	16.6	16.1	16.6
South East	15.0	15.2	14.8	14.6
England	13.9	13.9	14.0	13.9

So far in this report the evidence shows that deprivation is linked to medium and longer term poorer health outcomes and educational attainment. However, the SDQ scores in the health assessments of looked after children clearly show that there are immediate mental health issues health issues for this vulnerable group.

The Children's Act clearly gives responsibility to local government and health services to work together to ensure that children receive the services they need in response to their health assessments. [28] National evidence shows that there is substantial local variation in the availability of services with a large focus on mental health services to meet the needs of children and young people, including those who are looked after. Increasingly, innovative Children and Adolescent Mental Health Service (CAMHS) partnerships are providing designated or targeted CAMHS provision for looked after children.

Looked after children are not the only at risk group for worsened mental health. There is well documented evidence that children in poverty are also at increased risk of poor mental health.

For example, a recent survey in Scotland showed that people from the most deprived areas are more than three times as likely to be treated for mental illness. The report stated : "The more deprived an area, the higher its rate of psychiatric inpatient discharges". [29]

Use of hospital services

So far in this report we can see that not only does deprivation have an impact on longer term health outcomes, but also effects educational levels, which is a key way to actually reduce deprivation. We can now explore how deprivation also effects immediate use of health and other services.

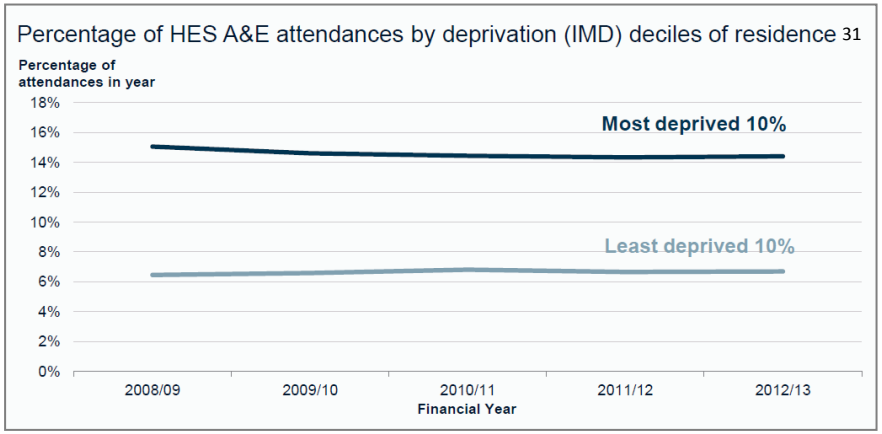
The consensus of the evidence available on the relationship of health service use in relation to deprivation is that GP use is broadly equitable by social economic group. However, evidence highlights a number of systematic differences between the use of secondary care by residents in deprived areas and compared to those in more affluent areas.

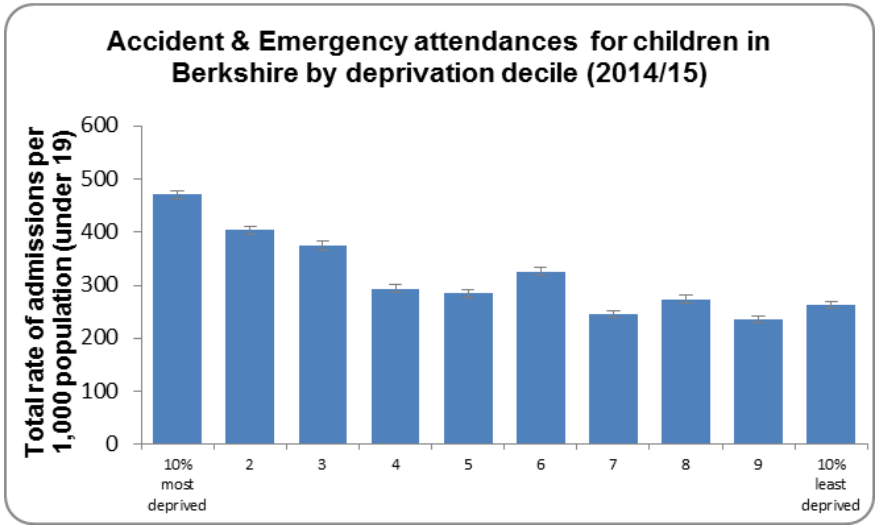
Compared with people in more affluent area, those living in deprived areas:

- use more emergency care
- use a similar amount of elective care
- attend A & E more frequently
- access outpatient care more via emergency channels
- fail to attend a larger proportion of outpatient appointments [30]

The pattern of A & E attendance has the steepest gradient, particularly in the relationship between attendance and the most deprived communities.

From 2008/09 to 2012/13, twice the number of attendances in all types of A & E departments have been by those living in the most deprived 10% of areas, compared to those in the least deprived 10%. [31] This national picture is replicated in the pattern of children's attendances in Berkshire.





Studies demonstrate a relationship between A & E use and deprivation for all assessed triage severities. This is most noticeable at the most severe end of the triage category, with five times the rate in most deprived communities. This compares to twice the rate for more minor illnesses and injuries. [32]

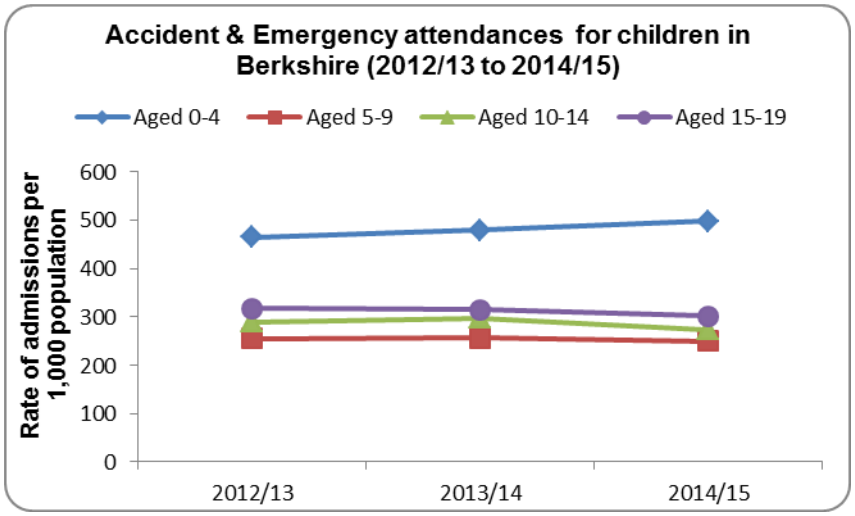
The higher use of A & E in more deprived communities can be partly explained by higher rates of illness and accidents, with the rate of accidents more prevalent in lower SEC groups. This also shows differing behaviours in response to illness and injury.

It is not just the relationships between deprivation and A & E use that is of relevance here. Children are key users of services, especially A & E, and are a key area of pressure in the NHS currently.

In recent years, numbers of A & E attendances have risen faster than the growth in the population nationally. This is largely driven by more minor (type 3) types of attendances which have risen at 11 times the rate of population, though the recent trend has dipped. [31] Nationally the highest percentage of A & E attendances are for very young children and those in their early twenties.

In 2012/13, there were at least 500 attendances at type 1 departments for every 1,000 people aged either under 2 or over 83 years in England. If this aspect of care is reviewed in more depth nationally, the proportion of attendances for over 64s at type 3 departments decreased by 2.2% points between 2008/09 and 2012/13. [31] The proportion of attendances for under 10s increased by 3.4% points. [30]

This pattern is also seen locally, driven by a rise in the 0-4 age groups.



The total number of A & E attendances in Berkshire has increased over the last two years. Children aged 0 to 10 have seen an increase of over 6% in this time period.

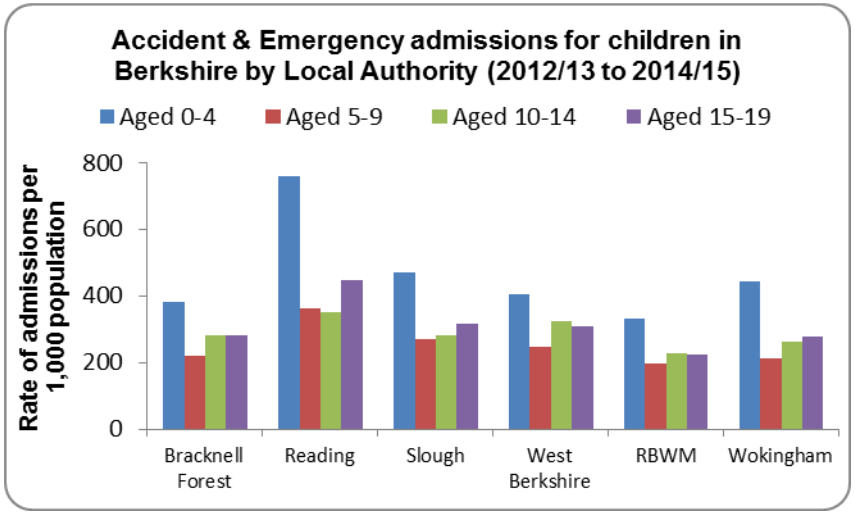
0-4 year olds use A & E the most across the UK, accounting for 3% of all attendances. People aged 80 account for less than 1% of all attendances.

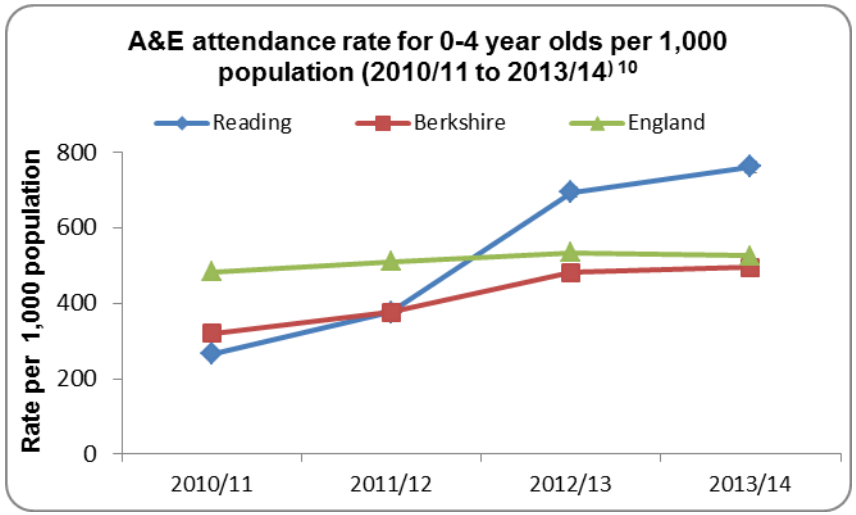
Similarly, the 0-4 age group has the highest number of emergency admissions, with approximately 225,000 nationally. This is a similar rate of attendances as 80 year olds .[31]

In 2013/14, there were 31,493 A&E attendances for children aged 0-4 years in Berkshire. Reading and Slough had the highest rates, and Reading's were significantly worse than the national rate at 763 per 1,000 population. This higher rate could be driven by the local proximity of the A&E department, as all rates of attendance are higher in this local authority. [10]

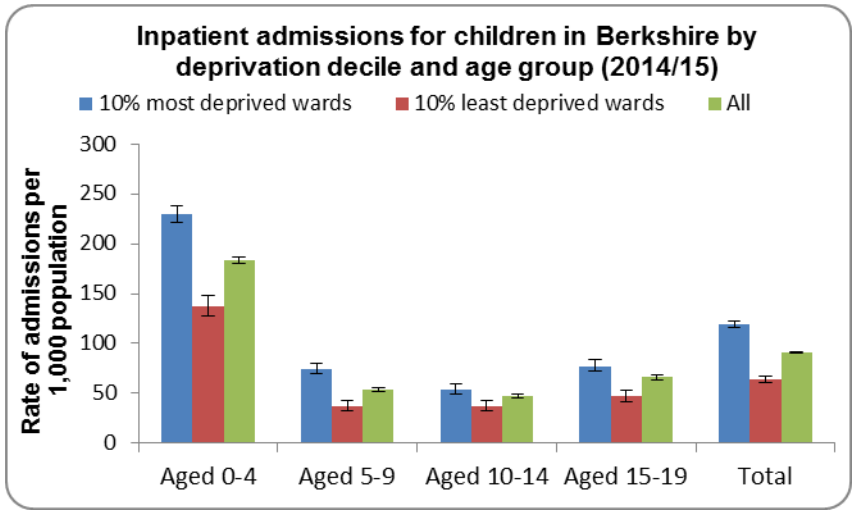
In each local authority, the highest rate of admissions were in the 0-4 year old age band. Other Berkshire local authorities had significantly better rates compared to England.

The rate of A & E attendances for 0-4 year olds is stable in all of the Berkshire local authorities, apart from Reading where it has increased over the past two years with a large increase from 2012/13 to 2013/14.





Finally whilst national data shows less of a relationship between inpatient admissions and deprivation, across all of the Berkshire local authorities it can been that children in more deprived communities are admitted more than their counterparts in more affluent areas.



Conclusions

The report pulls together a snapshot of the inequalities that exist with our children currently, and also describes the impact of these inequalities in later life and on current services. The evidence shows that if we are serious in addressing inequalities in our communities then the early years period presents a key intervention point.

The change of responsibility in commissioning health visiting services provides an opportunity to integrate how we support families and communities. Local authorities know their communities and understand local need, so links can be made with established wider services, such as housing and early years services, to enable the integration of children's services.

Babies are born with only 25% of their brains developed, but by the age of 3 their brains are 80% developed. If neglect and other adverse experiences occur in this period, it can profoundly effect a child's development. [33]

The mandated services for health visiting are :

- antenatal check at 28 weeks
- new born visit;
- 6 to 8 week review;
- 12 month assessment;
- 2 to 2½ year assessments

As the only universal service, health visitors can develop close working relationship with families and identify any support required. This can then be delivered through the community or multi disciplinary services.

In addition, health visitors are trained in recognising the risk factors, triggers of concern, and signs of abuse and neglect in children. They also know what needs to be done to protect them

In a time of budgetary constraints the tendency would be to focus services on children once they have presented with an issue to prevent escalation. However return on investment studies on a range of well-designed early years' interventions show that the benefits significantly exceed their costs: ranging from 75% to over 1,000% higher than costs. In addition the early years foundation estimates that spending on 'late intervention' on children (i.e. spending which could have been prevented) costs the NHS £3bn per year. [34]

A recently published OFSTED Chief Inspector's report identifies the important role that health visitors have in school readiness and the take up of free childcare for disadvantaged children has on system wide economic and societal benefits. [35]

Universal support to families will enable us to prevent issues developing and act quickly when problems occur. However integrating services in communities is not the only opportunity to address the current inequalities in health that exist in our population. The NHS tends to take a clinical/medical view of children and families, whilst local government is more adept at supporting at risk individuals and working in communities. If the NHS also adopted this approach then prevention could be targeted in a broader way and address a wider range of issues rather than specific clinical conditions and have a larger impact.

"Building their essential social and emotional capabilities means children are less likely to adopt antisocial or violent behaviour throughout life. It means fewer disruptive toddlers, fewer unmanageable school children, fewer young people engaging in crime and antisocial behaviour. Early intervention can forestall the physical and mental health problems that commonly perpetuate a cycle of dysfunction."

Graham Allen Early Intervention: The Next Steps [33]

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34 Department of Health (2015); Universal Health Visitor Reviews: Advice for local authorities in delivery of the mandated health visitor reviews from 1 Oct 2015

35 OFSTED (2015); Report of Her Majesty's Chief Inspector of Education, Children's Services and Skills 205: Early Years

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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% Q3**	This percentage relates to a small number of people and therefore there is a risk that a small shift in peformance means we could miss the target. In November a total of 74 clients received reablement, 9 of whom were not still at home 91 days after discharge from hosiptal. We have a strong focus on helping patients to get back home as we know this is what they want. Many of the people we care for are very frail and therefore there is always the risk that their needs will change considerably post discharge and they go onto to require a more intensive service. As we experience more success in preventing admissions to hospital those who do get
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 Q3**	Implementation of the Care Act (2014) has seen the threshold for eligibility for social care services lowered in West Berkshire and new duties e.g. prevention increasing our responsiblity. Our strategy in dealing with this is to move to a strengths based approach through the trialling of New Ways of Working. Early indicators are that whilst we have seen an increase in the number of people approaching the Council in need of help and an increase in our prevention work we are able to support many without the need for a long term service.
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% Q3**	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		↑	**46 Q3**	The number of LAC has reduced very slightly. We remain above the Comparator average of 41 per 10,000 but well below the national figure of 60.
CSC2	The number of child protection plans per 10,000 population	West Berkshire Children's Services	Quarterly	Between 28 and 34 per 10,000		↓	**41 Q3**	The number of children subject to CP Plans has increased in the past quarter. We almost identical to the national average of 42 per 10,000 but above the comparator average of 37.
CSC3	The number of Section 47 enquiries per 10,000 population	West Berkshire Children's Services	Quarterly	Between 80 and 100 per 10,000		↓	**189 Q3**	The number of Section 47 Enquiries is increasing. At 189 per 10,000 population we are above both the national avera goe 138 and the comparator average of 120.
CSC4	To maintain a high percentage of (single) assessments being completed within 45 working days	West Berkshire Children's Services	Quarterly		70%	↓	**79% Q3**	This indicator is calculated year to date. Although recent performance is much higher than 79%, our performance is negatively impacted by poor perfomance earlier in the year. The national average is 81%.
CSC5	Looked after children cases which were reviewed within required timescales	West Berkshire Children's Services	Quarterly		99%	↔	**99% Q3**	Performance agianst this indicator continues to be strong.
CSC6	Child Protection cases which were reviewed within required timescales	West Berkshire Children's Services	Quarterly		99%	↔	**98% Q3**	Performance agianst this indicator continues to be strong.
CSC7	Percentage of LAC with Health Assessments completed on time.	West Berkshire Children's Services	Quarterly		90%	↑	**93% Q3**	Performance in relation to health assessments is much improved. At 93%, we are now above the national average of 87%.

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%	↓	**95.1% Q3**	Throughout Q3, 95.1% 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 4.
		Hampshire Hospitals NHS Foundation Trust				↓	**88% Q3**	• A&E Remedial Action Plan (RAP) and associated trajectories have been agreed and are acceptable to commissioners. • Recovery expected by 30/4/16. • Full sign-off of the RAP is now only subject to Trust agreement on the fines/penalty scheme for the missed milestones. Expected completion date 12/2/16 (Drafting note only: Do not have update on this – will seek further clarification).
		Great Western Hospitals NHS Foundation Trust				↓	**90.9% Q3**	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't 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 Q3**	In Quarter 3 we continue to see a high number of attendances in A&E at all the acutes; this reflects the national picture. New performance reporting has been introduced and there are daily systems calls to allow each partner to discuss necessary actions. West Berkshire performance at the RBH continues to be strong, we are meeting both our weekly and weekend target. We are now focusing on improving performance with North Hants Hospital. We have had an inital meeting with them and they
		Great Western Hospitals NHS Foundation Trust				↑	**2.6 Q3**	
		Hampshire Hospitals NHS Foundation Trust				↑	**2.9 Q3**	

		Oxford University Hospitals NHS Trust				↑	**0.2 Q3**	have agreed to work with the team at the RBH to look at introducing a weekly 'fit list'. We are also going to be invited to participate in their system resilience group and calls to allow for closer monitoring. The key challenge for West Berkshire remains access to both homecare and nursing/residential placements.
		Royal Berks NHS Foundation Trust				↓	**2.7 Q3**	
		Total West Berkshire		14.7 (2012/2013 data)		↑	**9.1 Q3**	
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 Q3**	
		Great Western Hospitals NHS Foundation Trust				↓	**1.1 Q3**	
		Hampshire Hospitals NHS Foundation Trust				↑	**2.3 Q3**	
		Oxford University Hospitals NHS Trust				↔	**0.0 Q3**	
		Royal Berks NHS Foundation Trust				↑	**0.6 Q3**	
		Total West Berkshire			4	↔	**4.6 Q3**	
AS4	**Community Services** Average number of Delayed Transfers of Care (all delays by patients delayed)	Berkshire Healthcare Trust as a provider	Monthly		No Target	↔	**11 Q3**	The urgent care operational team, BHFT and the local authority are working to improve the systems flow and therefore resillience, including the introduction of the intergrated discharge team at Royal Berkshire Hospital and care coordinators in the community wards at West Berkshire Community Hospital who 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%	↑	**76% Q3**	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 November there was an improvement in performance and this can be seen in the table below. TV Geography Performance Sep-15 Oct-15 Nov-15 Red 1 67.6% 67.8% 70.8% Red 2 68.7% 71.7% 74.4% Red 19 92.6% 93.4% 94.8% This improvement is as a result of the actions SCAS are taking as part of the remedial action plan and also as a result of the National Ambulance Response Programme (NARP) pilot that SCAS started in October. This 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. The performance trajectories are currently on track and all 3 standards are expected to be achieved at Thames Valley level from March onwards.
AS6	A&E Attendances	Royal Berkshire Foundation Trust for Berkshire West	Monthly	1256 average monthly figure from 13/14		↓	**3941 Q3**	Q3 A&E attendances were in line with expected activity. The system focused on planning for the winter period and ensuring alternatives to Emergency Department were available so that patients did not default to A&E. Primary Care have been offering additional booked resilience appointments at peak times over the Winter period in order to ensure that patients who should be seen in primary care do not attend A&E.
		Hampshire Hospital Foundation Trust for Berkshire West	Monthly	300 average monthly figure from 13/14		↔	**1160 Q3**	
		Great Western Hospital for Berkshire West	Monthly	168 average monthly figure from 13/14		↔	**577 Q3**	
AS7	Number of non elective admissions	Royal Berkshire Foundation Trust for West Berkshire	Monthly	547 average monthly figure from 13/14		↓	**2098 Q3**	Q3 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		↔	**537 Q3**	
		Great Western Hospital for West Berkshire		84 average monthly figure from 13/14		↓	**319 Q3**	
AS8	Total number of 111 calls (Answered in 60 seconds)	Berkshire wide	Monthly		No Target	↑	**62,321 Q3**	During November, 91.9% of 111 calls were answered within 60 seconds across Berkshire against a target of 95%. The YTD performance remains above standard at 95.4%. During November, the 111 service suffered with more sickness weekends than normal expected levels for the time of year, especially at weekends. There has also been a continuation of unusual call patterns compared to previous years on weekends also. Additional contingency plans were therefore requested for managing sickness as part of the Christmas and New Year preparedness work. SCAS are forecasting an improvement in the latter half of January and then recovery in performance in February.

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% Q3**	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:	**Mental Health Street Triage Briefing Report**
Report to be considered by:	The Health and Wellbeing Board
Date of Meeting:	24th March 2016

Purpose of Report: **To Note**

Recommended Action: **N/A**

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

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

Is this item relevant to equality? Please tick relevant boxes	**Yes**	**No**
Does the policy affect service users, employees or the wider community and:		
• Is it likely to affect people with particular protected characteristics differently?	☐	☒
• Is it a major policy, significantly affecting how functions are delivered?	☐	☒
• Will the policy have a significant impact on how other organisations operate in terms of equality?	☐	☒
• Does the policy relate to functions that engagement has identified as being important to people with particular protected characteristics?	☐	☒
• Does the policy relate to an area with known inequalities?	☐	☒

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

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Executive Report

1. Introduction

1.1 The Berkshire West Street Triage One Year Pilot Project is part of collaborative funding arrangements between Berkshire West Clinical Commissioning Groups, 3 Local authorities and NHS England at a total cost of **£150k**. This service is based on the Oxford Street Triage Model of care to support the reduction of mental health patients being detained inappropriately in police custody, reduce the use of Section 136 and also to support the Local Crisis Care Concordat Action Plan Commitment from CCGs & LAs.

1.2 Street triage refers to a service where clinical mental health professionals (MHPs) accompany and/or assist police at incidents where the possible mental ill health of an individual gives rise to concern. The MHPs will assist in ensuring the best option for the individuals in crisis. They will do this by offering professional advice on the spot, accessing health information systems, and helping to liaise with other care services to identify the right kind of support required.

1.3 Thames Valley Police (TVP) in partnership with Berkshire Healthcare NHS Foundation Trust (BHFT) will provide a street triage service in Berkshire West (Wokingham, West Berkshire and Reading LA areas) providing dedicated MHPs working alongside police. The service will target incidents reported to police where individuals appear to be in immediate need of support for their mental ill health or following a mental health welfare/incident call made to the police.

1.4 The street triage service will provide timely interventions by MHPs and avoid unnecessary detention either in a police station or hospital, which will equate to a better experience for these individuals as well as achieving a substantial cost saving for these services. The street triage MHP works in partnership with TVP to provide mental health advice and guidance in an effort to assist the police in their decision making process around managing risk.

1.5 The street triage MHP seek to provide an inclusive service to ensure that people who come into contact with police and are considered having a mental disorder receive a high quality, competent and effective range of interventions. The service delivery will include liaison, prevention and ultimately if needed, equitable access to mental health services.

1.6 Between 1 April 2014 to 31st March 2015, there was a total of 216 Section 136 applied by Thames Valley Police officers in Berkshire West (136- Reading, 47- West Berkshire and 33- Wokingham). This was an increase of 23% on the previous year for Berkshire West. Mental Health incidents as reported by TVP, during the same period of time were reported (per 1000 population) Reading- 6.4, West Berkshire- 2.9 and Wokingham- 2.1. Reading has the third highest in the Thames Valley area, whilst West Berkshire and Wokingham were below the TVP average of 4.5.

2. Key Outcomes

- To reduce the number of Section 136's applied by Thames Valley Police (TVP) across Berkshire West.
- To provide alternative mental health outcomes to persons found in crisis by TVP officers in Berkshire West.
- Provide support to TVP regarding mental Health Welfare/ calls of concern calls received by TVP control room.
- Release/ free up TVP officer's time/ earlier return to non- Mental Health related duties.
- To prevent mental health patient being detained in police custody.

3. Aims/Objectives

- Improve the experience and outcomes for persons in mental health crisis
- Prompt assessment of persons in crisis to ensure the appropriate care pathway is identified
- Reduce the number of deprivations of liberty under S136 by identifying suitable, appropriate, less restrictive alternatives
- Reduce the amount of time police officers are spending managing crisis (or other) situations in public or private locations by providing support for mental health assessments and facilitating access to appropriate services
- Reduce the burden of inappropriate referrals to Emergency Departments
- Improve training, awareness, confidence and joint workings relationships between police and health professional's staff.
- Reduce the cost of MHA assessments across the police, Local authority and the local NHS.

4. Service Operating Times

- The service operate with one member of staff (Band 7 MHP) and a Thames Valley Police officer on duty between the hours of 17:00 hrs to 01:00, five days per week (Thursday to Monday), this historically and being the peak time for S136 detentions in Berkshire West.

5. Conclusion

5.1 We are planning an evaluation of this project in January 2016 to share the impact of this service in Berkshire West.

5.2 The plan is to develop a business case to seek recurrent funding for the Berkshire West Street Triage Service for 2016/17 from the CCGs & LAs.

6. Equalities

6.1 This item is not relevant to equality.

Appendices

There are no Appendices to this report.

Consultees

Local Stakeholders: BHFT, TV Police, SCAS, RBFT & LAs

Officers Consulted: MH Leads from each organisation

Other: N/A

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Better Care Fund 2016/17

Report being considered by:	The Health and Wellbeing Board
On:	24 March 2016
Report Author:	Tandra Forster and Shairoz Claridge
Item for:	Information

1. Purpose of the Report

1.1 To keep the Board up to date on the BCF and wider integration programme and to inform the Board of the process for 2016.

2. Recommendation(s)

2.1 That the Health and Wellbeing Board notes the report.

3. Introduction/Background

3.1 The Better Care Fund (BCF) is a government initiative established to fast track integration with Health and Social Care. 2015/16 was the first year of implementation, all Councils and CCGs had to agree a plan and then obtain approval from their Health and Wellbeing Boards.

3.2 As it was a General Election year it was announced as a one year programme, consequently there was some uncertainty about its existence in future years. The recent Spending Review confirmed that BCF would continue into 2016/17 and that the allocations would be slightly higher as the national pot had been increased by 1.9%.

3.3 Going forward the Better Care Fund team has indicated that where systems are able to demonstrate real progress in their plans for integration it will be possible to 'graduate' from the BCF process.

4. BCF National Policy Framework - Assurance

4.1 In common with last year all of the work delivered through the BCF has to meet a number of conditions. A BCF Policy framework published in January confirmed the details, importantly for the local authority 'Maintain provision of social care services' was still included as one of a number of national conditions. In addition the following two new conditions have been introduced:

(1) Agreement on the consequential impact of the changes on the providers that are predicted to be substantially affected by the plans

(2) Agreement to invest in NHS commissioned out-of-hospital services, which may include a wide range of services including social care

4.2 We are currently in discussion with the CCG to agree how these new conditions will be met and described in the narrative.

5. West Berkshire Locality BCF Plan

5.1 Despite delays within the Department of Health in confirming the timeline and the technical guidance the Council and the CCGs were able to commence negotiation of the 2016/17 financial plan; details of the initial proposals were discussed at Operations Board on the 14th January.

5.2 Subsequent to this meeting, allocations for localities were published. These confirmed the CCG minimum contribution at £8.807m, an increase of £279k and an increase in the capital grant to the Council (routed through the BCF) from £1.005m to £1,4m. The main element of the capital funding is for Disabled Facilities Grants.

5.3 In the local plan we have agreed with the CCG that £4.367m will now be provided in the 2016/17BCF to 'Maintain provision of social care services. This reflects a real terms increase on last year's amount, £4.021m, and fulfils the guidance 'As a minimum, it should maintain in real terms the level of protection as provided through the mandated minimum element of local Better Care Fund agreements of 2015-16.

5.4 The amount includes the £408k invested in the Joint Care Provider scheme. We very much consider this as our local flagship scheme; it has seen much closer working between the council and BFHT resulting in less duplication and good performance levels despite unprecedented challenges for the acute Trusts. The £408k allows us to maintain the existing capacity of our reablement service.

5.5 £500k has also been included to help us continue to deliver 7 Day Week Services. The council has made a number of changes to ensure a social work presence in hospitals at the weekend to ensure discharge is not now limited to weekdays. The intention is to build on this good work with other hospitals we work with and to extend our focus into the community to address non elective admissions.

5.6 The amount also includes funding for West of Berkshire projects. These include 'Connected Care' ,an ICT project that aims to support more effective information sharing across health and social care, a key requirement of any integration programme and 'Care Homes' which focuses on reducing the disproportionately high number of non elective admissions from care homes.

5.7 We have also agreed with the CCG to include investment related to the contract held with BFHT totalling £1,889,000. This covers a range of services including intermediate care, speech and language therapy and the community geriatrician.

5.8 Financial plan can be found at Appendix A.

5.9 Whilst the financial plan has been agreed with the CCG we are still in the process of completing the narrative that will sit alongside it. The Better Care Fund have introduced a new Key Lines of Enquiry document that they are confident will reduce the burden in this part of the process, last years plan ran to over 100 pages.

6. BCF Assurance Process

6.1 For 2016/17 the assurance is being managed collaboratively between NHS England, the Local Government Association and Association of Directors of Adult Social Care. We are working to timeline to ensure final ratification by April, key dates shown below:

(1) First draft of the financial plan submitted to NHS England 2nd March

(2) Full BCF plan submission 21st March

(3) Council and Health and Wellbeing Board sign off 14th April

(4) Final Plans, following Health and Wellbeing sign off, 25th April

7. Conclusion

7.1 The 2015/16 BCF has provided significant learning that should allow us to build on and plans for the coming year. We are clear on the projects for the coming year and the financial plan that underpins them and recommend that they are agreed.

8. Consultation and Engagement

Steve Duffin
Roz Haines
Patrick Leavey
Shairoz Claridge – Director of Operations, NDCCG
Perry Lewis - Finance Lead – Berkshire West 10 Integration Programme

9. Appendices

9.1 Appendix A – Equalities Impact Assessment

9.2 Appendix B – Extract from BCF financial template

Subject to Call-In:
Yes: ☐ No: ☒

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

Officer details:
Name: Tandra Forster
Job Title: Head of Adult Social Care
Tel No: 01635 519736
E-mail Address: tandra.forster@westberks.gov.uk

Chairman details:
Name: Graham Jones
Job Title: Chairman of the Health and Wellbeing Board
Tel No: (01235) 762744
E-mail Address: Graham.Jones@westberks.gov.uk

Appendix A

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:	Better Care Fund Programme 2016/17
Version and release date of item (if applicable):	V.01
Owner of item being assessed:	Tandra Forster
Name of assessor:	Tandra Forster
Date of assessment:	10th March 2016

Is this a:		**Is this:**	
Policy	**No**	**New or proposed**	**No**
Strategy	**Yes**	**Already exists and is being reviewed**	**Yes**
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:	The Better Care Fund Programme is a initiative established to promote greater integration between health and social care.
Objectives:	To outline the project initiatives and associated investment for the West Berkshire Locality Better Care Fund.
Outcomes:	The range of projects will help promote better integration between health and social care services, meet the national conditions as set out in the Better Care Fund Policy Framework.
Benefits:	Improved the experience of health and social care services for local residents by reducing duplication of services, increase access to health and social care by implementing 7 day work, better information sharing, protecting existing provision of social care.

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
Age	Improved access to services both in terms of pathways and availability	National conditions - see attached BCF Policy Framework Range of projects within the locality support this and robust assurance process is in place to ensure compliance.
Disability (frail elderly)	Improved access to services both in terms of pathways and availability	National conditions - see attached BCF Policy Framework Range of projects within the locality support this and robust assurance process is in place to ensure compliance.
Gender	This is not a distinguishing factor in this service	This is not a distinguishing factor in this service
Marriage and civil partnership	This is not a distinguishing factor in this service	This is not a distinguishing factor in this service
Pregnancy and maternity	No impact	This programme of work is currently focused on frail elderly
Race	This is not a distinguishing factor in this service	This is not a distinguishing factor in this service
Sex	This is not a distinguishing factor in this service	This is not a distinguishing factor in this service
Sexual Orientation	This is not a distinguishing factor in this service	This is not a distinguishing factor in this service
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	**No**

inequality?	
Please provide an explanation for your answer: The proposals are intended to enhance service provision and outcomes for service users/patients	
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: The proposals are intended to enhance service provision and outcomes for service users/patients. Appropriate arrangements are in place which mean employees are not disadvantaged by any new arrangements.	

If your answers to question 2 have identified potential adverse impacts and you have answered 'yes' to either of the sections at question 3, or you are unsure about the impact, then you should carry out a Stage 2 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:	X

Name: Tandra Forster **Date: 10.03.16**

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

Template for BCF submission 1: due on 02 March 2016

Sheet: 4. Health and Well-Being Board Expenditure Plan

Selected Health and Well Being Board:
West Berkshire

Data Submission Period:
2016/17

4. HWB Expenditure Plan

This sheet should be used to set out the full BCF scheme level spending plan. The table is set out to capture a range of information about how schemes are being funded and the types of services they are providing, which is required to demonstrate how the national policy framework is being achieved. Where a scheme has multiple funding sources this can be indicated and split out, but there may still be instances when several lines need to be completed in order to fully describe a single scheme. In this case please use the scheme name column to indicate this.
On this tab please enter the following information:
- Enter a scheme name in column B;
- Select the scheme type in column C from the dropdown menu (descriptions of each are located in cells B71 - C78); if the scheme type is not adequately described by one of the dropdown options please choose 'other' and give further explanation in column D;
- Select the area of spending the scheme is directed at using from the dropdown menu in column E; if the area of spending is not adequately described by one of the dropdown options please choose 'other' and give further explanation in column F;
- Select the commissioner and provider for the scheme using the dropdown menu in columns G and J, noting that if a scheme has more than one provider or commissioner, you should complete one row for each. For example, if both the CCG and the local authority will contract with a third party to provide a joint service, there would be two lines for the scheme: one for the CCG commissioning from the third party and one for the local authority commissioning from the third party;
- In Column K please state where the expenditure is being funded from. If this falls across multiple funding streams please enter the scheme across multiple lines;
- Complete column L to give the planned spending on the scheme in 2016/17;
- Please use column M to indicate whether this is a new or existing scheme.
- Please use column N to state the total 15-16 expenditure (if existing scheme) This is the only detailed information on BCF schemes being collected centrally for 2016-17 but it is expected that detailed scheme level plans will continue to be developed locally.

	Expenditure											
Scheme Name	Scheme Type (see table below for descriptions)	Please specify if 'Scheme Type' is 'other'	Area of Spend	Please specify if 'Area of Spend' is 'other'	Commissioner	if Joint % NHS	if Joint % LA	Provider	Source of Funding	2016/17 Expenditure (£)	New or Existing Scheme	Total 15-16 Expenditure (£) (if existing scheme)
Connected Care	Other	Better data sharing	Other	Health and Social Care	CCG			Private Sector	CCG Minimum Contribution	£333,000	Existing	£248,000
7 Day Week service	7 day working		Social Care		Local Authority			Local Authority	CCG Minimum Contribution	£500,000	Existing	£500,000
Patients Personal Recovery guide	Intermediate care services		Social Care		Local Authority			Charity/Voluntary Sector	CCG Minimum Contribution	£150,000	Existing	£310,000
Joint Care Provider	Reablement services		Other	Social Care & Community Health	Local Authority			Local Authority	CCG Minimum Contribution	£408,000	Existing	£400,000
Protecting Social Care services - the cared for	Other	Maintaining Provision for Social Care	Social Care		Local Authority			Private Sector	CCG Minimum Contribution	£1,505,000	Existing	£1,213,000
Protecting Social Care services - Carer	Support for carers		Social Care		Local Authority			Private Sector	CCG Minimum Contribution	£300,000	Existing	£294,000
Protecting Social Care services - Reablement	Reablement services		Social Care		Local Authority			Local Authority	CCG Minimum Contribution	£433,000	Existing	£425,000
Protecting Social Care services - Integrated Crisis & Rapid Respo	Integrated care teams		Social Care		Local Authority			Local Authority	CCG Minimum Contribution	£433,000	Existing	£425,000
Protecting Social Care services - Early supported discharge	Intermediate care services		Social Care		Local Authority			Local Authority	CCG Minimum Contribution	£377,000	Existing	£370,000
Protecting Social Care services - universal preventitive services	Personalised support/ care at home		Social Care		Local Authority			Charity/Voluntary Sector	CCG Minimum Contribution	£584,000	Existing	£573,000
Protecting Social Care services - Carers universal services	Support for carers		Social Care		Local Authority			Charity/Voluntary Sector	CCG Minimum Contribution	£327,000	Existing	£321,000
Protecting existing CCG reablement service	Reablement services		Community Health		CCG			NHS Community Provider	CCG Minimum Contribution	£755,000	Existing	£740,000
Care Homes	Personalised support/ care at hom		Community Health		CCG			NHS Community Provider	CCG Minimum Contribution	£495,000	New	
Speach and Language Therapy	Personalised support/ care at home		Community Health		CCG			NHS Community Provider	<Please Select>	£64,000	New	
Community Geriatrician	Improving healthcare services to c		Community Health		CCG			NHS Community Provider	CCG Minimum Contribution	£144,000	New	
Intermediate Care	Intermediate care services		Community Health		CCG			NHS Community Provider	CCG Minimum Contribution	£455,000	New	
Health Hub	Integrated care teams		Community Health		CCG			NHS Community Provider	CCG Minimum Contribution	£334,000	New	
Intermediate Care night sitting, rapid response, reablement and falls	Improving healthcare services to care homes		Community Health		CCG			NHS Community Provider	CCG Minimum Contribution	£629,000	New	
Care Homes in reach	Improving healthcare services to care homes		Community Health		CCG			NHS Community Provider	CCG Minimum Contribution	£263,000	New	
Programme Management	Other	Supporting Health and social cate Int	Other	Health and Social Care	Joint	52.0%	48.0%	Local Authority	Local Authority Social Services	£209,000	New	
Disabled Facilities Grant	Other	Capital	Other	Health and Social Care	Local Authority			Private Sector	Local Authority Social Services	£1,400,000	Existing	£726,000
Social Care Capital Grant	Other	Capital	Other	Health and Social Care	Local Authority			Private Sector	Local Authority Social Services	£0	Existing	£279,000
Contingency	Other	Contingency	Other	as required	Joint	50.0%	50.0%	Local Authority	Local Authority Social Services	£328,422	Existing	£231,000
Risk Share Agreement	Other	Risk Share	Acute		Joint	50.0%	50.0%	NHS Acute Provider	CCG Minimum Contribution	£243,000	Existing	£243,000

Scheme Type	Description
Reablement services	The development of support networks to maintain the patient at home independently or through appropriate interventions delivered in the community setting. Improved independence, avoids admissions, reduces need for home care packages.
Personalised support/ care at home	Schemes specifically designed to ensure that the patient can be supported at home instead of admission to hospital or to a care home. May promote self management/expert patient, establishment of 'home ward' for intensive period or to deliver support over the longer term. Admission avoidance, re-admission avoidance.
Intermediate care services	Community based services 24x7. Step-up and step-down. Requirement for more advanced nursing care. Admissions avoidance, early discharge.
Integrated care teams	Improving outcomes for patients by developing multi-disciplinary health and social care teams based in the community. Co-ordinated and proactive management of individual cases. Improved independence, reduction in hospital admissions.
Improving healthcare services to care homes	Improve the quality of primary and community health services delivered to care home residents. To improve the consistency and quality of healthcare outcomes for care home residents. Support Care Home workers to improve the delivery of non essential healthcare skills. Admission avoidance, re-admission avoidance.
Support for carers	Supporting people so they can continue in their roles as carers and avoiding hospital admissions. Advice, advocacy, information, assessment, emotional and physical support, training, access to services to support wellbeing and improve independence. Admission avoidance
7 day working	Seven day working across health and/or social care settings. Reablement and avoids admissions
Assistive Technologies	Supportive technologies for self management and telehealth. Admission avoidance and improves quality of care

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Title of Report:	**Joint Strategic Needs Assessment update**
Report to be considered by:	The Health and Wellbeing Board
Date of Meeting:	March 24th, 2016

Purpose of Report: **To share with the Board further data updates that will inform the JSNA and DNA**

Recommended Action: **For the Board to note new data sets and be informed about any change in trends that will affect the Health and Wellbeing of local residents.**

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: ☒

NOTE: Strategic Support is not able to accept your report without the following section being completed. For advice please visit http://intranet/EqIA or contact the Principal Policy Officer (Equality & Diversity) on Ext. 2441 or Team Leader/Solicitor - Corporate Team on Ext. 2626.

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

Health and Wellbeing Board Chairman details	
Name & Telephone No.:	Graham Jones – Tel 07767 690228
E-mail Address:	gjones@westberks.gov.uk

Contact Officer Details	
Name:	Lesley Wyman
Job Title:	Head of Health and Wellbeing
Tel. No.:	01635 503434

E-mail Address:	lesley.wyman@westberks.gov.uk

Executive Report

1. Introduction

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

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

This presentation shows the latest data that is currently informing the JSNA and is the second of two updates, the first being a report presented at the November 2015 Board meeting. The data items in the presentation are provided by the Berkshire Public Health Shared Information Team, based in Bracknell that provides JSNA updates throughout the year to all 6 Berkshire LAs. Public Health data sets are often delayed due to the requirement to process and clean data that is then made available nationally and locally which takes considerable time. Thus some data will go back to 13/14 and other data will refer to 14/15.

The updated JSNA chapters will incorporate this data and add in other locally provided data and information about available services. It is anticipated that all the JSNA chapters will be updated and available to become part of the West Berkshire District Needs Assessment by the end of April 2016. The DNA will then be available for commissioners, providers, partners and the general public on the Council website which will be updated throughout the year as new data becomes available.

The following areas are covered in this presentation:

Children in poverty

Oral health

Childhood obesity

Cancer screening

Seasonal flu

Adult mental health

Suicide rates

Mental health in old age

Safeguarding adults

Residential and nursing care

Delayed transfers of care

Independence in older age

Falls and mobility

Excess winter deaths

End of life care

Employment and income

Benefits claimants

Qualifications

Offenders

Environment

Housing and homelessness.

1.1

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.
Appendix A - *
Appendix B - *

Consultees

Local Stakeholders:

Officers Consulted: Berkshire PH Shared Information Team

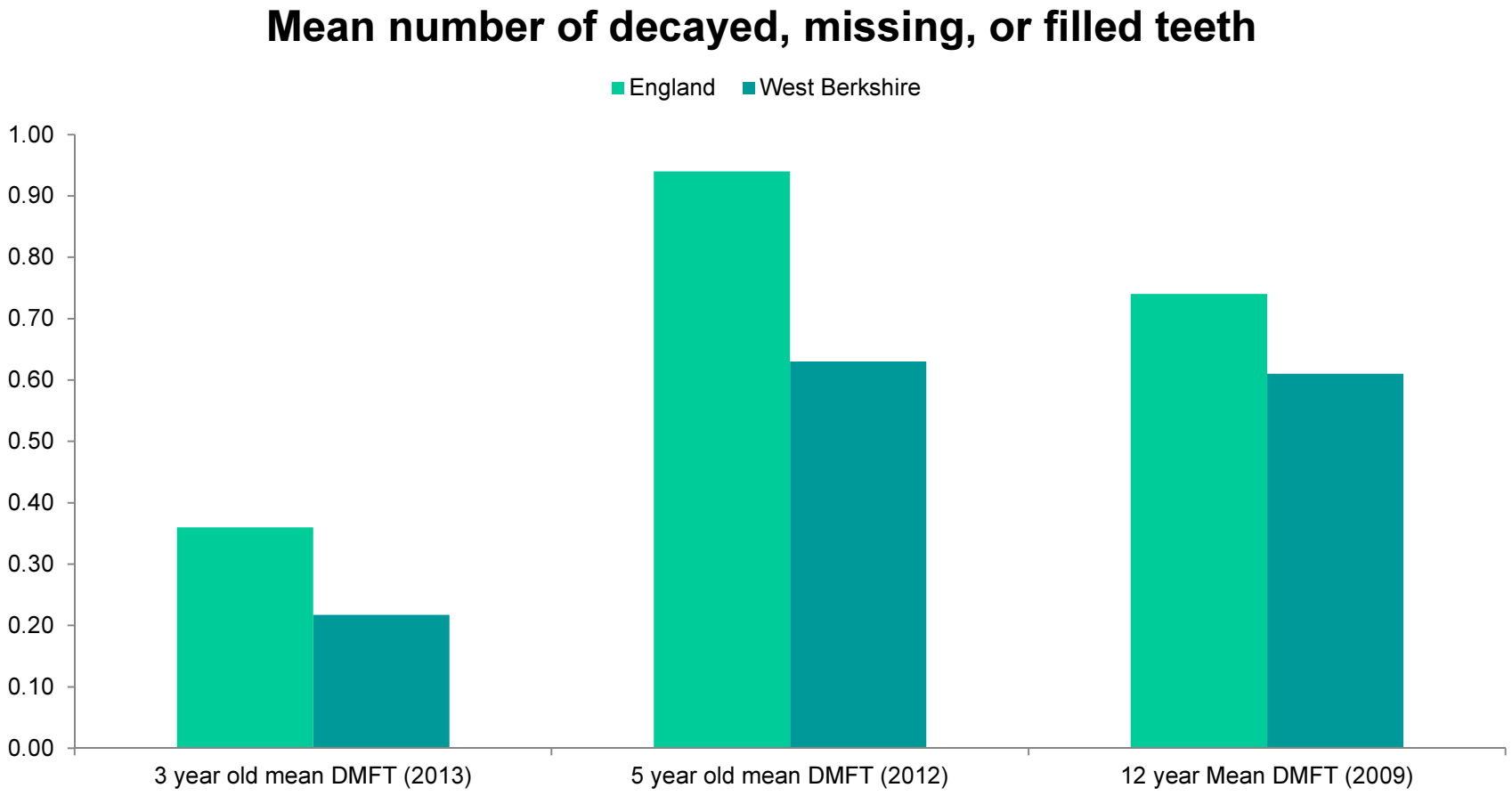
Members of the PH and Wellbeing Team, West Berkshire Council

Other:

Children in poverty (Jan 2016)

- 2015 Income Deprivation Affecting Children Index (IDACI) Score shows West Berkshire to be in the least deprived 10% LAs in the country
- 2012 PHOF indicated 10.9% of children under 16 in WB living in low income families (children living in families in receipt of out of work benefits or tax credits where their reported income is less than 60% median income) (nat 19.2%)

Oral health (Nov 2015)



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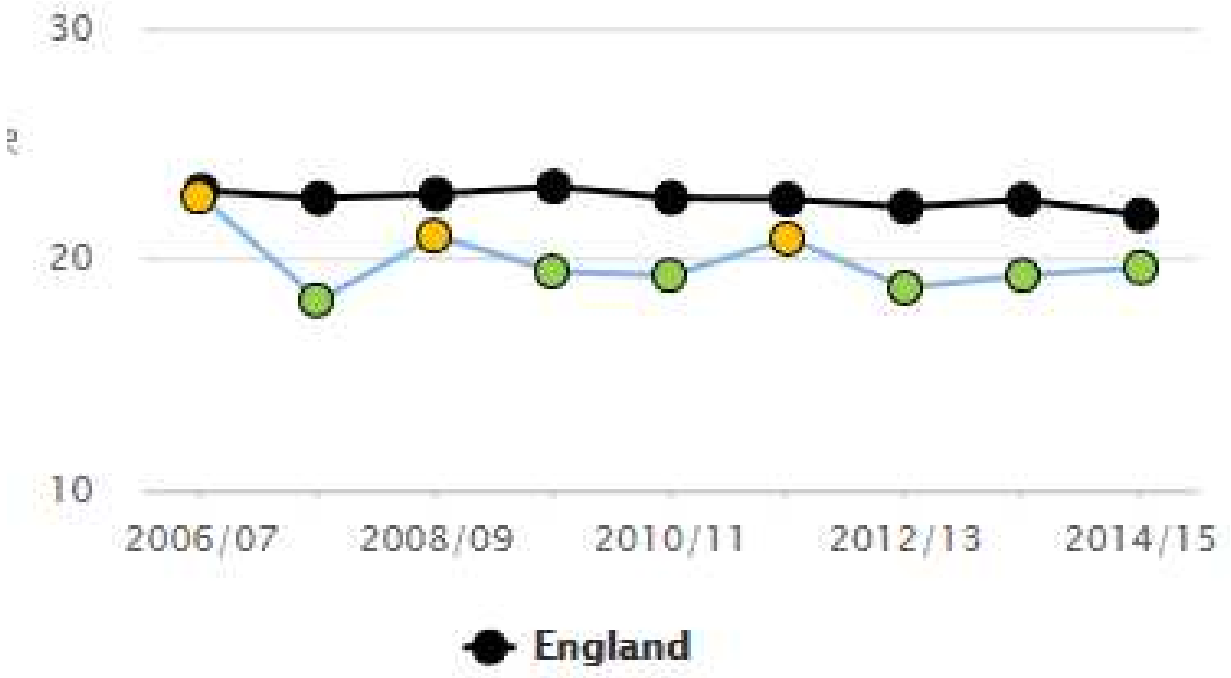
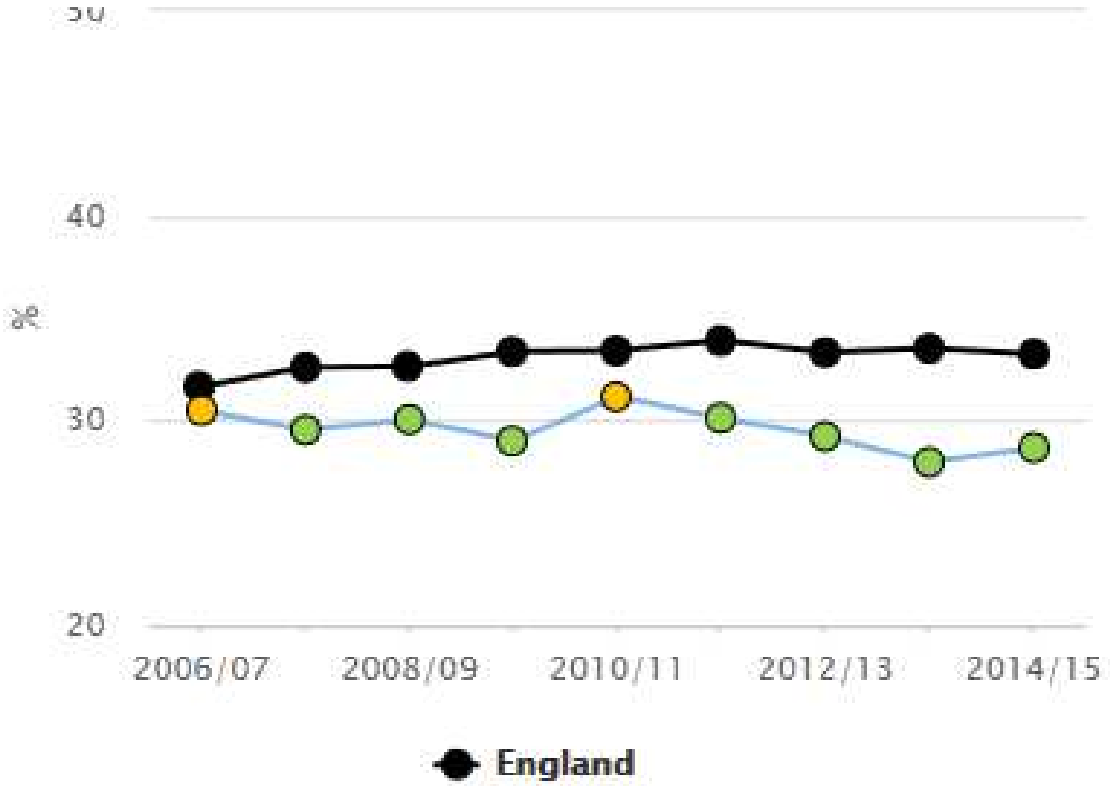
Antenatal and newborn screening (Aug 2015)

- Antenatal infectious disease screening (HIV, HepB)
- Downs syndrome – completion of lab request forms Q1+ 2 2014/15 not reaching acceptable
- Antenatal sickle cell and thalassaemia – timeliness of test under ach still acc coverage ok
- Newborn hearing
- Newborn bloodspot – coverage, timeliness of result, avoidable repeat tests

Excess weight in 4-5 yos (NCMP 20145/15)



Excess weight in 10-11 yos (NCMP)



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Cancer screening (Aug 2015)

- (31 March 2014) 81.8% eligible women received an adequate breast screening result in the previous 3 years (nat 75.9%)
- (31 March 2014) 78.1% eligible women received an adequate cervical screening result in the previous age appropriate time period (nat 74.2%)
- Take up of bowel screening and receiving an adequate test result was 61.8% for NDCCG and 62.1% for NWRCCG

Seasonal flu (April 2015)

- North & West Reading CCG's uptake of the seasonal flu vaccine was better than the national average for all groups in 2014/15. The uptake for children aged 2 - 4 years old were significantly better than the national figures and the CCG also met the national target of 75% for people aged 65 and over.

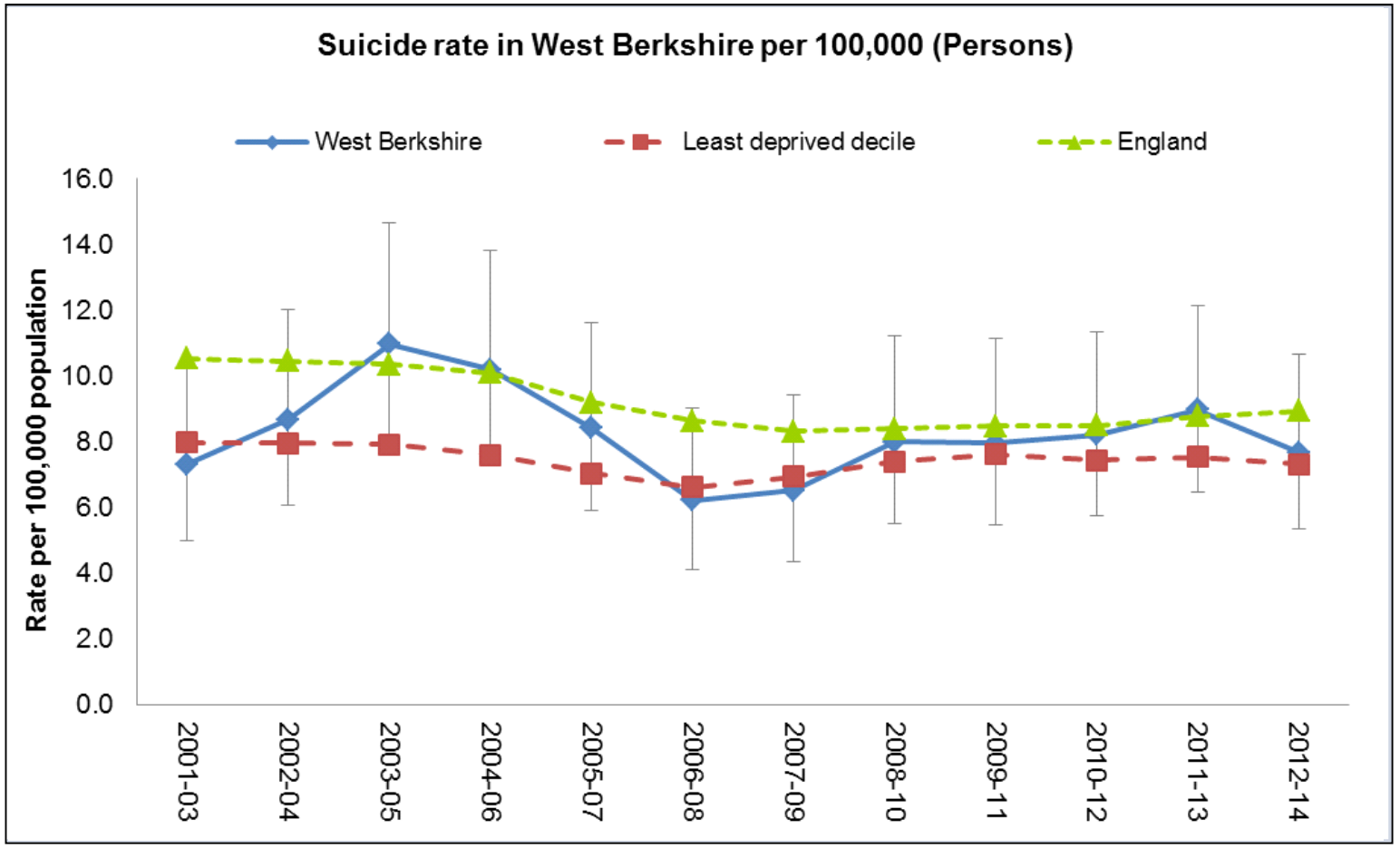
Seasonal flu (April 2015)

- ND and NWR CCG's uptake of the seasonal flu vaccine was better than the national average for all groups in 2014/15.
- The uptake for children aged 2 - 4 years old were significantly better than the national figures and the CCGs also met the national target of 75% for people aged 65 and over.
- ND CCG's uptake was lower than 2013/14 for all groups, except pregnant women, increased by 7.5%
- NWR CCG's uptake improved for pregnant women by 10.7% points over the year. There was also an increase for people aged 65 and over and children aged 3.

Adult mental health (Feb 2016)

- Recorded prevalence rates in WB 2014/15 (QOF)
  - Mental health 0.7% ⟷
  - Dementia 0.6% ⟷
  - Depression 6.8% ↑ from 6.2% in 13/14
- 2013/14 rate of < 75s mortality from serious mental illness is 458.8 per 100,000 which has increased from 12/13 and is higher than the national average of 351.8

Suicide rate



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Mental Health in Old age (May 2015)

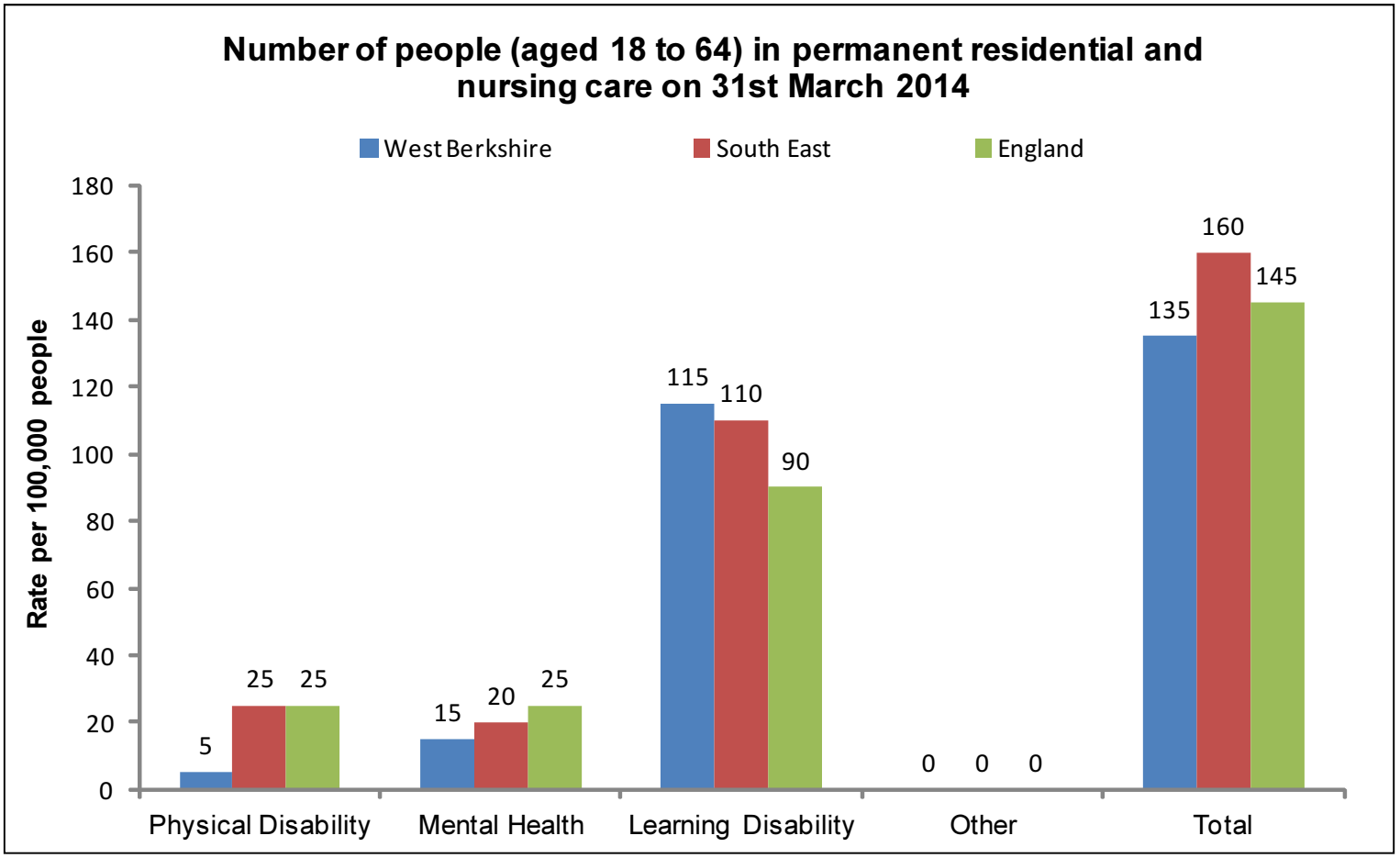
- A person will have to wait 6 weeks to be seen in a memory clinic (Nat memory clinics audit 2013)
- A person will have to wait 10 weeks for results from the memory clinic (nat memory clinics audit 2014)
- Nationally 48% of people with dementia have a diagnosis
- NDCCG – 48.1% NWRCCG – 50.2% (PCT 2012/13)

Safeguarding adults (June 2015)

- 64% service users reported feeling safe (nat 66%)
- 85% said the services they received made them feel safe (nat 79%)
- 70% receiving a ASC received a review in 13/14 (66% nat)
- 14% more deaths in winter months (20% nat) in 12/13

(HSCIC and PHE)

Residential and nursing care (July 2015)



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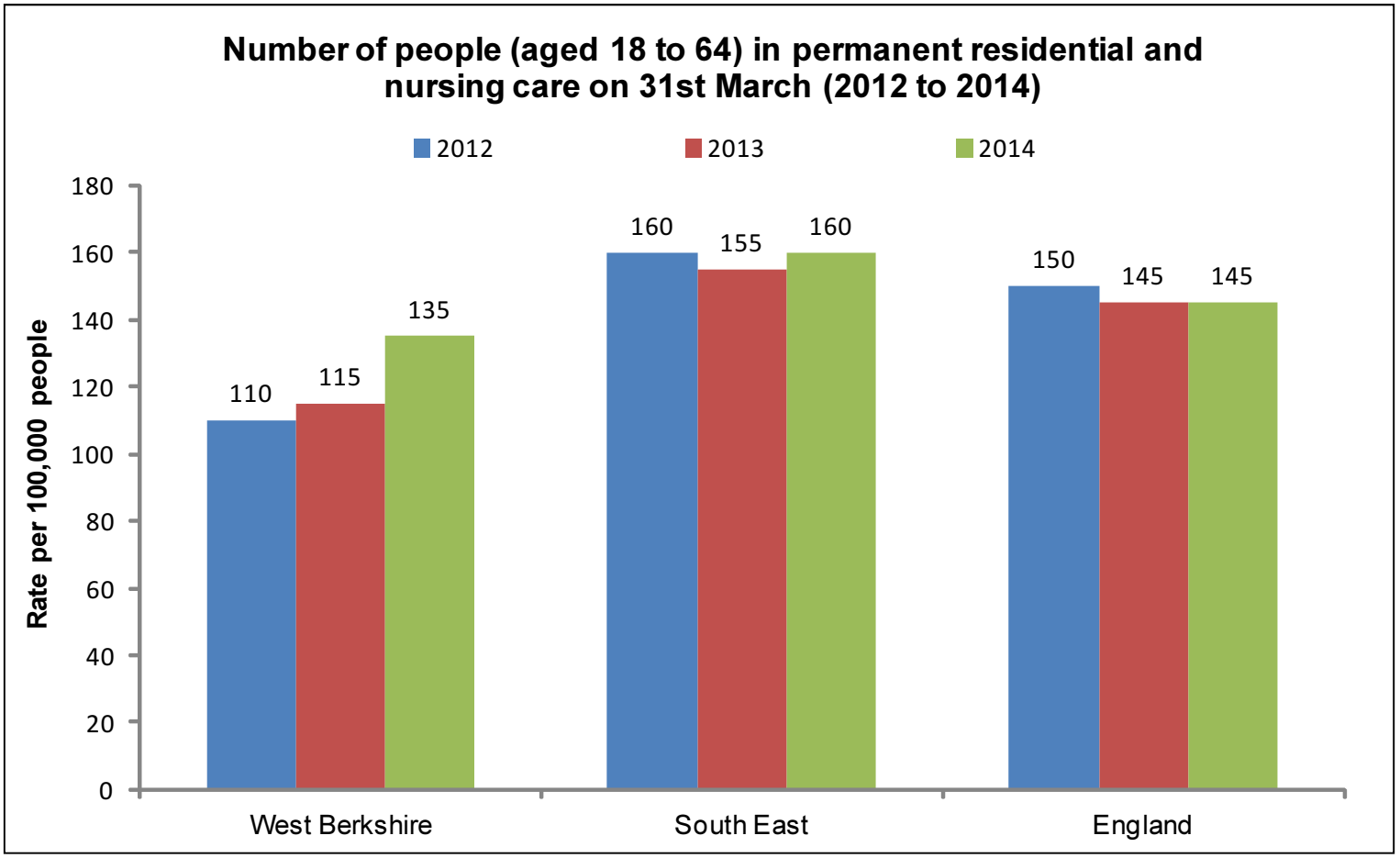
Residential and nursing care (July 2015)



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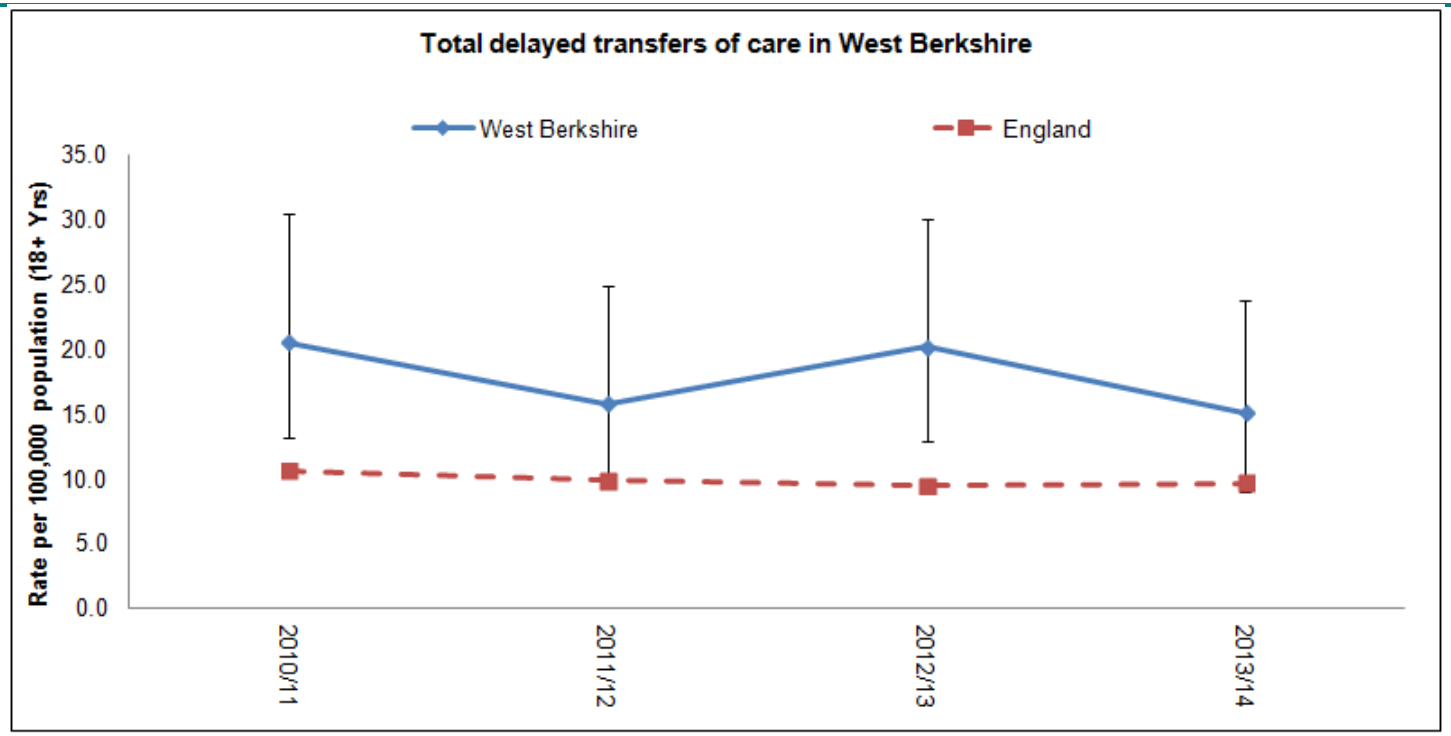
Delayed transfers of care (June 2015)



Source: Public Health Outcomes Framework (November 2014)

Total delayed transfers of care in per 100,000 people aged 18 and over in England

2010/11	2011/12	2012/13	2013/14
10.6	9.9	9.4	9.6

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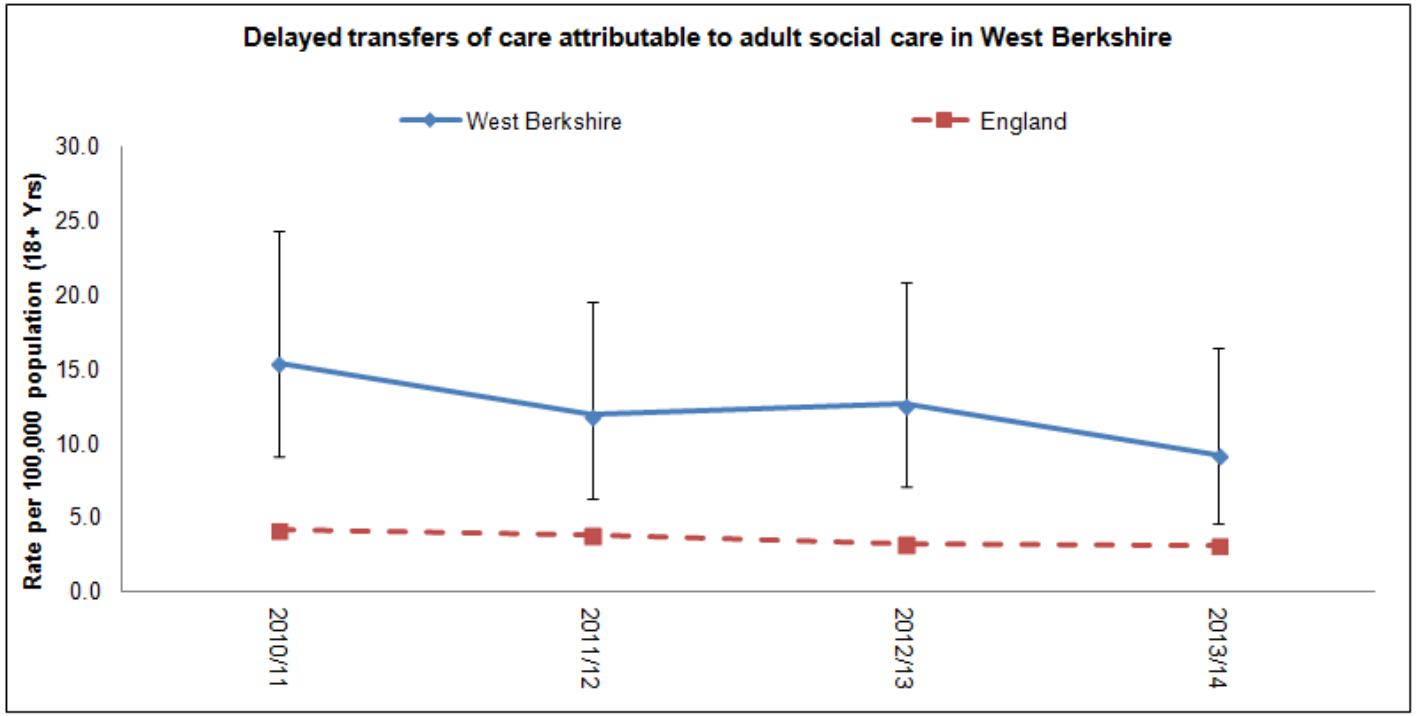
Delayed transfers of care (June 2015)

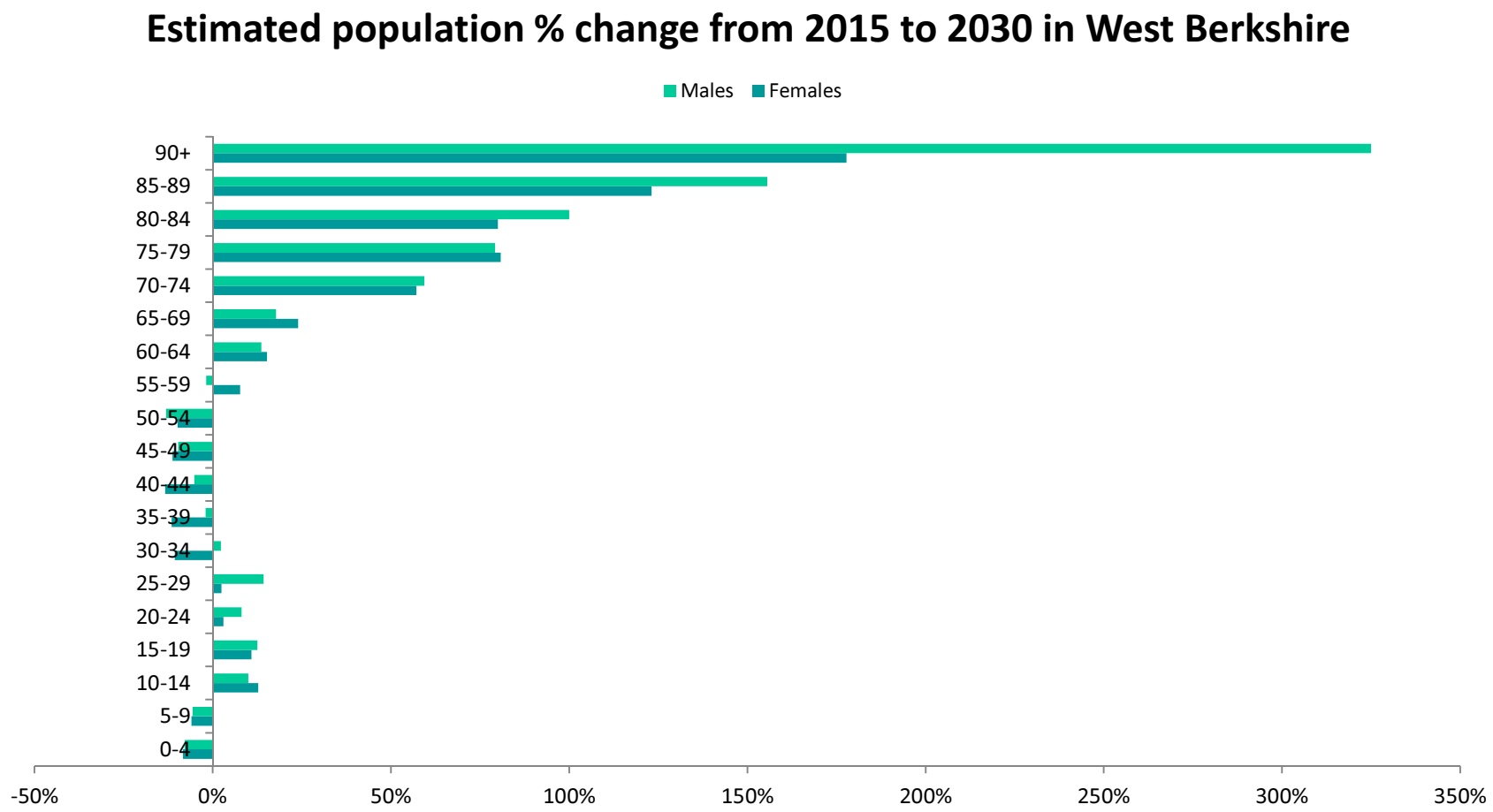


Source: Public Health Outcomes Framework (November 2014)

Delayed transfers of care attributable to adult social care per 100,000 people aged 18 and over in England

2010/11	2011/12	2012/13	2013/14
4.1	3.8	3.2	3.1

Population projections



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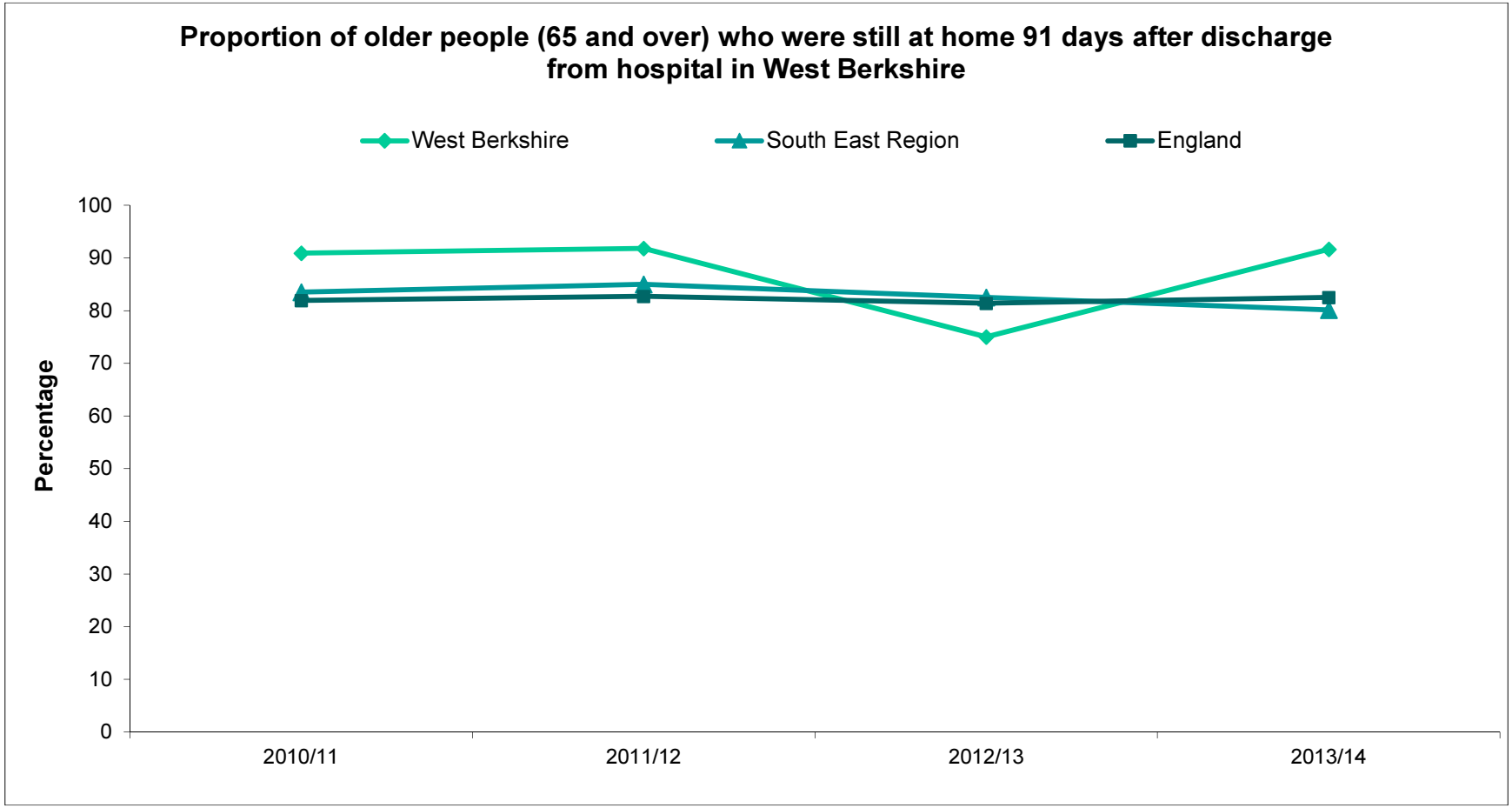
Independence in older age (July 2015)



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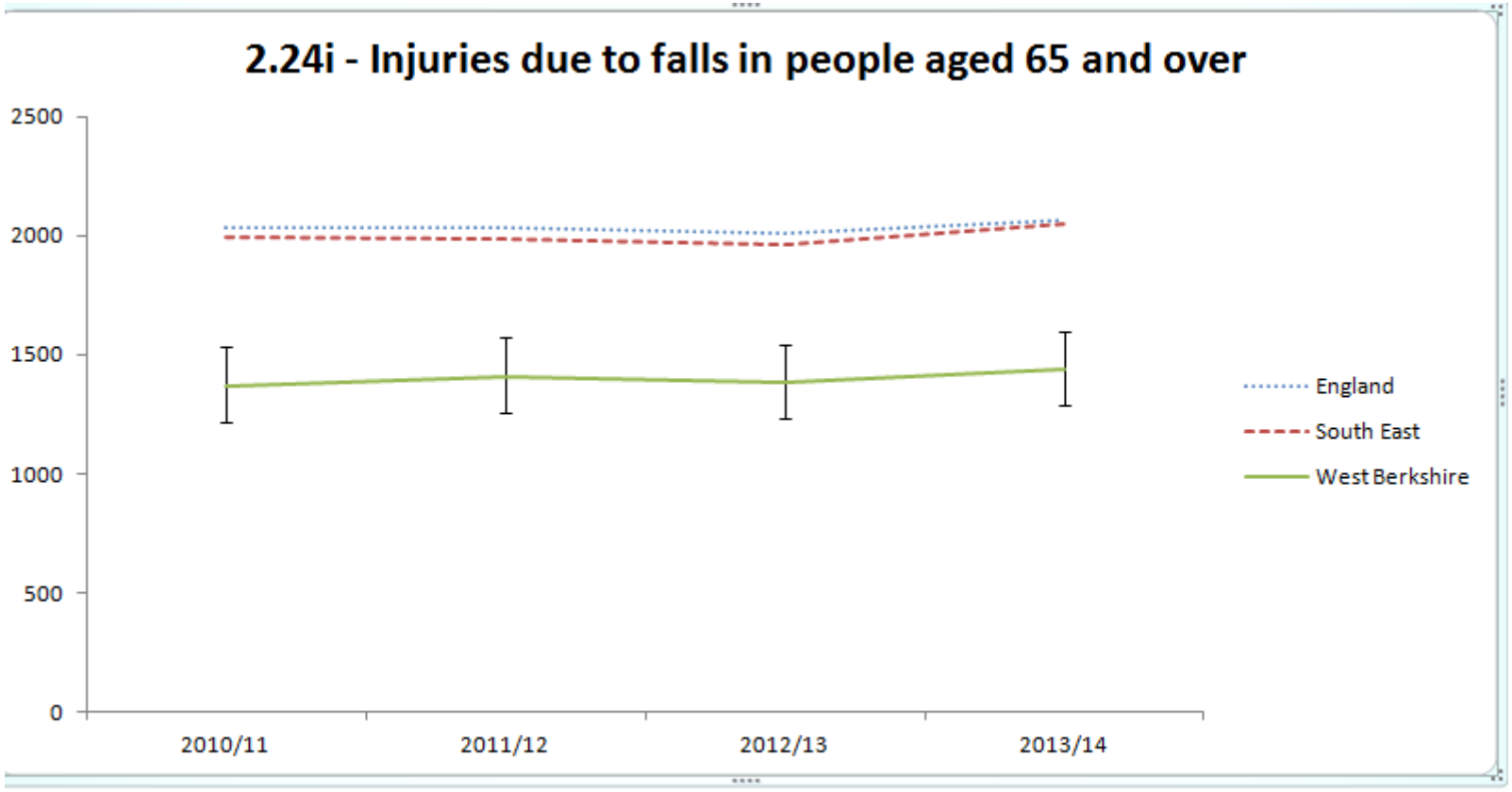
Falls and mobility (April 2015)



Source: Public Health Outcomes Framework

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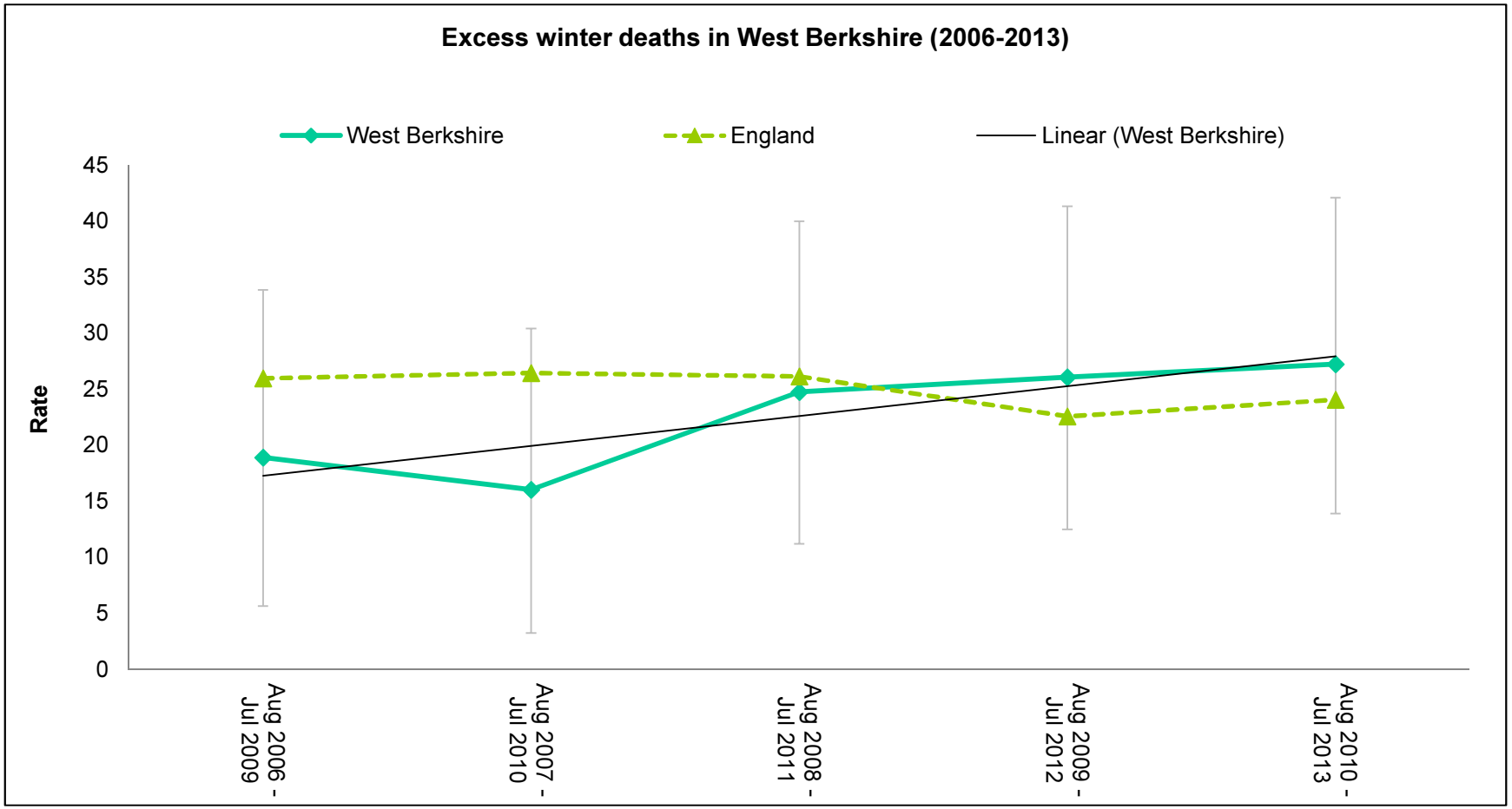
Falls and mobility – April 2015

Injuries due to falls in people aged 65 and over 2013/14

Area Name	Count	Rate per 100,000	Compared to England	Compared to South East
Bracknell Forest	300	1982.33	Same	Same
West Berkshire	370	1436.47	Lower	Lower
Reading	314	1522.82	Lower	Lower
Slough	340	2435.05	Higher	Higher
Windsor and Maidenhead	569	2009.30	Same	Same
Wokingham	382	1471.67	Lower	Lower

Source: Public Health Outcomes Framework

Excess winter deaths (April 2015)



End of Life care (August 2015) Newbury and District CCG

Place of death 2010-12 (average)

Place of death	Value	ll	ul	number	significance	national
Hospital	55.5	52.1	58.8	454	high	49.31
Home	23.7	20.9	26.8	194	none	22.16
Care home	17.1	14.7	19.9	140	low	20.74
Hospice	1.6	0.9	2.7	13	low	5.65
Other places	2.1	1.3	3.3	17	none	2.14

Source: National End of Life Profiles (Public Health England)

West Berkshire place of death

	WB	SE
Hospital deaths all ages	53.6%	44.4%
Care home deaths all ages	17.2%	24.4%
Hospice deaths all ages	2.5%	5.5%
Home deaths all ages	24.1%	21.4%

- 2013 - End of Life Care National profiles (PHE)

End of Life care (August 2015) North and West Reading CCG

- **Place of death 2010-12 (average)**

Place of death	Value	ll	ul	number	significance	national
Hospital	48.0	44.4	51.6	349	none	49.31
Home	24.2	21.2	27.4	176	none	22.16
Care home	17.6	15.0	20.5	128	low	20.74
Hospice	7.4	5.7	9.5	54	high	5.65
Other places	2.8	1.9	4.3	21	none	2.14

Source: National End of Life Profiles (Public Health England)

Employment and income (April 2015)

- ONS annual population survey Oct 2013-Sept 2014 showed the following:
- 85.5% of adults aged 16-64 were economically active (77.5% nat)
- 82,700 were employees (61.6% nat)
- 11,700 self employed (10.3% nat)
- 3.3% were unemployed (6.5% nat)

Employment and income (April 2015)

- Of those who are economically inactive (16-64)
  - 21.3% students (26.8 nat)
  - 37.9% looking after family/home (25.9 nat)
  - 9.9% long term sick (20.7 nat)
  - 15.7% retired (14.6% nat)

Qualifications – Jan – Dec 2013)

	% WB	% nat
NVQ 4 and above	41%	35%
NVQ 3 and above	61%	55%
NVQ 2 and above	78%	72%
NVQ 1 and above	91%	84%
No qualifications	4.7%	9.2%

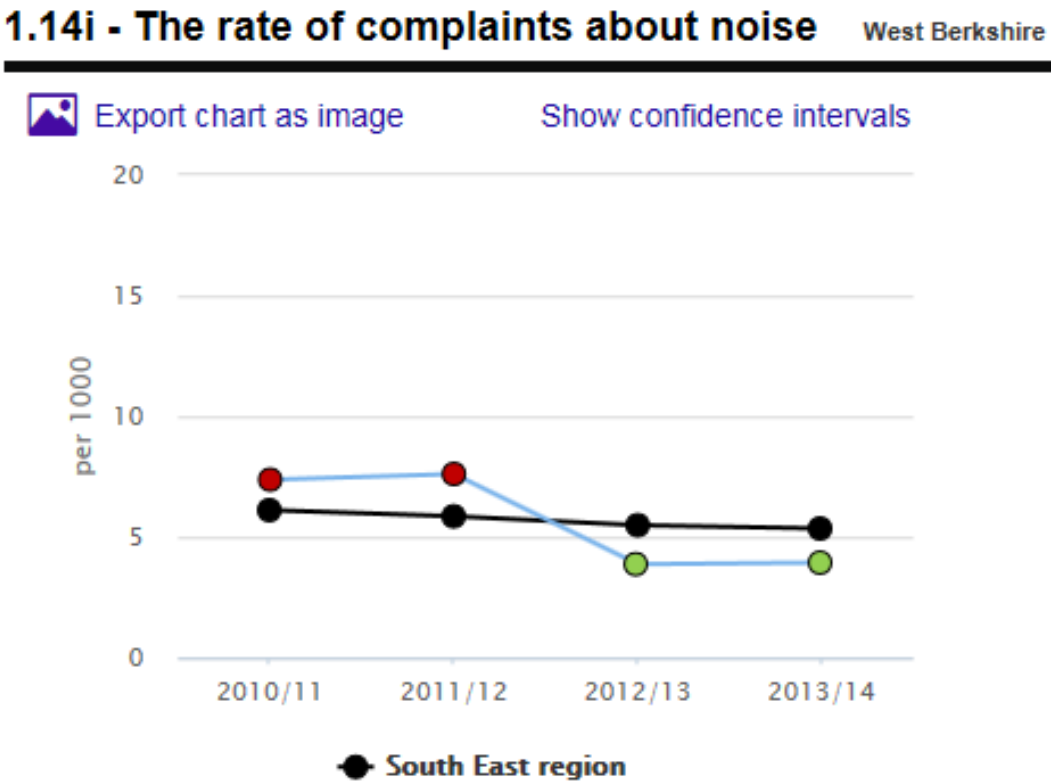
Key Benefit claimants (Aug 2014)

	WB	nat
Job seekers	0.7%	2.1%
ESA / incapacity benefits	3.4%	6%
Lone parents	0.7%	1.2%
Carers	0.8 %	1.4%
Disabled	0.9%	1.1%
Bereaved	0.2%	0.2%
Other income related benefits	0.2%	0.3%

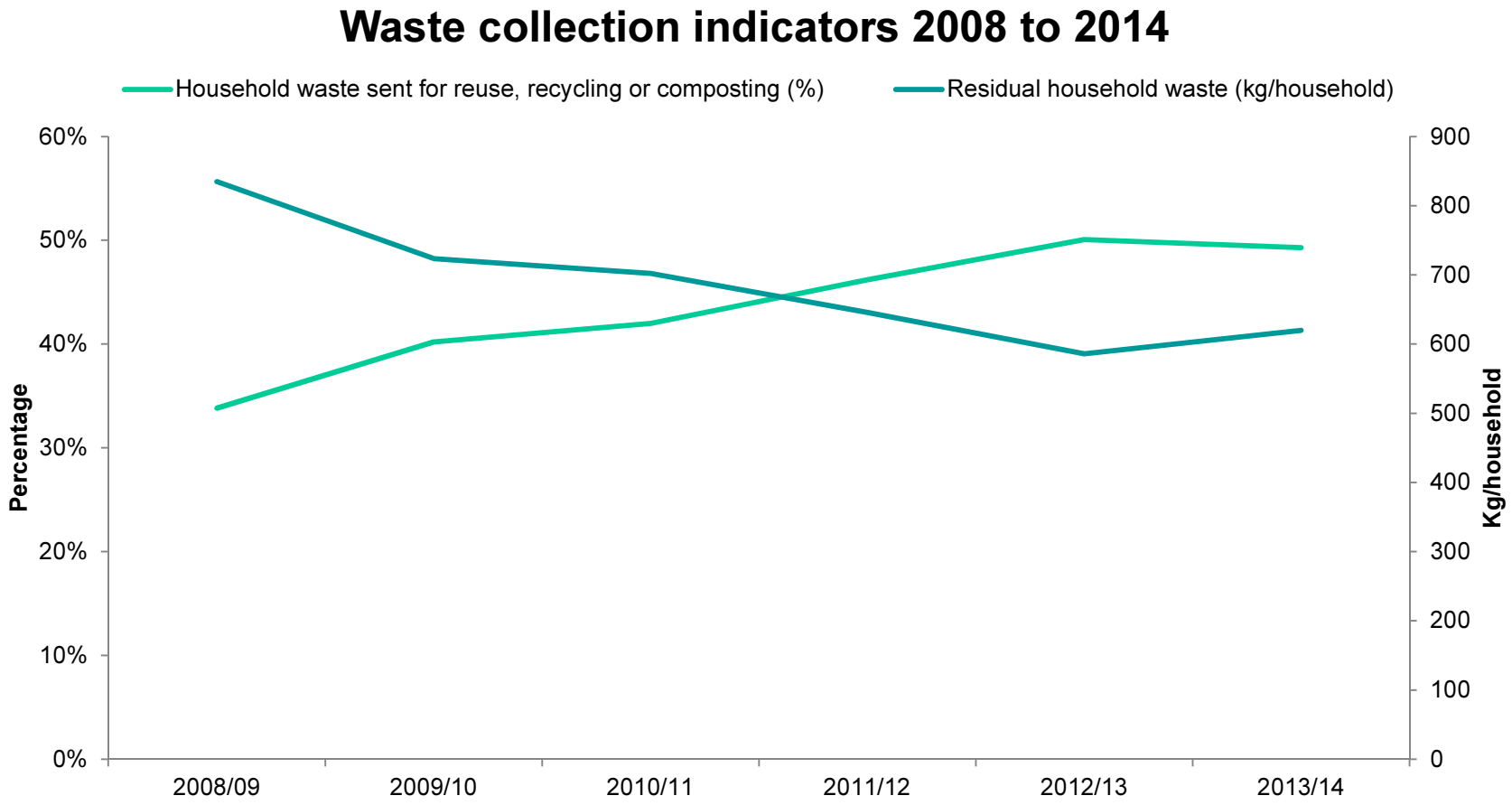
Offenders (Jan 2016)

- Report from the Thames Valley Community Rehabilitation Company (2015) showed that:
- Majority of people using the service were 18-35
- Most prevalent disability is mental illness (between 25 and 32% in different age groups)
- Accommodation, employment, education, emotional wellbeing, finance, alcohol and drugs
- 50% alcohol need, 31% with a drug issue
- 32% unemployed
- 41% had general health issues

Environment (June 2015)



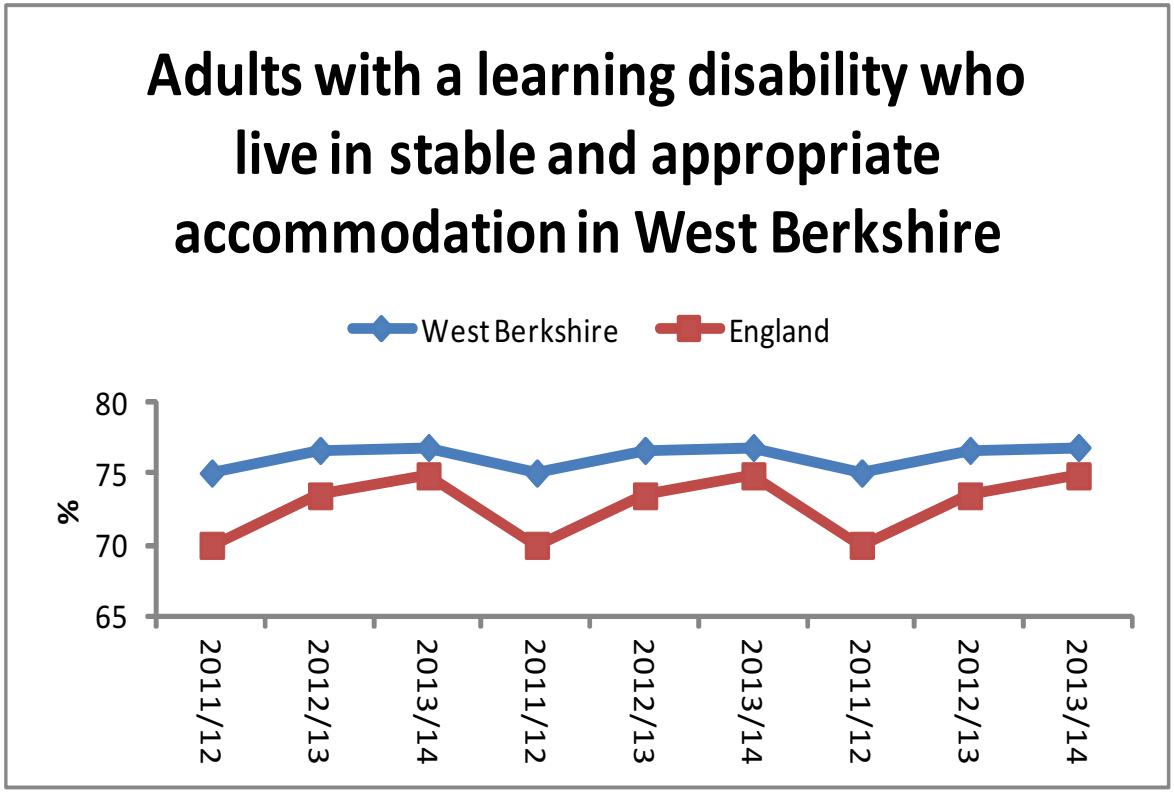
Environment (June 2015)



West Berkshire Council

Housing and homelessness (June 2015)

- PHOF



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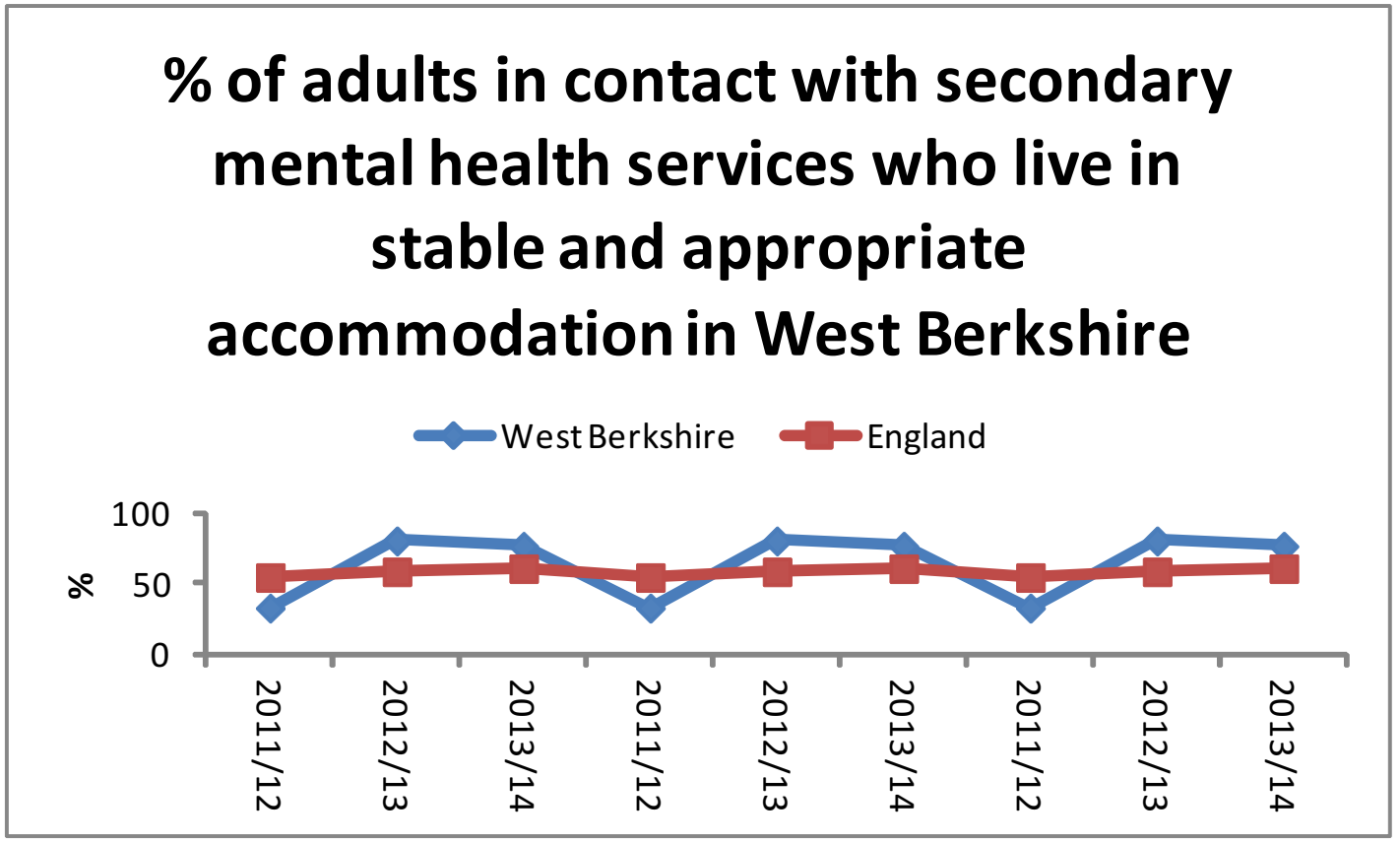
Housing and homelessness



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NHS
Newbury and District
Clinical Commissioning Group

Alignment of Commissioning Plans

Tandra Forster
Head of Adult Social Care WBC

Shairoz Claridge
Director of Operations Newbury and District Clinical Commissioning Group

West Berkshire COUNCIL

Background (1)

- The ambition behind the introduction of health and wellbeing boards was to build strong and effective partnerships, which improve the commissioning and delivery of services across NHS and local government, leading in turn to improved health and wellbeing for local people.
- The health and social care organisations across Berkshire West have come together to form the Berkshire West 10 Partnership. An early success of the partnership is a shared commitment to improving outcomes for local people through providing more integrated care to improve patient experience and achieve financial sustainability for all organisations.

Background (2)

The Berkshire West 10 Partnership working together have proposed the following objectives:

- Developing a shared understanding of how we spend our money, the opportunities for pooling resources to get the best value and outcomes for our communities, and the opportunities for providing more efficient care pathways
- Developing pilot initiatives looking at what it means to age well in Berkshire West, working with communities and local partners to gain insight and build on what is already working well
- Developing a proposal describing which new or existing models of care would work best for the Berkshire West system in the context NHS England's strategic plan and other national policies
- Developing proposals for improved system-wide governance arrangements across health and social care

Aligning Commissioning Plans

- Aligning commissioning plans and commissioning services jointly would strength the partnership's commissioning abilities and move towards delivering this ambition

Current status – Adult Social Care Commissioning

- ASC commissioning budget £35m
- Annual market position statement setting out intentions for the year
- Categories of spend include:
  - Residential/nursing beds
  - Domiciliary care
  - Supported living
  - Day opportunities
  - Equipment
  - Telecare
  - Advocacy
- Majority of investment is spot purchase

Current Status – CCG commissioning

The Newbury and District Clinical Commissioning Group has a budget of £117 million to commission health services for the Newbury population. We work in a federated arrangement with the three other CCGs across the Berkshire West area (including North & West Reading, South Reading and Wokingham CCGs) and all four CCGs work collaboratively to commissioning health services.

Below are the main health services commissioned:

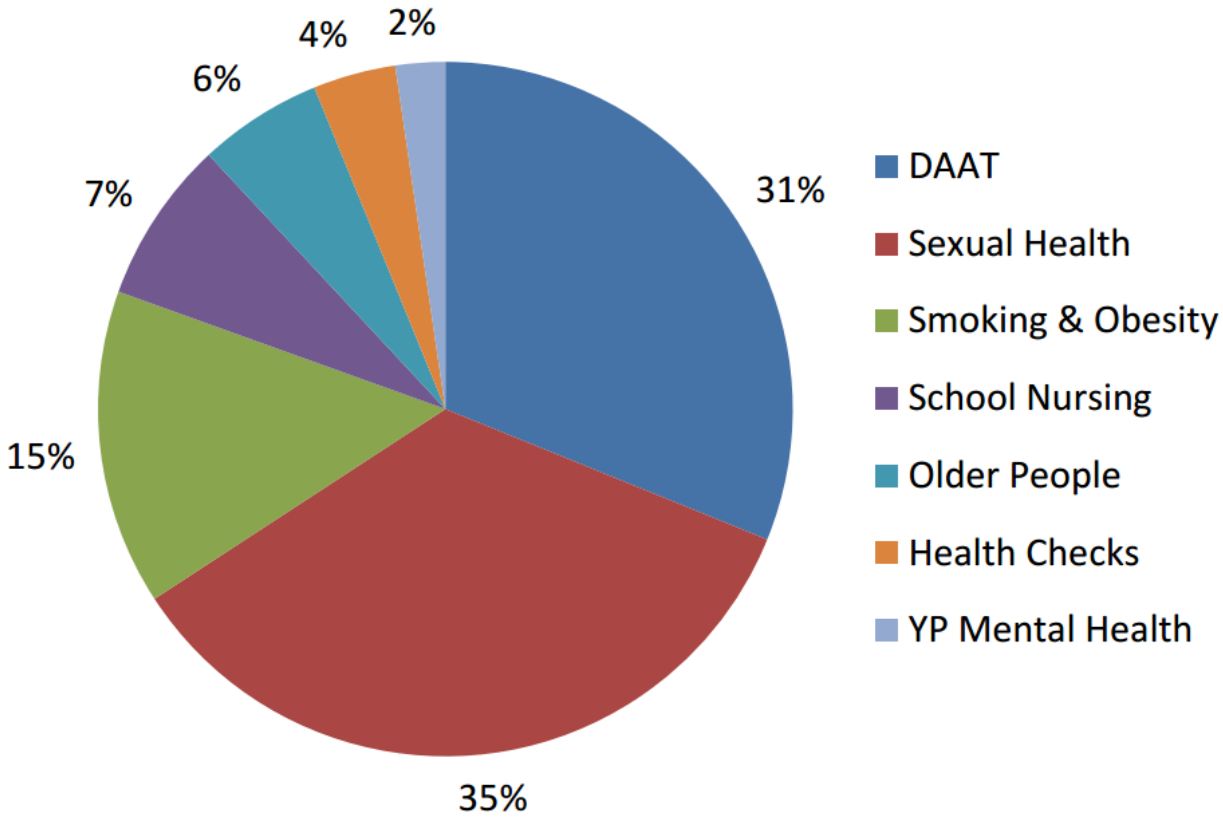
- Secondary Care Services (including urgent and planned services)
- Community and Mental Health Services
- Ambulance Services
- Prescribing
- Continuing Health Care

The four CCGs are in the process of applying to transfer the commission primary care services to CCGs from April 2016.

Current Status – Public Health commissioning

- 2015/16 budget £4,519,000
- Commissioning driven by the national Public Health Outcomes Framework under the following headings:
  - narrowing the health gap between areas of deprivation
  - Health improvement
  - Health protection
  - Healthcare and premature mortality
  - Wider determinants of health

Public Health main areas of spend in 2015/16



Current Status

Below are areas where the CCGs and Local Authorities across West of Berkshire (or Berkshire) are already working to align plans and commissioning services together:

1. Better Care Fund:
   - Joint Care Provider
   - Personal Recovery Guide
   - Enhanced Support to Care Homes
   - Designing an integrated pathway to manage the frail elderly
   - Integrated Carers Commissioning
   - Connected Care

2. Mental Health:
   - Street Triage
   - Crisis Concordat
   - CAMHs
   - Mental Health Advocacy

Current Status

1. Transforming care for LD
   - Developing community based care and support options for adults currently in long stay hospitals
2. Carers
   - Key priorities and service standards
   - Information and advice
3. Prevention
   - Public Health
   - New ways of working in Adult Social Care

Opportunities

The CCG Director of Joint Commissioning has been working with local authorities across West of Berkshire to look at potential areas for alignment/joint commissioning. These include:

- Children's services e.g. Children's and Youth counselling services
- Opportunities identified by crisis concordat
- Voluntary Sector Prospectus
- Out of hours provision
- Respite
- Residential/Nursing Care

Discussion

South, Central and West
Commissioning Support Unit

Meeting summary

Whole system communication & engagement event – West Berkshire

December 2015

Introduction

In December 2015, 36 colleagues from across the health, social and voluntary sector service West Berkshire met for the first time to discuss better partnership and cooperation between organisations in the system. The meeting was facilitated by Steven Buckley from South, Central and West Commissioning Support Unit.

The impetus for the meeting came from a Community Engagement Strategy commissioned by the West Berkshire Health and Wellbeing Board earlier this year. The strategy sets out the challenges and context for the system over the next five years:

- Health and social care facing severe resource restrictions
- Increasing demands from an ageing population and enduring health inequalities
- There is a real risk of consultation fatigue among the population.

Reconfiguration of local services, new ways of working with patients, care users and the public make for an opportunity to make big changes for the better, but the strategy is clear - residents must be properly listened to and engaged, and the system should better coordinate combined resources.

The strategy is summarised further in the workshop slides shown in appendix 1 and the full document is available online.

The following pages document the discussions that took place in support of the strategy on 10th December.

Agreed actions

Essential

- Complete the feedback form and email register
  (distribution list of participants to be shared in January)
- Be open to approaches to collaborate
- Proactively amplify and support one another's activities - review the common grid (page xx) - are there opportunities for you to amplify, collaborate with, or help a partner in West Berkshire?

Recommended

- Read full HWB engagement strategy : http://bit.ly/WestBerksHWBcomms
  (direct link to PDF, if link doesn't work when clicked then cut and paste to browser)
- Watch the Kings Fund film on how the NHS is structured
- Register your details on the Berkshire Health Network

Next meeting

- Date
  - tbc
- Frequency
  - quarterly
- Location
  - Broadway House or West Berkshire Hospital
- Proposed agenda items (for group discussion nearer to event)
  - Themed content discussion (eg. Dementia)
  - Social media training
  - Introduction to Health and Wellbeing Board
  - Case studies of partnership working
  - Project and best practice sharing
  - Speed dating
  - Hot focus on small number of partners

Discussion #1 **how is the system perceived?**

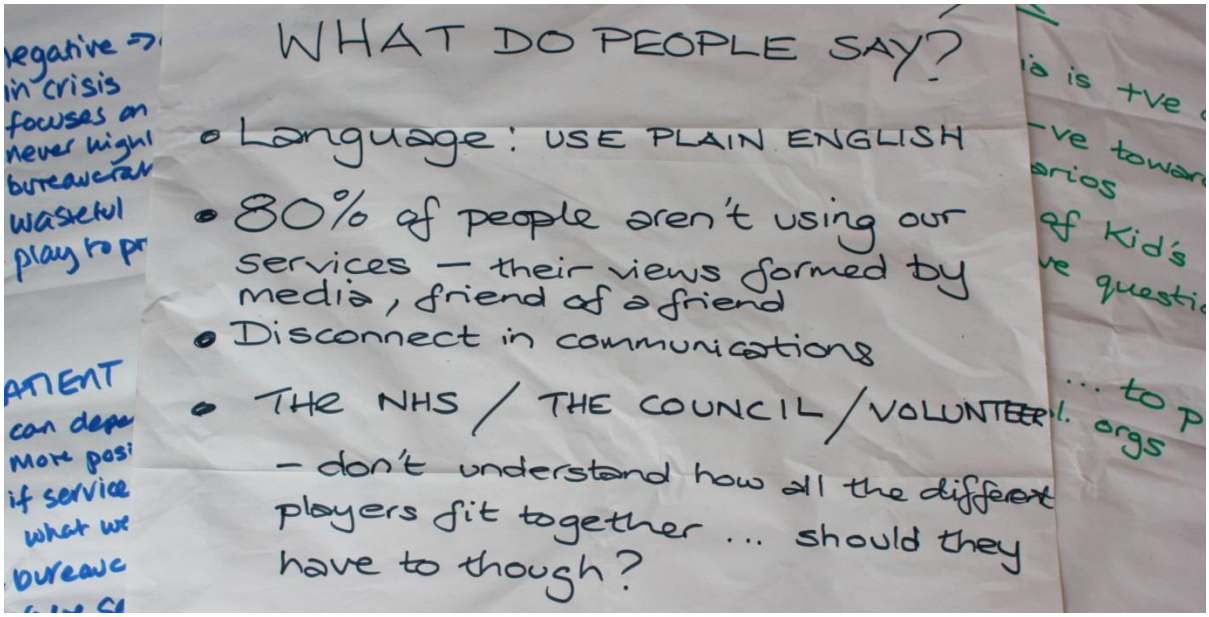


Table groups considered a) How voluntary, social and health sector presented in the media b) How system perceived by patients and service users, and c) what people outside the system say about the system.

Media

The media is vital at holding the system to account and very influential, however:

- Reporting is overly negative, focussing on mistakes and cuts and hardly ever the successes; "the 98% we get right isn't reported"
- Portrays a system that's in crisis, bureaucratic and wasteful of taxpayer funds, though generally more positive towards voluntary sector organisations
- Government targets often skew reporting; "RBH get more thank you's than complaints but this isn't recorded in national figures, so that never gets reported".
- Public struggle to understand service offering from reporting and the consequence of negative reporting can be frightening patients and service users away from treatment.

Patients and service users

Views can be mixed, though most will struggle to navigate the complexities of the system.

- We fail to properly explain the outcomes and consequences of changes (and cuts we're making).
- Opinions about the system can be polarised based on personal experience.
- People don't speak up for a service until it's about to change
- There are often unrealistic expectations about what should be provided by the system and what it costs to run services.
- People question whether they really have a voice in influencing local decision making.

How the system is perceived from outside the system

Expectations on the system are very high and can be hard to deliver. While hospitals and voluntary sector are typically held in high regard;

- Tangental issues can skew opinion – such as delays in being seen, trouble car parking etc.
- 80% of residents aren't using our services on a regular basis, but their opinion is shaped by the media and experience of friends / family.
- The system is seen as needlessly complex and chaotic, there's little understanding of the component parts and people don't understand why services don't work / fit together.
- People see the lack of plain English as obfuscating.
- The voluntary sector sometimes seen as part of the formal system, for instance Citizens Advice Bureau not considered a charity.

Plenary discussion

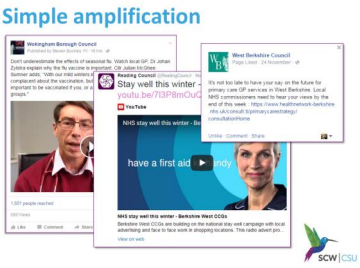
- Dealing with complexity is important. If the group members struggle to navigate the system, how must it be for residents, patients and service users?
- Media negativity can be problematic. However, providing readily usable human interest content, coupled with understanding that the media is actually about the conflict of ideas, will mean that media pick up stories where a genuine difference is being made (or different approach taken).

- The public are not entirely reliant on media for opinion forming. Social media creates a huge opportunity for the West Berkshire System to tell its stories through its own channels. The challenge for the group is to leverage those channels far better.

Action point to take forward

The challenge in West Berkshire is to tell (and resource) good news stories, deal with complexity and work together better as a system. We need to recognise the severe risk of consultation fatigue and coordinate our activities.

Amplifying and supporting one another



What we can do straight away

- Sharing and 'liking' each other's social media content
- Telling each other when new resources are available
- Providing ready-made content for partners to use on their own channels, including public meetings, newsletters and intranet sites.
- Leverage the village agent network (more info here)
- Send content for community newsletters (including Church and faith groups)
- Circulate information via parish council contacts (Peta at WBC can support)
- Leverage Get Berkshire Active's activity finder - http://www.getberkshireactive.org/events/
- Consider pooling resources for joint promotional materials etc.

The challenge from the Health and Wellbeing board

The HWB have challenged us to go further still and ask for:

- Common register of consultations and engagement on our websites
- Joint events (where appropriate)
- One joint consultation exercise in year 1
- Shared information and data
- Expanding partnership beyond health and social care.

Discussion #2

Making partnership working a reality

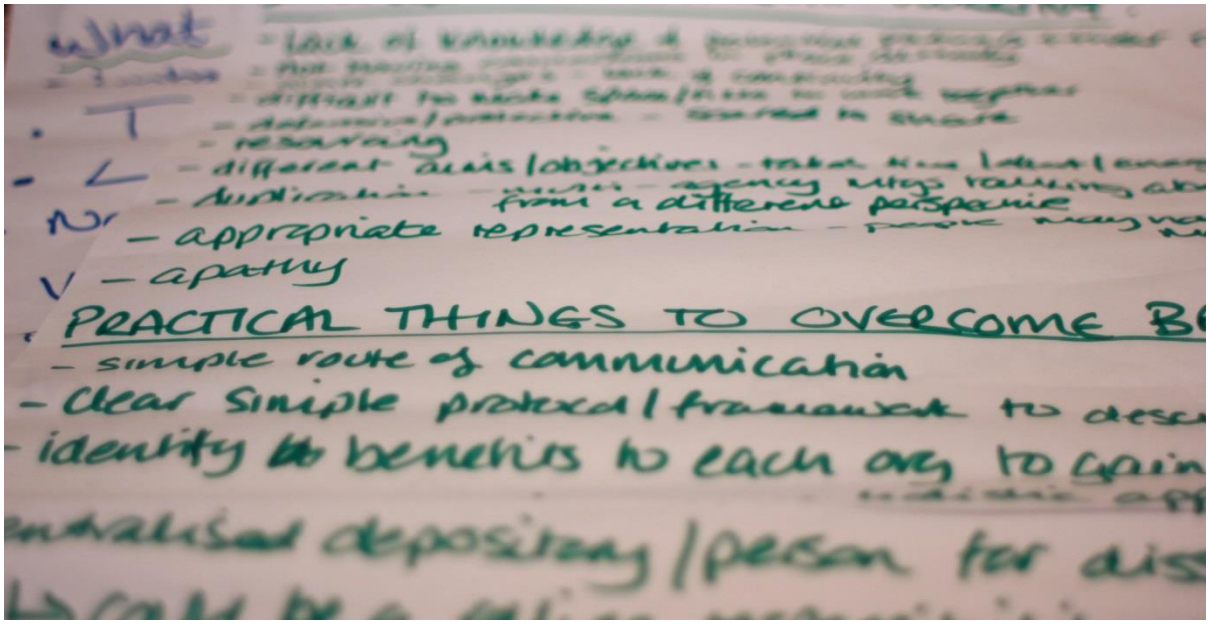


Table groups considered a) the barriers to partnership working, b) the things the group can practically do to overcome barriers, c) how is partnership balanced and self-organising, and d) when is it OK to say 'no'.

Potential barriers to partnership working

- Lack of resources – time, budget, people, knowledge, energy
- Differing organisational agendas and priorities
- Formal contractual arrangements
- Imbalance of power (within system and within sectors)
- Continuity of contacts
- Failure to see benefits of partnership
- Competitive behaviours - 'scared to share'

Practical steps to address barriers

The meeting was of a mind that the barriers are surmountable and recognised that each member is responsible for owning 'partnership' and taking responsibility for the success of the group.

Specific steps to address barriers were:

- Recognise everyone in the group is an equal partner – whether employed or volunteer, large or small organisation.
- Agree a common vision for the group and establish a partnership mindset, exercising trust with one another.
- Be realistic about what the group can achieve together, search out quick wins and offer early case studies to demonstrate benefits of partnership working.
- Seek common ground, joint agendas and pooling of resources where OK to do so, have the maturity of relationship to say 'no' when organisational priorities (or lack of resource) stands in the way of partnership working.
- Ensure meetings are action oriented and opportunity to learn / share best practice
- Combined key moments calendar and selected joint working against (eg. World Mental Health Day)
- Find time to network and collaborate – work to get to know partners better and pick up the phone, or instant message, rather than emailing one another.
- Engaging with each other's client groups and service users.
- Establish common tools and resources to support the group, and make sure resources already in place are leveraged (such as the Empowering West Berkshire database)
- Inform senior leaders about what the group is trying to achieve, ask for their support and be prepared to share measurable outcomes of partnership.

Action point to take forward

We know that our organisational priorities and resources won't always align, but there's a clear desire to work in partnership across the system where we can do so. Let's seek early opportunities to support and collaborate with one another.

Discussion #3

Towards a common grid

Participants worked in pairs to identify communications and engagement priorities for January – March 2016. The following pages are very much work in progress and will be refined as the group begins to see the benefits of working together

Note: not all pairs completed forms during the workshop.

January

Theme / activity	Organisation	Help needed
○ Awards promotion	Get Berkshire Active	○ Promote event to networks
○ Awareness of benefits of advice services for young ppl	West Berks CAB	○ Access to stakeholders / comms channels
○ Request for case studies	Support at Home	○ Support to promote referrals ○ Request for short citations
○ Outreach to seldom heard groups	CCG	○ Access to lists ○ Collaboration to define cohort
○ Improve access to information leaflets	Great Western Hospital NHS FT	○ Healthwatch support
○ Raise public awareness of Healthwatch and encourage volunteers	Healthwatch west berkshire	○ System wide promotion
○ Children and Young People voluntary sector forum meeting	Empowering WB	○ Promote event / event outcome
○ Community conversation – Calcot		○ tbc
○ Promotion of NHS winter messages	All health sector orgs	○ Amplify and use organic content.
○ Patient leader programme	BHFT	○ Promote opportunity to join / existence of programme

○ Finding VIAs throughout WB	Village agents	○ Partners to support search for volunteers
○ Four houses corner refurbishment (gypsy and traveller site)	West Berks Council	○ Multi agency support - tbc

February

Theme / activity	Organisation	Help needed
○ Promo videos for GBA	Get Berkshire Active	○ Share films
○ Awards promotion		○ Promote event to networks
○ Build referral pathways	West Berks CAB	○ Access to NHS and Local authority stakeholders / comms channels
○ Talking therapies promotion	IAPT team	○ Links w/ local community, GPs, vol sector
○ Disseminating Young People with Dementia (www.ypwd.info) information	Younger people with dementia	○ Share events and content on partner channels
○ Event to network and explain service	West Berkshire Independent Living Network (WBILN)	○ Promotion of event
○ Single service offer	West Berkshire Council	○ Service providers to promote single service offer and offer consistent information.
○ New surgery at Strawberry Hill	Patient Information Point (PIP)	○ Promote the PIP
○ Support for elderly, isolated parishoners	East Downland Churches	○ Promote village agents / social prescribing
○ Unknown carers / young carers project	CCG	○ Help to promote importance of registering as a carer with GP.
○ Myth busting – dealing with top 3 complaints	Great Western Hospital NHS FT	○ Help to counter negative perceptions / distribute information.
○ Promote fundraising	West Berks therapy centre	○ Share information with

and relocation of service		networks
○ Promote role and purpose of Health and Wellbeing board	CCG	○ Awareness raising of HWB ○ Support to create vision and mission statement
○ Voluntary sector event	Empowering WB	○ Support for and attendance at event
○ Mental health local forum participation	BHFT	○ Encourage people to share views on MHPPI
○ Promote village agents service	Village agents	○ Partners to promote service on own channels.
○ New ways of working in adult social care	West Berkshire Council	○ Partners to share information about changes

March

Theme / activity	Organisation	Help needed
○ Promote service offering	Horse sense for life CIC	○ Access to partner newsletters / intranet channels
○ New 'It's my life' resource	Patient Information Point (PIP)	○ Share and promote use of leaflet
○ Launch 2016/17 training programme and resources	Empowering WB	○ Partners help to promote
○ Support for referrals	Village agents	○ Health and social care partners to assist in informing professionals

APPENDIX 1 - Workshop slides

West Berkshire HWB
Community engagement strategy

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

- save money, by reducing duplication and exploiting economies of scale
- increase effectiveness by sharing skills and capacity
- do things which would not otherwise be possible
- develop deeper insight into the needs and views of patients, care users and the public, by pooling the intelligence of each of the parties
- reduce 'consultation fatigue' by not repeatedly approaching the same sections of the public for feedback.

West Berkshire HWB
Community engagement strategy

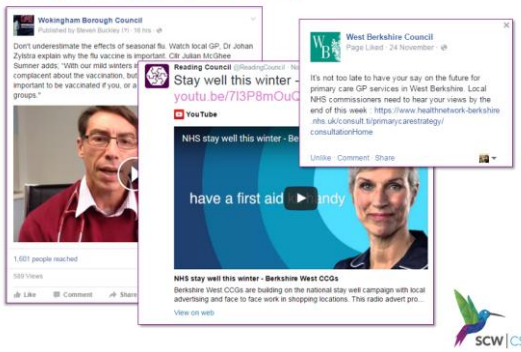
Risk

- Tremendous strain on the relationships between partners in system.
- Trying to achieve too much (through partnership), or insufficient and inconsistent commitment.

Need

- Strong personal relationships
- Recognise and respect interests of each org.

Simple amplification



Simple amplification

- Retweets
- Likes and shares
- Embedded organic content
- Newsletters
- Intranet pages
- ....?

The challenge from the HWB

- Common register of consultations and engagement
- Joint events (where appropriate)
- One joint consultation exercise in year 1
- Shared information and data
- Expanding beyond health and social care.

Discussion #2
Making partnership working a reality

What are the barriers to partnership working?

What are the things we can practically do to overcome any barriers?

How is partnership balanced and self organising, and when is it OK to say 'no'

- Work in table groups
- 30m for discussion – inject after 15m
- Rapporteur notes
- Another to feedback key points to room following lunch.

Discussion #3
Getting to a common grid

Priorities for Q4
(Jan to March 2016)

Support you need from the system / opportunity to collaborate.

(if time – what's on the horizon for Q1/2 16-17)

- Work in pairs
- 20min for completion of sheets
- Collated and shared post event.

Wrap up... next adjacent step

- Write up workshop and actions
- Aggregate first quarter plans

❑Feedback form (email distribution list)
❑Be open to approaches from the system
❑Seek opportunities to collaborate
❑Next meeting? When, where, focus area?