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# Notice of Meeting

# Health and Wellbeing Board

## Thursday 25 May 2017 at 9.30am

in West Berkshire Community Hospital, London Rd, Benham Hill, Thatcham RG18 3AS

Date of despatch of Agenda: Wednesday, 17 May 2017

For further information about this Agenda, or to inspect any background documents referred to in Part I reports, please contact Jo Reeves / Jessica Bailiss on (01635) 519486/503124
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Further information and Minutes are also available on the Council's website at www.westberks.gov.uk

West Berkshire COUNCIL

**To:** Heather Bowman (Executive Director, Housing & Communities (Sovereign)), Garry Poulson (Volunteer Centre West Berkshire), Paul Jones (Group Manager (RBFRS)), Dr Bal Bahia (Newbury and District CCG), Dr Barbara Barrie (North and West Reading CCG), Rachael Wardell (WBC - Community Services), Cathy Winfield (Berkshire West CCGs), Councillor Lynne Doherty (Executive Portfolio: Children's Services), Councillor Graham Jones (Leader of the Council & Conservative Group Leader), Councillor Mollie Lock (Shadow Executive Portfolio: Education and Young People, Adult Social Care), Andrew Sharp (Healthwatch), Councillor Rick Jones (Executive Portfolio: Adult Social Care), Councillor James Fredrickson (Executive Portfolio: Health and Wellbeing), Councillor Marcus Franks (Executive Portfolio: Community Resilience & Partnerships), Jim Weems (Thames Valley Police) and Judith Wright (Public Health)

# Agenda

## Part I

**Page No.**

1 **Election of the Chairman and Appointment of the Vice Chairman**
To elect a Chairman and appoint a Vice-Chairman for the 2017/18 Municipal Year.

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

3 **Minutes** 5 - 18
To approve as a correct record the Minutes of the meeting of the Board held on 30 March 2017 and the Special meeting held on 4 May 2017.

4 **Health and Wellbeing Board Forward Plan** 19 - 20
An opportunity for Board Members to suggest items to go on to the Forward Plan.

5 **Actions arising from previous meetings** 21 - 22
To consider outstanding actions from previous meeting(s).

6 **Declarations of Interest**
To remind Members of the need to record the existence and nature of any personal, disclosable pecuniary or other registrable interests in items on the agenda, in accordance with the Members' Code of Conduct.

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

8 **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.

## Strategic Aim: Reduce Premature Mortality by Helping Everyone Live Healthier Lives

9 **Annual Report from the Director of Public Health** 23 - 48
For the Board to focus on it's medium term objective to 'reduce premature mortality by helping people live healthier lives', which is the subject of the Annual Report from the Director for Public Health.

## Health and Social Care Integration

10 **Accountable Care System Update (Cathy Winfield)** 49 - 58
To provide an update on the Accountable Care System.

## Programme Management

11 **Delivering the Health and Wellbeing Strategy (Delivery Plans) (Jo Reeves)** 59 - 80
To outline the activities that will be completed by the sub-groups to deliver measurable progress towards the aims and objectives in the Health and Wellbeing Strategy.

12 **Alcohol Harm Reduction Partnership Update (Debi Joyce)** 81 - 138
For the Alcohol Harm Reduction Partnership to provide an update on progress against the Board's priority for 2017 to 'reduce alcohol related harm across the district for all age groups'.

13 **Community Conversations Update (Susan Powell)** 139 - 150
For the Building Communities Together Partnership to to provide an update on progress against the Board's strategic focus to 'increase the number of Community Conversations through which local issues are identified and addressed.'

14 **Review of the Health and Wellbeing Conference held on 27 April 2017** 151 - 160
To summarise the content of the conference and consider the next steps for the actions which arose.

# Items for Information

15 **Berkshire West CCGs Cancer Framework 2016-2020** 161 - 164
To communicate to the Health and Wellbeing Board the plan for locally delivering the national cancer strategy and to confirm any involvement from Health and Wellbeing members especially around the prevention element of the framework.

16 **Members' Questions**
Members of the Health and Wellbeing Board to answer questions submitted by Councillors in accordance with the Executive Procedure Rules contained in the Council's Constitution. *(Note: There were no questions submitted relating to items not included on this Agenda.)*

17 **Future meeting dates**
Development Session, 6th July 2017, 9.30am in the Council Chamber
Health and Wellbeing Board, 28th September 2017, 9.30am in the Council Chamber

Andy Day
Head of Strategic Support

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

**DRAFT**

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

# HEALTH AND WELLBEING BOARD

# MINUTES OF THE MEETING HELD ON THURSDAY, 30 MARCH 2017

**Present**: Garry Poulson (Volunteer Centre West Berkshire), Paul Jones (Group Manager (RBFRS)), Dr Bal Bahia (Newbury and District CCG), Dr Barbara Barrie (North and West Reading CCG), Rachael Wardell (WBC - Corporate Director: Communities), Councillor Lynne Doherty (Executive Portfolio: Children's Services), Councillor Mollie Lock (Shadow Executive Portfolio: Education and Young People, Adult Social Care), Andrew Sharp (Healthwatch), Richard Benyon, Councillor Hilary Cole (Executive Portfolio: Planning, Housing and Leisure Centres) and Councillor Marigold Jaques (Council Member)

**Also Present:** Alison Foster (Healthwatch), Tandra Forster (WBC - Adult Social Care), Jo Reeves (Principal Policy Officer), Adrian Barker (Healthwatch), Darrell Gale (Wokingham Borough Council), Jason Jongali (Berkshire West CCGs), Deborah Joyce (Senior Programme Officer), Susan Powell (Safer Communities Partnership Team Manager), Beverley Searle (Berkshire NHS) and Dr Angus Tallini (GP Clinical Lead NDCCG)

**Apologies for inability to attend the meeting:** Heather Bowman, Dr Lise Llewellyn, Cathy Winfield, Councillor Graham Jones, Councillor Rick Jones and Councillor Marcus Franks

## PART I

### 29 Minutes

Dr Bal Bahia opened the meeting by explaining that Councillor Roger Croft, Leader of the Council and a member of the Health and Wellbeing Board, had died on Friday 24th March 2017 after being unable to recover from the serious injuries he sustained in a car accident while travelling in France five weeks previously. Dr Bahia noted with sadness that Mrs Zelda Croft died in the accident. Councillor Croft was a friend and colleague to many of the Health and Wellbeing Board members; Dr Bahia expressed sympathy to all of his friends and family at this difficult time.

Dr Bahia welcomed Richard Benyon MP to the Health and Wellbeing Board.

The Minutes of the meeting held on 24 November 2016 were approved as a true and correct record and signed by the Vice-Chairman.

### 30 Health and Wellbeing Board Forward Plan

The Health and Wellbeing Board noted the forward plan.

### 31 Actions arising from previous meetings

The Health and Wellbeing Board noted that there were no outstanding actions arising from the previous meeting.

### 32 Declarations of Interest

Dr Bal Bahia and Dr Barbara Barrie declared an interest in all matters pertaining to Primary Care, by virtue of the fact that they were General Practitioners, but reported that as their interest was personal and not a disclosable pecuniary or other registrable

interest, they 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 a disclosable pecuniary or other registrable interest, he determined to remain to take part in the debate and vote on the matters where appropriate.

## 33 Public Questions

### a Question submitted by Ms Pam Hayden:

A question standing in the name of Ms Pam Hayden on the subject of support for homeless people with severe mental health issues was answered by Dr Bahia on behalf of the Board.

### b Question submitted by Ms Pam Hayden:

A question standing in the name of Ms Pam Hayden on the subject of mechanisms to support communication between homeless people with mental health issues and their support workers was answered by Dr Bahia on behalf of the Board.

### c Question submitted by Ms Pam Hayden:

A question standing in the name of Ms Pam Hayden on the subject of new government funding for mental health was answered by Dr Bahia on behalf of the Board.

### d Question submitted by Mrs Martha Vickers:

A question standing in the name of Mrs Martha Vickers on the subject of a new community resilience officer was answered by Dr Bahia on behalf of the Board.

### e Question submitted by Mrs Martha Vickers:

A question standing in the name of Mrs Martha Vickers on the subject of Mental Health First Aid courses was answered by Dr Bahia on behalf of the Board.

### f Question submitted by Mrs Martha Vickers:

A question standing in the name of Mrs Martha Vickers on the subject of incidents of asthma in Newbury compared to other towns was answered by Dr Bahia on behalf of the Board.

## 34 Petitions

There were no petitions presented to the Board.

## 35 Mental Health Focus (Richard Benyon MP, Alison Foster, Darrell Gale, Bev Searle, Jason Jongali, Rachel Johnson)

Dr Bal Bahia opened discussion of the item by stating that the Board had planned to choose particular areas of interest on which to focus meetings of the Health and Wellbeing Board. It was timely that the Board should focus on mental health in this meeting, considering the launch of the Brighter Berkshire campaign. Richard Benyon MP was invited to make a statement to open the discussion.

Richard Benyon MP thanked the Board for the opportunity to speak about mental health and expressed the view that a step change was needed in the way the statutory,

voluntary and community organisations worked together to improve the way that people with mental health issues were supported.

One in four people experience mental health issues at some point in their lives, demonstrating how common mental health disorders were. The predicted economic cost to society of mental health problems was £105 billion which was equivalent to the entire NHS budget. Mental health problems were more likely to affect young people and people on low to medium incomes.

In the workplace, one in five working adults is affected by mental health issues and nearly one in seven experience mental health problems in the workplace. In 2015 the estimated cost to employers was estimated to be around £9 billion.

2017 was the Year of Mental Health and Brighter Berkshire was a fantastic campaign looking to fund mental health projects and reduce duplication with its mantra 'do once for Berkshire'.

'Making Every Adult Matter' was an ambitious campaign which sought to end rough sleeping and tackle homelessness. The connection between homelessness and mental health was somewhat obvious as mental health problems could be exacerbated or caused by homelessness and vice versa. Thanks were owed to Lindsey Finch from Thames Valley Police who had agreed to take forward the work to make every adult matter.

The Government had recently announced that £11.7 billion would be made available for preventing and treating mental health issues. The Prime Minister, in a speech to the Charity Commission on 9th January 2017 had outlined plans to offer further support for mental health and Richard Benyon wanted to ensure that residents in West Berkshire would benefit from these plans. The government planned to pilot new approaches such as offering mental health first aid training for teachers and staff to help them identify and assist children experiencing mental health problems and ensure that schools and colleges worked closer together with local NHS services to provide dedicated children and young people's mental health services. In the workplace, the government wanted to strengthen links with employers to support people with mental health problems back into work. In communities the government would make up to £15 million of extra funding available for community clinics, crisis cafes, and alternative places of safety. There would be investment in digital mental health services which would be of particular benefit to residents in West Berkshire who experienced rurality and isolation.

Locally, there were three particular issues which Richard Benyon asked the Board to consider how they might help: first, the Friends in Need needed continued funding if it was to continue its good work. Second, no mental health charities had received CCG funding. Thirdly, from his casework, Richard Benyon advised that people were not always discharged from Prospect Park with the appropriate support. He concluded by saying that the Brighter Berkshire campaign offered an opportunity to create a step change in the way that mental health services were provided.

Ali Foster, on behalf of the Brighter Berkshire campaign, addressed the Board. Brighter Berkshire was a year long, volunteer lead campaign which wanted to raise awareness about mental health. It sought to encourage organisations and individuals to understand that everyone had a role in improving mental health. Mental health services often felt disjointed, with no one person being responsible for oversight of mental health in Berkshire.

The Brighter Berkshire campaign had launched a website and a logo, a song writing competition and had held a Walk and Talk event. They would be broadcasting a regular

programme on BBC Radio Berkshire to raise awareness of the campaign and try to reduce the stigma around discussing mental health openly.

Ali Foster expressed the view that CCG funding had halved and had been prioritised towards children and family services rather than adults only mental health services. The Suicide Prevention Strategy for Berkshire did not include children. It was difficult to acquire information from professionals via informal channels and there was a disconnect between decision-makers and service users. She encouraged all the organisations represented at the Health and Wellbeing Board to make a pledge to outline how they would support the Brighter Berkshire campaign.

Councillor Lynne Doherty noted that the CCGs had given some funding to HomeStart to support perinatal mental health. She accepted that more could be done to raise visibility of West Berkshire's mental health 'offer'.

Rachael Wardell advised that the Adult Social Care service was open to people with mental health problems, as was the Social Care Information Point; she suggested that better links could be made between those service and Brighter Berkshire.

Andrew Sharp expressed the view that the Health and Wellbeing Board might have a role to give some structure to the Mental Health Forum to ensure that the communication between different services was improved.

Shairoz Claridge noted that the way different services worked together was not always perfect but the other speakers would pick up on the ways that integrated working was being pursued. Regarding the specific point about the Friends in Need service, Shairoz Claridge explained that the group did not meet the CCG's strict criteria.

Darrel Gale presented the Board with the draft Berkshire Suicide Prevention Strategy. The NHS Five Year Forward View for Mental Health set a target on all NHS agencies and partners to reduce the current level of suicide by 10% by 2020. To achieve this, the Department of Health recommended, in the National Suicide Prevention Strategy, that all top tier local authorities produce suicide prevention actions plans. In Berkshire, this has been coordinated by a multi-agency suicide prevention group who have drafted a strategy which includes a Berkshire-wide action plan, and local action plans responding to the unique needs and circumstances of each of the six unitary authorities in Berkshire. The action plans would be reliant on multi-agency working and partners across the health and public sectors are in the process of endorsing the strategy.

Berkshire Authorities had not published a suicide prevention action plan at the time of the 2015 All Party Parliamentary Group inquiry into local suicide prevention plans in England. Action plans were a recommendation of the England Suicide Prevention Strategy published in 2012. Since 2015, a high-level multi-agency steering group met in Berkshire to plan a local audit of suicides and to work together on a strategy and action plans for the local authorities. This draft strategy was the result of this work and a recommendation of the strategy was that all six local health and wellbeing boards endorse the strategy and their local action plans.

The strategy included a target to reduce suicides by 25% as the steering group had expressed the view that it would be possible to be more ambitious than the national recommendation.

Darrel Gale outlined the recommendations of the strategy and summarised that the strategy would be formally published in September 2017 on World Suicide Prevention Day.

Rachael Wardell expressed the view that unless there was an evidence base for the 25% reduction target it would be more ambitious to set a zero- target to demonstrate that no suicides would be deemed to be tolerable.

Councillor Quentin Webb noted the good work of the Charlie Waller Memorial Trust and enquired whether there had been any decrease in the number of suicides as a result of their work. Darrel Gale responded that it would be difficult to tell due to a lag in the data but supported the charity.

Darrel Gale gave a warning that although suicide among children was extremely rare, the internet offered easy access to material which promoted suicide and thought was being given nationally to what could be done about it.

Dr Bal Bahia noted that the Berkshire Healthcare Foundation Trust and Royal Berkshire Healthcare Trust promoted a zero-suicide target. He concluded that the Health and Wellbeing Board approved the Berkshire Suicide Prevention Strategy with the advisory that they would like to see a zero suicide target.

Bev Searle, on behalf on the Berkshire Healthcare Foundation Trust, presented the Berkshire West Mental Health Strategy which had been developed with the unitary authorities and commissioners. In Berkshire West there was a good foundation to meet the targets in the NHS Five Year Forward View as services such as Talking Therapies and the Child and Adolescent Mental Health Service (CAMHS) performed well despite below-average funding. Over 20,000 responses to the consultation had been received from service users, which had been used to guide the development of services.

Overall the aim was to deliver ‘safer, improved services with better outcomes, supported by technology.’ Joint working between GPs, Local Authorities, the acute hospitals and the voluntary and community sector would be vital to the success of delivering the strategy.

Jason Jongali and Angus Tallini, on behalf of the Berkshire West CCGs, provided an overview of the services which were commissioned by the CCGs. The priorities were to improve access to psychological therapies, ensure early intervention in psychosis, reduce the number of suicides, reduce CAMHS waiting time invest in perinatal mental health and achieve a better crisis support service.

Andrew Sharp commented that the successes of local services were fantastic but the uplift in funding for mental health was not proportionate to the overall uplift in NHS funding. There were some gaps and with support, the voluntary and community sector would be able to provide more services.

Councillor Mollie Lock noted the excellent work of the Emotional Health Academy and asked by how much waiting times had been reduced. Angus Tallini advised he would provide that information.

Rachel Johnson and Adrian Barker, on behalf of the Mental Health Collaborative (MHC), addressed the Board. The MHC was established in 2014 as a group of professionals from a variety of organisations who had an interest in mental health. The MHC was writing a strategy for West Berkshire and would report progress of actions to the Board. The strategy would take into account the whole complex system and require interventions at different levels. Particularly, preventative interventions could release resources previously used for treatment.

Councillor Hilary Cole expressed the view that a local mental health strategy should not duplicate the work and actions already identified in the other strategies which had been presented to the Board.

Rachael Wardell noted that West Berkshire was a place that was better resourced than many others but the resource was not necessarily in the traditional places.

Richard Benyon stated that fantastic things were going on in West Berkshire and many speakers had mentioned raising awareness of mental health issues. Awareness would only be helpful if it lead to action. Across the different organisations who supported mental health in West Berkshire, timescales should be shortened to ensure pace and momentum. There was often a gulf between strategies and resources, national campaigns and local needs. Richard Benyon advised that he was encouraged to see so much activity and mentioned that Garry Poulson was coordination a suicide action group to be attended by representatives from the local farming and racing industries. Some lateral thinking would benefit everybody to be more effective.

Dr Bal Bahia agreed that organisations could link together better and expressed the view that service users experience was sometime missing from plans. The Mental Health Collaborative and the Board's Steering Group would pick up on the themes discussed.

**RESOLVED that**

The West Berkshire Health and Wellbeing Board pledge to develop and implement an action plan to build on the commitment it has made in its refreshed Strategy to support mental health and wellbeing throughout life.

The Health and Wellbeing Board approve the adoption of the Berkshire Suicide Prevention Strategy with an advisory that they would prefer a zero suicide target.

The Health and Wellbeing Board note the information presented on the Berkshire West Mental Health Strategy 2016-2021.

The Health and Wellbeing Board note the progress of the Mental Health Collaborative to support the aim in the Health and Wellbeing Strategy to 'support mental health and wellbeing throughout life'.

## 36 Better Care Fund 2017/19 (Tandra Forster/ Shairoz Claridge)

The Board considered a report (Agenda Item 10) which provided an update on the status of the Better Care Fund plan for 2017/19. Tandra Forster advised that she had expected to be presenting the final plan for the Board's approval but the guidance has not yet been published and the submission deadline had been delayed. The delay was in part due to the additional funding for adult social care which had been announced by the Government; it was not yet known how much there would be for West Berkshire but there were already many ideas on how it might be invested.

**RESOLVED that** the report be noted.

## 37 Feedback from the Hot Focus Session: Systems Resilience Dashboard (Jo Reeves)

The Board considered a report (Agenda Item 10) which informed of the outcomes of the Hot Focus Session held on 23 February 2017 to refresh the Systems Resilience Dashboard.

Jo Reeves explained that a new performance reporting framework was in the process of being developed to help monitor the delivery of the Health and Wellbeing Strategy. This would include exception reports being provided to Board on issues with exceptional over or under performance. This performance data would be used to aid comparison with performance in other areas.

Future Hot Focus Sessions would be renamed 'Problem Solving Sessions' and the Community Conversations approach would be used to help identify and resolve system resilience issues.

Collaboration between partners would be a key aspect in taking forward and widening systems resilience.

**RESOLVED that** the new approach of performance monitoring and problem solving be approved:

- Future Health and Wellbeing Development Sessions (private meetings in between Board meetings) would feature a standing item for members to share 'good news' stories and organisational resilience concerns.
- A new performance reporting framework would be developed to report indicators linked to the Health and Wellbeing Strategy. The Steering Group would receive the information and ensure that exception reports were provided to the Board on issues with exceptional over or under performance.
- The Board would consider the performance of the West Berkshire system in comparison with other areas annually as part of its Annual Report.
- Future Hot Focus Sessions would be renamed 'Problem Solving Sessions' and would use the Community Conversations approach to identify and resolve system resilience issues.

## 38 Report from the Health and Wellbeing Steering Group (Jo Reeves)

The Board considered a report (Agenda Item 11) which informed members of the latest progress achieved by its sub-groups in delivering the Health and Wellbeing Strategy.

Jo Reeves explained that in order to clarify how the Strategy would be delivered, the Chairs of the sub-groups had been asked to develop strategic action plans. These plans would serve to clarify the sub-group's objectives, intended impacts, key performance indicators and actions. This work involved holding partner organisations to account and helped to show the value being added by the work of the sub-groups.

Jo Reeves then drew attention to the report received at the Steering Group meeting on 2 March 2017 from the Special Education Needs and Disability (SEND) Reform Steering Group. This report identified a number of strengths and areas for improvement, and the Steering Group would be involved in developing an action plan for this area of activity. An area needing particular focus was identified as transitions for young people moving from children's to adult's services. This would be taken forward as part of a problem solving session, attended by Board members and other stakeholders, to find solutions to help improve the experiences of children when moving from one phase or service to another.

Councillor Lynne Doherty was pleased to note progress made to date and was hopeful that the action plan would soon be presented and the problem solving session would soon be arranged. She then made reference to a recent meeting of the Corporate Parenting Panel where there was also a focus on SEND transition. The Panel viewed a very informative DVD and she felt it would be useful if this was also available for the problem solving session.

**RESOLVED that** the report be noted.

## 39 Review of Community Conversations (Susan Powell)

The Board considered a report (Agenda Item 11a) which reviewed the success of community conversations. Susan Powell advised that as on Monday 3rd March 2017 she would start her new role as the manager of the Building Communities Together Team which would inherit responsibility for coordinating community conversations. Susan stated that she was pleased to report that the team would be inheriting good work and future plans would go beyond geographical communities to encourage communities of interest to hold conversations.

Councillor Lynne Doherty stated that she was pleased to see attention afforded to children and young people's issues in the conversations which had been undertaken so far, particularly noting the Peer Mentoring scheme. Councillor Doherty reported that she was pleased to see that understanding the outcomes and impacts of this way of working was part of the next steps for the new team. Susan Powell advised that there would be a peer mentoring conference on 23rd June 2017 and a symposium later in the year.

Susan Powell made reference to a discussion which had been held regarding cyber crime and advised that the team was already looking into holding online conversations.

**RESOLVED that** the report be noted.

## 40 Update on Alcohol Reduction Partnership Activities (Debi Joyce)

The Board considered a report (Agenda Item 11b) regarding an update from the Alcohol Harm Reduction Partnership. Deborah Joyce reported that the Partnership had a broad membership and would be expended to include service users when appropriate. The Partnership had used Public Health England's Alcohol CLeaR toolkit to conduct a self assessment and had identified that a strength in West Berkshire was the preventative initiatives undertaken in schools. Through the use of the tool, the Partnership had been able to identify two projects which would support areas for improvement.

Deborah Joyce advised that a Blue Light Project would be initiated with a focus on treatment-resistant drinkers, whose behaviour put pressure on public services. By working intensively with a small cohort of people, it was anticipated that there could be a benefit in reducing demand on the whole system.

A second project, Identification and Brief Advice, was already used widely in General Practice but was intended to be expanded into a number of health and social care roles. It would be a preventative approach to helping at-risk drinkers make an informed choice about their drinking by delivering structured information.

Dr Bal Bahia enquired whether there was a plan on how to deliver these projects; Deborah Joyce confirmed that she was working on the project briefs. Dr Bahia advised that as alcohol was the Board's focus for 2017 he would like to see an update at each meeting of the Health and Wellbeing Board.

Councillor Quentin Webb asked whether it would be realistic to expect that the projects could be completed within 12 months. Deborah Joyce responded that the Identification and Brief Advice project was expected to be embedded in practice within 12 months but not to be withdrawn after that time.

Andrew Sharp noted that the night time economy was heavily regulated but the work of the Partnership had identified that many people were drinking in the home; it would be for the Health and Wellbeing Board to lobby the government on minimum pricing in order to impact home drinkers.

**RESOLVED that** the Board noted the report.

## 41 The Buckinghamshire, Oxfordshire and Berkshire West (BOB) NHS Sustainability and Transformation Plan (STP) (Cathy Winfield)

The Board noted the report.

## 42 Berkshire West Clinical Commissioning Groups (CCGs) Operational Plan (Cathy Winfield)

The Board noted the report.

## 43 Members' Questions

There were no Member Questions submitted to the Board.

## 44 Future meeting dates

The Health and Wellbeing Board noted that a Special meeting would be held at 9am on 4th May 2017 in Committee Room 1. The next ordinary meeting would be on 25th May 2017 at 9.30am in West Berkshire Community Hospital.

*(The meeting commenced at 3.00 pm and closed at 5.22 pm)*

**CHAIRMAN** …….

**Date of Signature** …….

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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, 4 MAY 2017

**Present**: Dr Bal Bahia (Newbury and District CCG), Dr Barbara Barrie (North and West Reading CCG), Cathy Winfield (Berkshire West CCGs), 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 Rick Jones (Executive Porfolio: Adult Social Care)

**Also Present:** Shairoz Claridge (Newbury and District CCG), Councillor Quentin Webb (Vice-Chairman of Council), Andrea King (Head of Prevention and Developing Community Resilience) and Sally Murray (NHS Berks West CCGs)

**Apologies for inability to attend the meeting:** Heather Bowman, Garry Poulson, Paul Jones, Dr Lise Llewellyn and Rachael Wardell

## PART I

### 45 Declarations of Interest

There were no declarations of interest received.

### 46 Refreshed Local Transformation Plan for Children and Young People's Emotional Health and Wellbeing (Andrea King/ Sally Murray)

The Board considered a report (Agenda Item 4) which provided an early descriptive indication of the changes to the children and young people's mental health system following the implementation of Local Transformation Plans.

The report of the government's Children and Young People's Mental Health Taskforce, "Future in Mind – promoting, protecting and improving our children and young people's mental health and wellbeing", was launched on 17 March 2015 with the requirement for system wide transformation by 2020.

West Berkshire's Health and Wellbeing Board approved the local plans in October 2015 which has enabled additional recurrent funding to be released from NHS England to the West of Berkshire Clinical Commissioning Group (CCG).

There was insufficient consistency in national or regional comparator information, to enable reliable benchmarking of local performance however service managers were pleased with the direction of travel indicated by performance data.

Berkshire Adolescent Unit (BHFT) was now a 7 day, 24 hour a day service that was also a registered tier 4 provision in Berkshire. The number of beds had increased from 7 to 9 and so fewer children requiring this level of intervention needed to be placed outside of Berkshire.

The Common Point of Entry (CPE) was now open 8am until 8pm Monday to Friday. The current average waiting time for referrals to CPE was 5 weeks. National indications suggest that the national waiting time for a first CAMHs appointment was approximately 9 weeks.

Initial indications suggested a reduction in waiting times, with more children and young people receiving timely evidence based treatment across all 5 care pathways. The indications from the data also suggested that the number of children waiting for help had also reduced.

The Child and Adolescent Mental Health Service (CAMHS) Urgent Response Pilot ran throughout 16/17 and had been commissioned for 17/18. Short term intensive interventions in the community were provided to young people who had experienced a mental health crisis with the aim of reducing the number of children and young people who had a second or subsequent crisis. The service also provided wrap around support when there were delays in sourcing a Tier 4 in CAMHS patient bed. Response time to assessment has reduced and length of stay in both A&E and the paediatric wards had reduced with improved facilitation of admission to Tier 4 units when required. Current information suggested a reduction in use of agency Registered Mental Nurses at Royal Berkshire Hospital. There had also been a reduction in the number of minors admitted to the Place of Safety at Prospect Park Hospital.

Information suggested that Berkshire West waiting times for autism assessment i.e. 40 weeks was lower than the national average. However waits remained longer than both the commissioner and provider wanted locally. The current local target was to reduce waiting times for autism assessment to a maximum of 12 weeks by October 2017. The Children's Delivery Group would be running a conference in May to check that schools were making appropriate referrals.

Sally Murray concluded by informing the Board that a 'Little Blue Book of Sunshine' had been produced, targeted at children in years 10 and 11 which included advice and signposted to websites and library books.

Councillor Lynne Doherty expressed the view that the work was a good piece of system transformation and the qualitative data in the appendix to the report provided powerful feedback regarding the success. She enquired whether the increase from 7 to 9 beds in the Berkshire Adolescent Unit was sufficient. Sally Murray advised that these beds were commissioned nationally as a specialist service and so were available to any child in the UK. She reported that there was not strong evidence that inpatient care was effective for treating children with eating disorders so there was a drive around strengthening the support available in the community.

Councillor Doherty asked whether the CPE was open at weekends. Sally Murray advised that it was not but the Urgent Care service was open. At present there did not appear to be the demand for the CPE at weekends but demand would be monitored and if there were changes the service would respond to this.

Councillor Doherty noted that the waiting times for autism diagnoses were unacceptable and requested that a report come back to the Board to review performance. She further asked what communication there had been with parents regarding children's' emotional resilience. Sally Murray advised that 8-13 May was Mental Health Awareness Week and there would be a press release. Andrea King advised that under the Emotional Health Academy there were bespoke parent/ carer interventions as they acknowledged that family change was often required to support a child's recovery.

Councillor Quentin Webb enquired how West Berkshire's CAMHS waiting times compared with other areas. Andrea King advised that it was not possible to have reliable national benchmarking.

Councillor Mollie Lock enquired whether the Little Blue Book of Sunshine would be made available to other age groups. Sally Murray advised that it was targeted to children in year 10 and above and had been published to coincide with examination season. There

were no current plans to target other age groups. Superintendent Jim Weems expressed his support for the material and advised that he would like to promote the booklets through the neighbourhood policing teams.

Dr Anees Pari commended the good work under the transformation plan. He expressed concern that the umber of hospital admissions of children who had harmed themselves was increasing and higher than the South East and England average; he asked how the transformation plan would address this. Andrea King advised that a sub-group of the Local Children's Safeguarding Board was monitoring this issue with CAMHS and suggested that Dr Pari might wish to join the group. Cathy Winfield suggested that the additional capacity in CAMHS might have caused a spike in admissions as there was now somewhere for children to be admitted to.

Andrew Sharp informed the Board that Healthwatch had been working with students at Newbury College who had mentioned unprompted that self harm was an issue in their peer group. He expressed the view that services needed to be prepared for the potential impact of the media, such as the new Netflix series '13 Reasons Why'. Andrew Sharp expressed support for the Little Blue Book of Sunshine and asked to promote the material at Healthwatch's stand in the Market Square, Newbury as part of their Mental Health Awareness Week campaign.

Tandra Forster mentioned that there had been discussion at the Autism Partnership Board about the lack of services post diagnosis. She advised that the perspective of parents was often that there was a cliff edge between children's and adult's special educational needs services. Tandra Forster also enquired what support there was available to parents generally around speaking to their children about their emotional health. Andrea King acknowledged that parents needed to have the literacy to discuss their own emotional health in order to effectively support their children. Councillor Rick Jones acknowledged that there might be a wider community role for supporting children with their emotional health and community conversations might be an effective tool for initiating those discussions.

*Councillor Lynne Doherty left the meeting at 9.49am.*

Councillor Graham Jones commended the good example of collaborative working demonstrated under the transformation plan for children and young people's emotional health and wellbeing.

**RESOLVED that** the Health and Wellbeing Board noted the progress made in line with Department of Health governance requirements.

## 47 Better Care Fund 2017/19 (Tandra Forster/ Shairoz Claridge)

The Board considered a report (Agenda Item 3) which sought the Health and Wellbeing Board's approval for the draft BCF plan for 2017/19, subject to the Head of Adult Social Care, in consultation with the Chairman and Vice-Chairman of the Health and Wellbeing Board, ensuring the plan aligned with the BCF National Guidance once it is published. Due to the announcement of the General Election to be held on 8 June 2017, Tandra Forster reported that it was unlikely that the plan could be submitted until mid to late June. Officers were confident that they had a mature plan.

Shairoz Claridge advised that the vision for the original Better Care Fund had been to improve outcomes in the delivery of care and Newbury and District and North and West Reading Clinical Commissioning Groups had performance in the top quartile for non-elective admissions. The focus for the next Better Care Fund plan would be using step

down beds to improve performance on delayed transfers of care and supporting self funders.

Tandra Forster commented that plan had an increased focus on support for mental health and learning disability services so that they had parity with physical health. Proposals included a link worker in Prospect Park to support discharges and Birchwood Care Home step down beds would include support for older people with mental health issues and dementia.

Cathy Winfield commended the plan and endorsed the strength of the joint working. She noted that the plan targeted the pressure points in the system and expressed her full support.

Andrew Sharp enquired whether there would be any flexibility in the plan to include other projects, for example improved community nursing might prevent non elective admissions. Shairoz Claridge advised that work was ongoing to develop integrated care teams to include social workers and community nurses.

Councillor Rick Jones stated that one advantage to the delay in the publication of the guidance was that he had been able to meet with Tandra several times to discuss the plan. He endorsed the good work presented tot he Board.

Councillor Quentin Webb queried whether there would be sufficient resources to support the Getting Home Project. Tandra Forster advised that phase one effected internal processes and was sufficiently resourced. The primary issue but the main issue in relation to delayed transfers of care continued to be capacity in effecting resourcing was the care market.

**RESOLVED that** the Health and Wellbeing Board approves the draft plan and delegates authority to the Head of Adult Social Care, in consultation with the Chairman and Vice-Chairman of the Health and Wellbeing Board, to approve the final plans for the Better Care Fund 2017/19.

*(The meeting commenced at 9.02 am and closed at 10.01 am)*

**CHAIRMAN** …….

**Date of Signature** …….

# Health and Wellbeing Board Forward Plan 2017/18

| 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? |
|---|---|---|---|---|---|---|
| **29th June 2017- Health and Wellbeing Problem Solving Session, SEND Transitions (Shaw House)** | | | | | | |
| **6th July 2017 Development Session** | | | | | | |
| System Resilience conversation | For members of the Board to share good news and challenges facing their organisations. | For discussion | 23rd June 2017 | | | |
| Health and Social Care Dashboard | To present the Dashboard and highlight any emerging issues | For information and discussion | 23rd June 2017 | | Health and Wellbeing Steering Group | |
| Opportunities for integration between WBC, CCG and RBFRS | To consider how these organisations are integrated in Gloucestershire and what learning could be applied to West Berkshire. | For information and discussion | 23rd June 2017 | | | |
| **28th September 2017 - Board meeting** | | | | | | |
| **System Resilience** | | | | | | |
| Health and Social Care Dashboard | To present the Dashboard and highlight any emerging issues | For information and discussion | 15th September 2017 | Jo Reeves | Health and Wellbeing Steering Group | Part I |
| **Programme Management** | | | | | | |
| Report from the Steering Group on the Status of Current Activity | To provide exception reports for activity in the health, social care and community resilience system. | For information and discussion | 19th September 2017 | Bal Bahia/ Jo Reeves | Health and Wellbeing Steering Group | Part I |
| Medium Term Aims - Deep Dive | Update on progress with the five objectives. | For information and discussion | 19th September 2017 | tbc | Health and Wellbeing Steering Group | Part I |
| Alcohol Harm Reduction | For the Alcohol Harm Reduction Partnership to provide an update on progress against the Board's strategic focus to 'reduce alcohol related harm across the district for all age groups'. | For information and discussion | 19th September 2017 | Debi Joyce | Health and Wellbeing Steering Group | Part I |
| Community Conversations | For the Stronger Communities Partnership to provide an update on progress against the Board's strategic focus to 'increase the percentage of communities where community conversations have successfully run and local action plans have been jointly developed'. | For information and discussion | 19th September 2017 | Susan Powell | Health and Wellbeing Steering Group | Part I |
| Health and Social Care Integration | For the Locality Integration Board to provide an update on integration activity at the Berkshire West and BOB level. | For information and discussion | 19th September 2017 | Tandra Forster/ Shairoz Claridge | Health and Wellbeing Steering Group | Part I |
| **Strategic Matters** | | | | | | |
| Local Safeguarding Childrens Board Annual Report | For the Board to note the annual report from the Local Childrens Safeguarding Board | For information | 19th September 2017 | TBC | Health and Wellbeing Steering Group | Part I |
| Pharmaceutical Needs Assessment | For the Board to approve the updated Pharmaceutical Needs Assessment | For decision | 19th September 2017 | Judith Wright | Health and Wellbeing Steering Group | Part I |
| Improving the Physical Health of people with a Severe Mental Illness | For the Board to consider how it can respond to the numbers of people dying with a preventable mental illness | For information and discussion | 19th September 2017 | Annes Pari/ Rachel Johnson | Health and Wellbeing Steering Group | Part I |
| Delayed Transfers of Care | For the Board to consider the outcomes from the OSMC task group and Hot Focus Session on Delayed Transfers of Care. | For information and discussion | 19th September 2017 | TBC | Health and Wellbeing Steering Group | Part I |
| **Consultation and Communication** | | | | | | |
| Communications Forward Plan | For the Board to consider the Communications Forward Plan. | For information and discussion | 19th September 2017 | tbc | Health and Wellbeing Steering Group, Patient and Public Engagement Group | Part I |
| **19th October 2017- Health and Wellbeing Problem Solving Session, topic tbc (Shaw House)** | | | | | | |
| **29th November 2017 Development Session** | | | | | | |
| System Resilience conversation | For members of the Board to share good news and challenges facing their organisations. | For discussion | | All | | |
| Health and Social Care Dashboard | To present the Dashboard and highlight any emerging issues | For information and discussion | 10th November 2017 | Tandra Forster/Shairoz Claridge/Rachael Wardell | Health and Wellbeing Steering Group | Part I |
| Draft Health and Wellbeing Board Annual Report 2017 | For the Board to consider the draft Annual Report for 2017 | | 14th November 2017 | Cllr Graham Jones | | Part I |

| | | | | | | |
|---|---|---|---|---|---|---|
| **25th January 2018 - Board meeting** | | | | | | |
| **System Resilience** | | | | | | |
| Health and Social Care Dashboard | To present the Dashboard and highlight any emerging issues | For information and discussion | 12th January 2018 | Tandra Forster/Shairoz Claridge/Rachael Wardell | Health and Wellbeing Steering Group | Part I |
| **Programme Management** | | | | | | |
| Report from the Steering Group on the Status of Current Activity | To provide exception reports for activity in the health, social care and community resilience system. | For information and discussion | 16th January 2018 | Bal Bahia/ Jo Reeves | Health and Wellbeing Steering Group | Part I |
| Medium Term Objectives - Deep Dive | Update on progress with the five objectives. | For information and discussion | 16th January 2018 | tbc | Health and Wellbeing Steering Group | Part I |
| Alcohol Harm Reduction | For the Alcohol Harm Reduction Partnership to provide an update on progress against the Board's strategic focus to 'reduce alcohol related harm across the district for all age groups'. | For information and discussion | 16th January 2018 | Debi Joyce | Health and Wellbeing Steering Group | Part I |
| Community Conversations | For the Stronger Communities Partnership to provide an update on progress against the Board's strategic focus to 'increase the percentage of communities where community conversations have successfully run and local action plans have been jointly developed'. | For information and discussion | 16th January 2018 | Susan Powell | Health and Wellbeing Steering Group | Part I |
| Health and Social Care Integration | For the Locality Integration Board to provide an update on integration activity at the Berkshire West and BOB level. | For information and discussion | 16th January 2018 | Tandra Forster/ Shairoz Claridge | Health and Wellbeing Steering Group | Part I |
| **Strategic Matters** | | | | | | |
| Health and Wellbeing Board Annual Report 2017 | For the Board to present its Annual Report for 2017 | For information and discussion | 16th January 2018 | Cllr Graham Jones | Health and Wellbeing Steering Group | Part I |
| Autism Diagnosis Waiting List | To review the work around the waiting times for autism diagnosis. | For information and discussion | 16th January 2018 | Andrea King/ Sally Murray | Health and Wellbeing Steering Group | Part I |
| Safeguarding Adults Annual Report 2016/17 | For the Board to note the annual report from the Safeguarding Adults Board. | For information and discussion | 16th January 2018 | Sue Brain | Health and Wellbeing Steering Group | Part I |
| **Consultation and Communication** | | | | | | |
| Communications Forward Plan | For the Board to consider the Communications Forward Plan. | For information and discussion | 16th January 2018 | | Health and Wellbeing Steering Group, Patient and Public Engagement Group | Part I |
| **22nd February 2018- Health and Wellbeing Problem Solving Session, topic tbc (Council Chamber)** | | | | | | |
| **29th March 2018 Development Session** | | | | | | |
| System Resilience conversation | For members of the Board to share good news and challenges facing their organisations. | For discussion | | All | | |
| Health and Social Care Dashboard | To present the Dashboard and highlight any emerging issues | For information and discussion | 16th January 2018 | Tandra Forster/Shairoz Claridge/Rachael Wardell | Health and Wellbeing Steering Group | Part I |
| **24th May 2018 - Board meeting** | | | | | | |
| **System Resilience** | | | | | | |
| Health and Social Care Dashboard | To present the Dashboard and highlight any emerging issues | For information and discussion | 11th May 2018 | Tandra Forster/Shairoz Claridge/Rachael Wardell | Health and Wellbeing Steering Group | Part I |
| **Programme Management** | | | | | | |
| Report from the Steering Group on the Status of Current Activity | To provide exception reports for activity in the health, social care and community resilience system. | For information and discussion | 15th May 2018 | Bal Bahia/ Jo Reeves | Health and Wellbeing Steering Group | Part I |
| Medium Term Objectives - Deep Dive | Update on progress with the five objectives. | For information and discussion | 15th May 2018 | tbc | Health and Wellbeing Steering Group | Part I |
| Alcohol Harm Reduction | For the Alcohol Harm Reduction Partnership to provide an update on progress against the Board's strategic focus to 'reduce alcohol related harm across the district for all age groups'. | For information and discussion | 15th May 2018 | Debi Joyce | Health and Wellbeing Steering Group | Part I |
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| **Strategic Matters** | | | | | | |
| tbc | | For information and discussion | 15th May 2018 | | Health and Wellbeing Steering Group | |
| **Consultation and Communication** | | | | | | |
| Communications Forward Plan | For the Board to consider the Communications Forward Plan. | For information and discussion | 15th May 2018 | tbc | Health and Wellbeing Steering Group, Patient and Public Engagement Group | Part I |

# Actions arising from Previous Meetings of the Health and Wellbeing Board

| RefNo | Meeting | Action | Action Lead | Agency | Agenda item | Comment |
|---|---|---|---|---|---|---|
| 84 | 24/11/16 | Children's Delivery Group to be consulted to develop clear recommendations for the Board and report back at a later date, including the best ways to spend Pupil Premium Grant. | Ian Pearson/ Andrea King | WBC | Educational Attainment and Health Outcomes for Children from Vulnerable Families | The Children's Delivery Group to incorporate this work into its Strategic Action Plan. |
| 85 | 04/05/17 | A report on autism diagnosis waiting times to be presented to the Board at a future meeting | Andrea King/ Sally Murray | WBC | Refreshed Local Transformation Plan for Children and Young People's Emotional Health and Wellbeing | On the forward plan for January 2018 |

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# Director of Public Health Annual Report – West Berkshire

Lise Llewellyn

2017

# Avoidable and preventable mortality

Life expectancy has improved through the ages. In the middle ages the average life expectancy was thought to be around 35 years, rising to 47 in 1900, 65 in the 1950's, and 65 in 1971 and in 2015 it was 79 (men) [1].

Now the focus is on reducing avoidable deaths. Avoidable deaths can be divided into 2 major area: amenable and preventable deaths. Avoidable deaths in general focus on those deaths that occur prematurely before 75 years.

> "People who die prematurely from avoidable causes lose an average of 23 potential years of life"

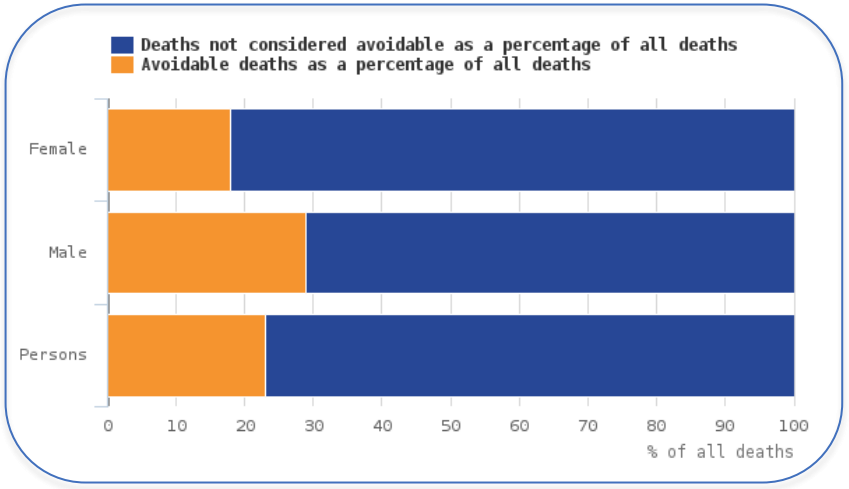
In 2014, nearly a quarter of all deaths (23%; 116,489 out of 501,424) in England and Wales were from causes considered potentially avoidable either through timely and effective healthcare (amenable) or public health interventions (preventable) [2].

While we may say that a particular condition can be considered avoidable, this doesn't mean that every death from that condition could be prevented. Analysis focuses on deaths prior to 75 years.

Males were more likely to die from an avoidable cause than females and accounted for approximately 60% of all avoidable deaths.

Approximately 29% of all male deaths were from avoidable causes (70,108 out of 245,142 deaths) compared with 18% of all female deaths (46,381 out of 256,282 deaths).

**Figure 1: Percentage of deaths nationally that are avoidable**




*Source:* *ONS: Avoidable Mortality England and Wales 2014*

Cancers were the leading cause of avoidable deaths accounting for 35% of all avoidable deaths in England and Wales in 2014.

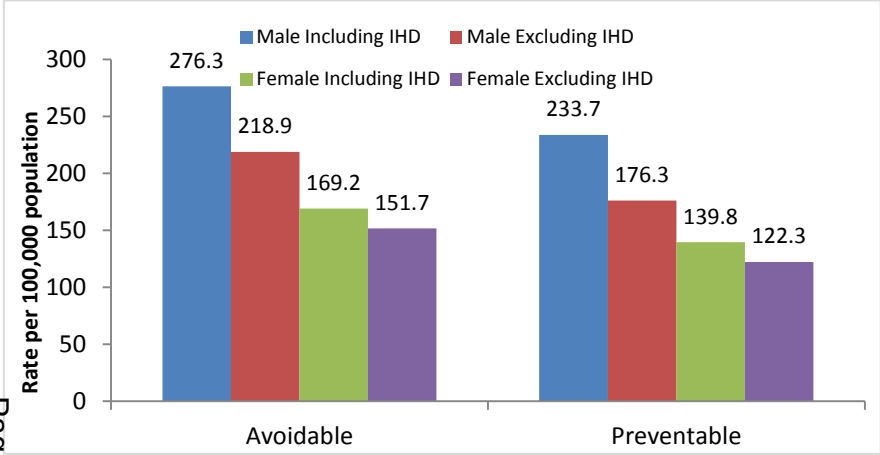
Ischaemic heart disease is the most common single disease that leads to avoidable death.

Amenable deaths are those where the causes of death are amenable (treatable) if, in the light of medical knowledge and technology at the time of death, all or most deaths from that cause (subject to age limits if appropriate) could be avoided through good quality healthcare.

Preventable deaths are those that through our understanding of the determinants of health at time of death, all or most deaths from that Cause (subject to age limits if appropriate) could be avoided by public Health interventions in the broadest sense.

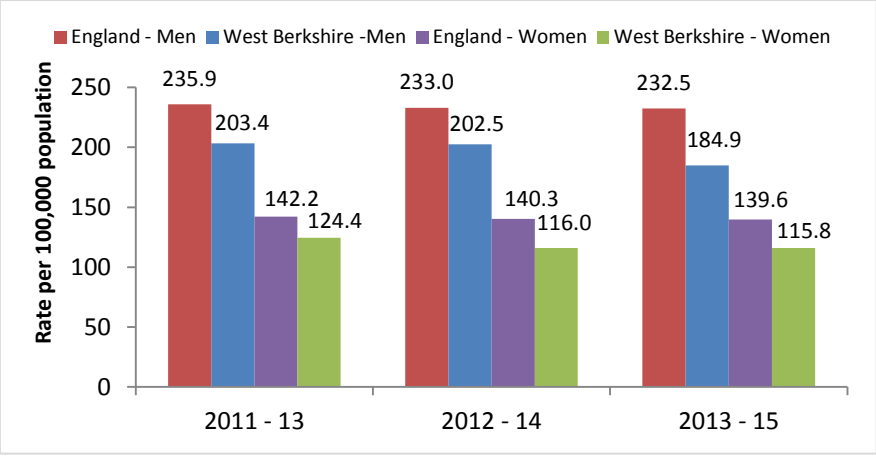
# Local preventable deaths

**Figure 2: Rates of avoidable and preventable deaths**




*Source: PHE: Public Health Outcomes Framework*

**Figure 3: Mortality rate from causes considered preventable 2011-2015**




*Source: PHE: Public Health Outcomes Framework*

As shown in **Fig 2,** addressing these would have the biggest impact on reducing total numbers of avoidable deaths .

We can measure preventable death rates in our own locality. The England age standardised rate for preventable deaths is 184 deaths per 100,000, with the rate in West Berkshire being lower at 150 per 100,000 (2013-2015) meaning fewer preventable deaths in West Berkshire **(Fig 3).**

We can see that the rate of preventable deaths is lower than the national average, and reducing, in both men and women in West Berkshire.

These figures could be expected given that West Berkshire has a low rate of premature deaths 279 /100,000 (2013-15)[26], the 19th best in England. Nevertheless the impact on health, early death and health care by more sustained application of public health measures by health and social care organisations, communities and individuals will reduce early deaths and hence also the demand on our services, and improve health considerably at the local level .

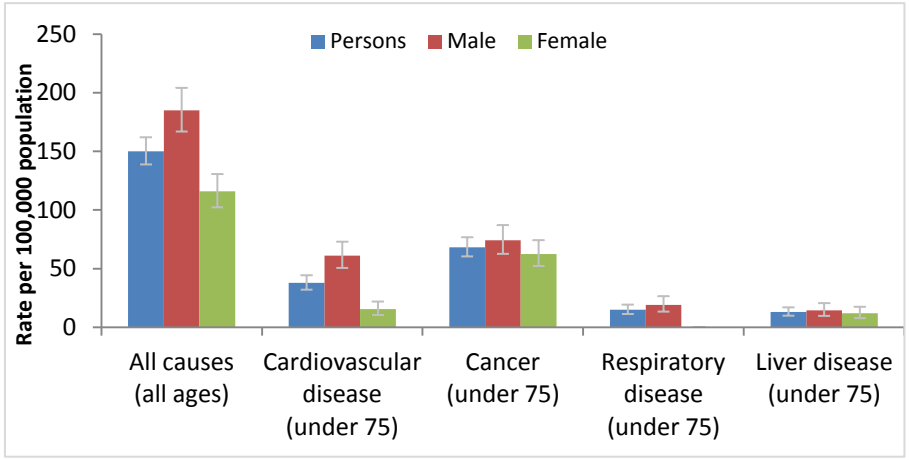
## Causes

If we look at the major causes of early preventable death within West Berkshire, we see a similar picture to that seen nationally with the biggest single generic cause being cancer for all persons, and the impact being greater for all preventable causes on male deaths. In West Berkshire the impact of cancer on men is the highest single cause **(Fig 6)**.

If we examine preventable premature mortality rate across West Berkshire in more detail by clinical groups then we see that cancer is the biggest single clinical group cause .

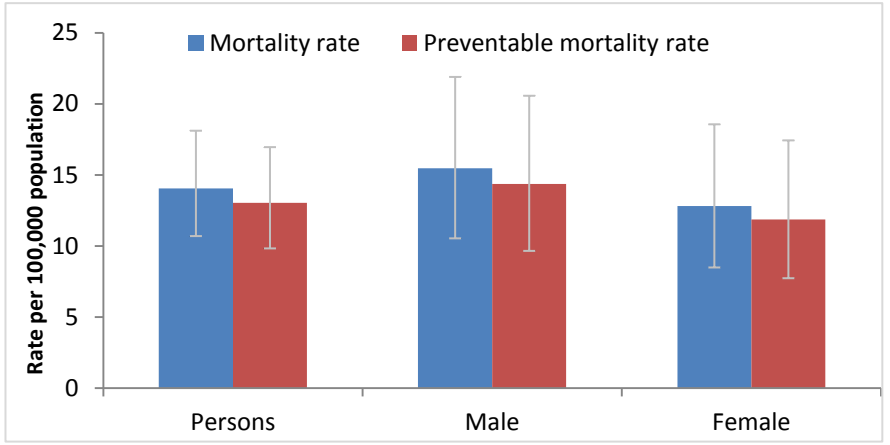
# Local preventable deaths

**Figure 4: Preventable mortality per 100,000 population in West Berkshire (2013-15)**




*Source: PHE: Public Health Outcomes Framework*

**Figure 5: Under 75 mortality rates for Liver disease in West Berkshire (2013-15)**




*Source: PHE: Public Health Outcomes Framework*

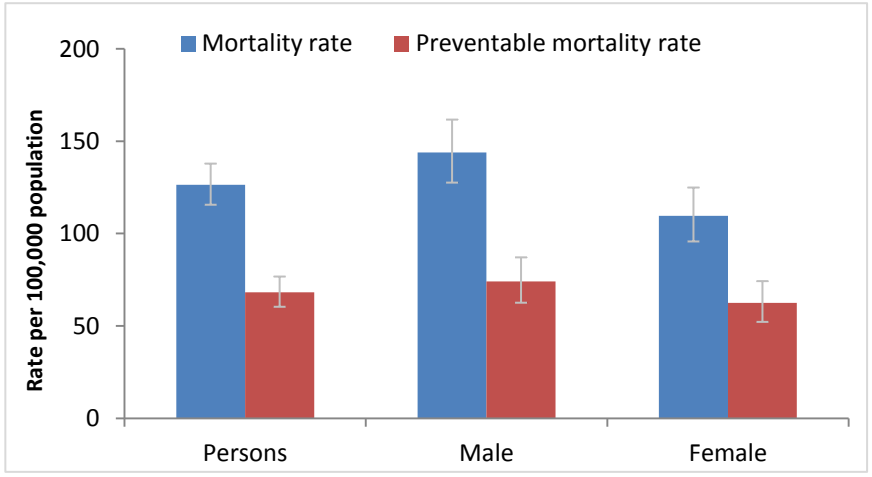
For cardiovascular causes, the male preventable mortality rate is four times that of females: the highest difference between men and women across Berkshire.

In West Berkshire we see a low rate of premature mortality from liver disease, but this is the only UA in Berkshire where the impact of liver disease is measurable in women - over 90% of female deaths being preventable.

In respiratory disease the numbers of preventable deaths in females is too small to be calculated.

In cancer locally we see that the percentage of preventable deaths due to cancer is higher than the national picture for men with again a greater percentage being preventable in women versus men.

**Figure 6: Under 75 mortality rates for Cancer in West Berkshire (2013-15)**




*Source: PHE: Public Health Outcomes Framework*

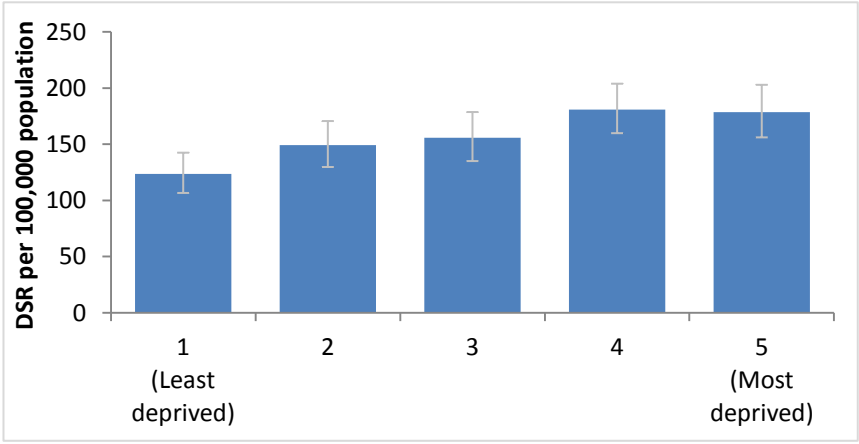
# Preventable deaths

The impact of premature mortality from preventable causes can be examined by geography and deprivation. Across all preventable deaths there is a link with deprivation when we group wards by their level of affluence [3].

This is not unexpected since the evidence shows a consistent pattern in the prevalence of multiple unhealthy behaviours, at the core of preventable causes of ill health, with men, younger age groups and those in lower social classes and with lower levels of education being most likely to have exhibited these multiple lifestyle risks [4].

In 2008 4.2% of professional men exhibited all 4 unhealthy lifestyle behaviours, compared to 8.4% of male unskilled manual workers. Similarly, 3.1% of professional women exhibited these behaviours, compared to 7.0% of female unskilled manual workers.

**Figure 7: All cause preventable mortality rate per 100,000 population in West Berkshire by deprivation quintile (2011-2015)**




*Source: NHS Digital (2016); Primary Care Mortality Database – Restricted*

Worryingly this pattern is persisting with improvement in lifestyle being greatest in those in most affluent groups so the gap is widening [4].

The strongest risk factors for avoidable hospital admission are age and deprivation [5].

Clustered poor health behaviours are associated with increased risk of hospital admissions among older people in the UK. Life course interventions to reduce the number of poor health behaviours could have substantial beneficial impact on health and use of healthcare in later life [6]. Studies have shown that among men and women, an increased number of poor health behaviours was strongly associated ($p<0.01$) with a greater risk of long stay and emergency admissions and 30-day emergency readmissions.

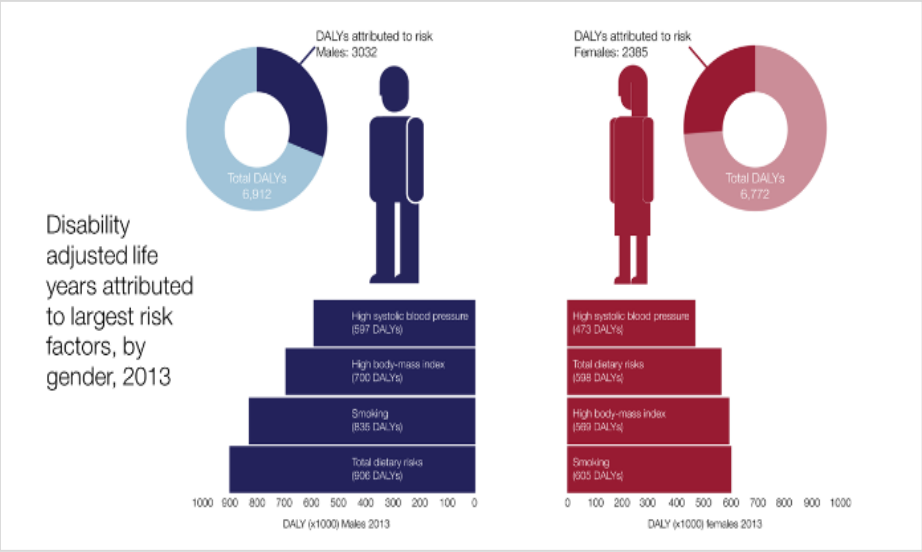
Those with three to four poor health behaviours were, in men, 1.37 [95% CI:1.11,1.69] times more likely to be admitted to hospital than those with no poor health attributes. In women, this figure was 1.84 [95% CI:1.22,2.77]. Associations were unaltered by adjustment for age, BMI and co-morbidity.

The impact of improving lifestyle behaviours is not restricted by age. In a study of over 65 year olds that examined the impact of having higher self-care confidence and being on an exercise program on decreasing avoidable hospitalizations, it was found that starting an exercise program at an older age decreased hospital admissions and utilization of emergency services in the short and medium term [7].

# Addressing early preventable deaths

There are eight commonly agreed risk factors that if addressed would reduce preventable deaths; alcohol use, tobacco use, high blood pressure, high body mass index, high cholesterol, high blood glucose, low fruit and vegetable intake and physical inactivity.

**Figure 8: Disability adjusted life years attributed to largest risk factors, 2013**




*Source: [PHE: Burden of Disease Study for England]*

It is estimated that 80% cases of heart disease, stroke and type 2 diabetes, and 40% of cases of cancer could be avoided if common lifestyle risk factors were eliminated (WHO 2005).

An estimated 42% of cancer cases each year in the UK are linked to a combination of 14 major lifestyle and other factors [8]. The proportion is higher in men (45%) than women (40%), mainly due to gender differences in smoking (CRUK).

The impact of these lifestyle factors is not only key in causing early death within our communities but also as a major cause of illness it drives our increasing utilisation of health and care resources.

In the following section we will briefly review five of the major lifestyle and risk factors for preventable deaths, where there is significant evidence regarding interventions that make a difference. We will briefly describe the pattern of these factors in our community, the impact of each in terms of illness and death, but also in terms of impact on our services.

It should be noted that whilst we look at each individually there is data that shows that risky health behaviours interact and have a multiplicative rather than simply additive impact. That is, they have a greater effect together than the sum of each individual risk. For example, obesity and alcohol consumption which interact to increase risks of liver disease mortality to a greater extent than the sum of each individual risk [9].

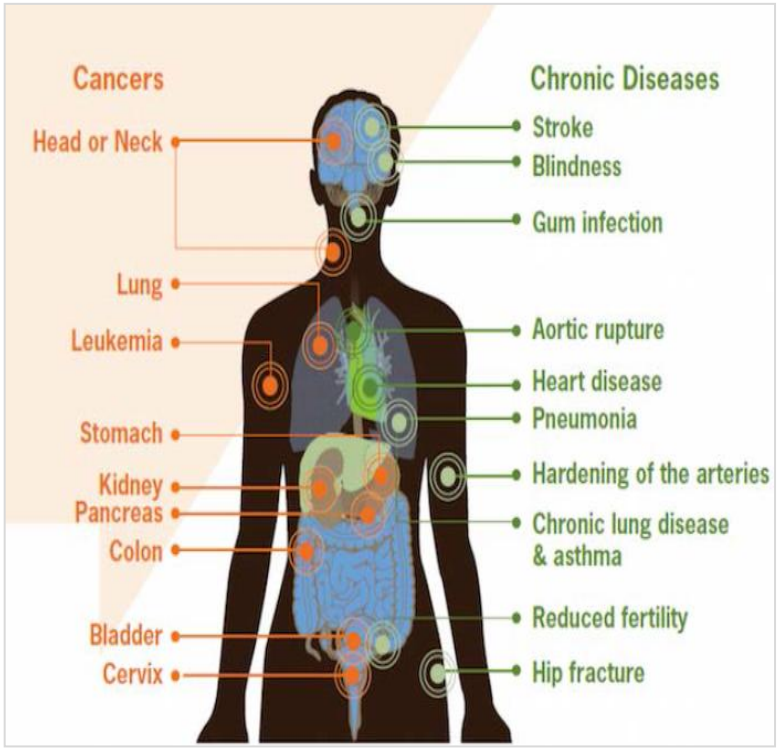
Or alcohol and smoking, which together are associated with a greater combined risk for cancer than the sum of the two individual effects [10]. This may be one reason why we see greater alcohol related harm in socioeconomically deprived groups compared to affluent groups, even when the level of alcohol consumption is held constant. It's because the more deprived groups are more likely to be engaging in multiple risky lifestyle behaviours.

# Smoking

Smoking remains the biggest single lifestyle cause of preventable mortality and morbidity in the world. The Tobacco Control Plan for England states that it accounts for 1 in 6 of all deaths in England.

Its impact is seen on every organ of the body.

**Figure 9: Health Effects of Tobacco Use**




*Source:* *CDC: Smoking & Tobacco Use - Health Effects of Tobacco Use*

Nationally the prevalence of smoking is decreasing; 19% of people smoked in 2016 v 46% at its peak in 1976 and average daily consumption is also reducing; 11 cigarettes a day in 2016 from 16 in 1974.

Smoking is more prevalent in adult men (20% v 17%), more prevalent deprived communities (30% routine and manual v 11% professional) and more prevalent in those with less formal education (9% in those with degrees). Younger people are more likely to smoke (9255 16-34 v 11% >60). In children and young people, more girls smoke regularly and the major influence is smoking in the home [11].

**Figure 10: Local Tobacco Profiles Annual Population Survey**

| 2015/16 | West Berks BC | England |
|---|---|---|
| Never smoked (APS*) | 47% | 48.6% |
| Adults resident smoking rate (APS*) | 14.1% | 16.9% |
| Manual and routine smoking rate (APS*) | 25.8% | 26.5% |
| Current smokers aged 15 – 2014/15 (WAY Survey) | 6% | 5.5% |
| Smoking in residents with severe mental illness | 37.2% | 40.2% |

*Source:* *PHE: Local Tobacco Control Profiles for England*

**APS – Annual Population Survey*

It is recognised that smoking has a profound impact on health inequalities. There is greater health inequality between smokers and people who have never smoked than between people of the same sex and smoking status but different social positions.

In both women and men, people who are the most deprived in our society who had never smoked had substantially better survival rates than smokers in even the highest social classes [12]. 85% of the observed inequalities between socioeconomic groups can be attributed to smoking [13].

# Smoking - impact

In 2012-14, there were 275 smoking attributable deaths per 100,000 population in England. In 2012/14 in West Berkshire the rate was 230 per 100,000, aged 35+.

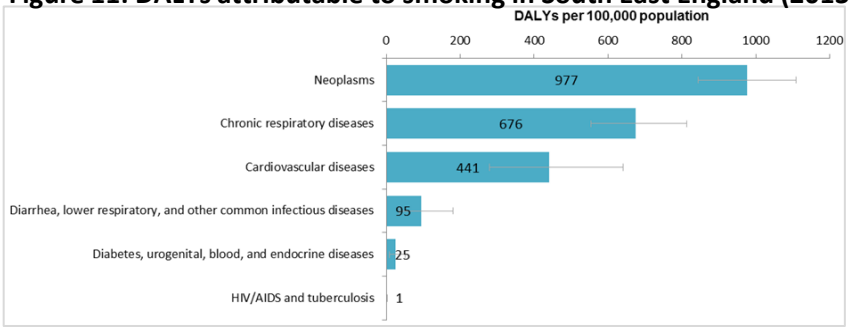
**In 2012/14 559 deaths were attributed to smoking in West Berkshire.**

Disability adjusted life years (DALYs) are an important measure used in health care as they not only measure the number of years of life lost (early deaths) but also the number of years lived with disability – so give an assessment of the impact on the life of the individual affected and the impact on health and care service usage. This analysis is now available for the South East.

Smoking is the most significant single lifestyle factor that causes the highest number of DALYs lost both regionally and nationally. 9.1% of DALYs in the South East Region were attributable to smoking in 2013 (2,215 per 100,000 population).

Figure 11 shows the wide impact of tobacco in the South East [14]. The largest numbers of DALYs attributable to smoking in general causes were for cancers, chronic respiratory diseases and cardiovascular diseases.

**Figure 11: DALYs attributable to smoking in South East England (2013)**




*Source:* *Global Burden of Disease (GBD)*

If we look at data for specific clinical illnesses and the impact of smoking on each of these then we see a different pattern; smoking accounts for at least 56% of all chronic lung disease conditions, 70% of COPD and 80% of lung cancer [14].

23% of DALYs for neoplasms were attributable to smoking. Again, this was higher for certain cancers; 79% of DALYs for tracheal, bronchus and lung cancer, 54.1% lip and oral cavity cancer, 53% oesophageal cancer.

We know that smoking prevalence is greater in men and in the most deprived communities and its impact increases over time.

If we look at men aged 55-79, smoking is, as could be expected, the single largest cause of DALYS (accounting for 12 – 14%) in the most affluent areas. In the most deprived communities however smoking accounts for 19 – 21% of DALYS which translates into one in five. This is significantly more than in wealthier areas. A similar pattern is seen in women.

In a study which looked at chances of survival and smoking after 28 years, people in the lowest socioeconomic groups who had never smoked had substantially better survival rates (56% women and 36% of men) than smokers in the highest social classes (41% women and 24% men) [12].

**Tobacco accounts for 90% of health inequalities**

# Smoking - impact

With the major impact on illness, it is not surprising that smoking is also responsible for significant care use both in primary and hospital settings. Tobacco use accounts for approximately 5.5% of the NHS budget.

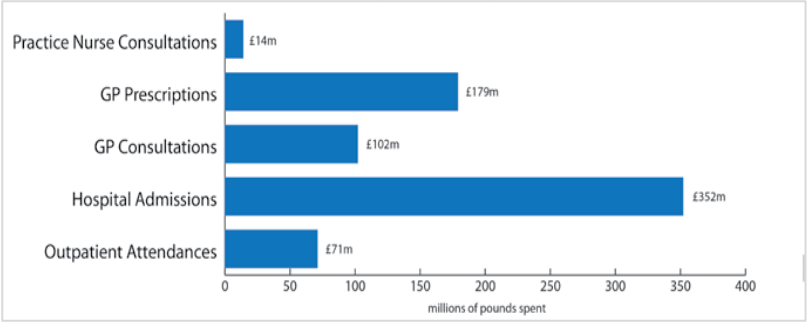
There were 1.7 million admissions in 2014/15 across the UK for conditions that could be caused by smoking, an increase of 22% from 2004/5. With 475,000 hospital admissions attributable to smoking in 2014/15, up from 452,000 in 2004/05. This represents 4% of all hospital admissions (6% of male admissions and 3% of females) [14,16].

**23% of respiratory, 15% of cardiac and nearly 10% of Cancer admissions are attributable to smoking**

Individuals with mental health problems smoke more heavily than the general population, contributing to as much as 43% of tobacco consumption in the UK [16] and it is estimated 3 million UK adults with mental health disorders who are also smokers incur Total smoking-attributable costs of £2.34 billion .

A total of £719 million was spent treating smoking-related disease among people with mental health disorders of which £352m were due to hospital admissions, while other cases were treatments of cancer, cardiovascular disease and respiratory diseases [18].

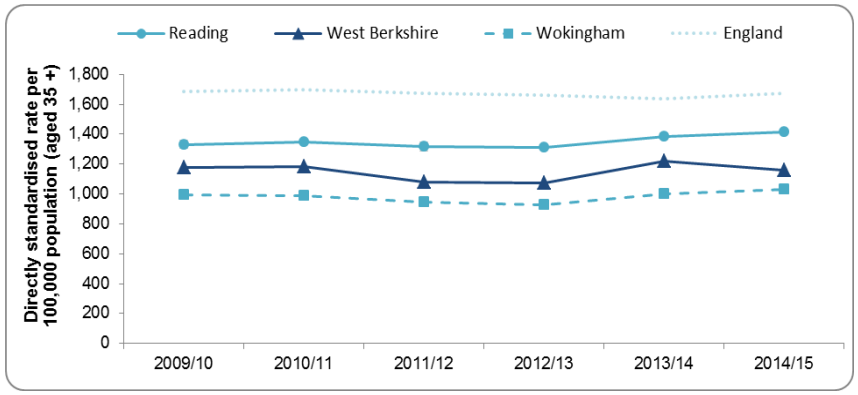
**Figure 12: Costs due to smoking-related diseases among people with mental health conditions (2009/10)**




*Source: Ash: The Stolen Years, the mental health and smoking action report*

Locally, in line with the lower prevalence of smoking (and our lower than average admissions in general) our rates of smoking related admissions are lower than the England average, with Reading having the highest rates across Berkshire [15,17].

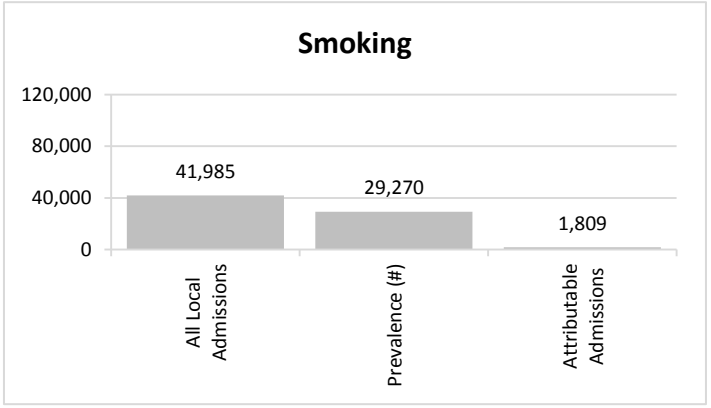
**Figure: 13**




*Source: PHE: Local Tobacco Control Profiles for England*

Though in West Berkshire it can be seen that over 1800 admissions a year are solely attributable to the effects of smoking [16].

**Figure 14: Smoking figures**




*Source: LKIS 2017*

# Smoking - impact

The costs of smoking to the NHS and to the economy in general are well understood, however, there are also costs to the social care system, which are less well known [19].

Recent research, based on adults over 50, compared the care needs of current and former smokers with those of never smokers. The key findings were that whilst no difference could be seen in use of residential care (small sample size), smokers were more likely to have difficulties in the majority of activities of daily living and so were at double the risk of developing care needs. In just over half of the activities of daily living, ex-smokers also showed more difficulties.

The impact of smoking related ill health on the social care system, is estimated to be a cost of £1.4 billion every year, up from £1.1 billion in 2014. This is made up of £760 million in costs borne by local authorities, with a further £630 million being spent by those who have to self-fund their care.

**Figure 15: Smoking Cessation figures**

| 2015/16 | Rates per 100,000 population (actual numbers) | | |
|---|---|---|---|
| | Setting quit date | Successful quitters | Validated quitters (CO) |
| England | 862 | 440 | 314 |
| South East | 674 | 375 | 271 |
| West Berkshire BC | 897 (1,117) | 595 (741) | 335 (417) |

*Source: Calculated figures from PHE: Local Tobacco Control Profiles for England and ONS 2015 Mid Year Estimates*

### *Interventions - What Works*

The biggest short-term savings opportunity lies in helping smokers who are in contact with the NHS to quit. The greatest long-term savings would come from preventing people from ever smoking altogether. Prevention of smoking requires strong partnership working including the promotion of smoke free environments and reducing counterfeit and illegal tobacco sales.

Smoking cessation services are widely available and the West Berkshire service continues to see more residents than the England average. In 2015/16, 897 per 100,000 set a quit date (v 862 England) and 595 per 100,000 reporting quitting at 4 weeks (v 440 England) [20].

### *Interventions - Local Gaps*

Although we offer some support to patients within health care settings to give up smoking, we have still to maximise this approach.

Recently Berkshire Healthcare Foundation Trust have been proactive in ensuring that all mental health facilities are smoke free, with patients being offered nicotine replacement therapy. However all smokers should be identified during treatment and at minimum offered brief intervention and advice to promote smoking cessation as part of their treatment plans. Pregnant women should be screened via carbon monoxide screening and offered specialist support [20] as a matter of course [21].

For those unable or unwilling to stop smoking permanently then temporary abstinence supported by nicotine replacement medication will deliver harm reduction. Smokers having elective surgery are six times more likely to have a surgical site infection and so have lengthier post operative stays and recovery periods. Simply supporting abstinence prior to surgery can reduce this risk, improve outcomes and reduce costs associated with care .

# Lifestyles – High blood pressure

Blood pressure is recorded with two numbers. The systolic pressure (higher number) is the force at which your heart pumps blood around your body. The diastolic pressure (lower number) is the resistance to the blood flow in the blood vessels. They are both measured in millimetres of mercury (mmHg).

As a general guide:

•high blood pressure is considered to be 140/90mmHg or higher
•ideal blood pressure is considered to be between 90/60mmHg and 120/80mmHg

High blood pressure is normally distributed in the population and the risk associated with increasing blood pressure is progressive, with each 2 mmHg rise in systolic blood pressure being associated with a 7% increased risk of death from ischaemic heart disease and a 10% increased risk of mortality from stroke.

***Risk factors for high blood pressure***

Overweight or obese
Poor diet: high salt & less than 5 a day fruit and vegetables
Low physical activity levels
High alcohol use
Smoker
Over the age of 65
Don't get much sleep or have disturbed sleep
African or Caribbean descent
Family history of high blood pressure

At least one quarter of adults (and more than half of those older than 60) have high blood pressure [22].

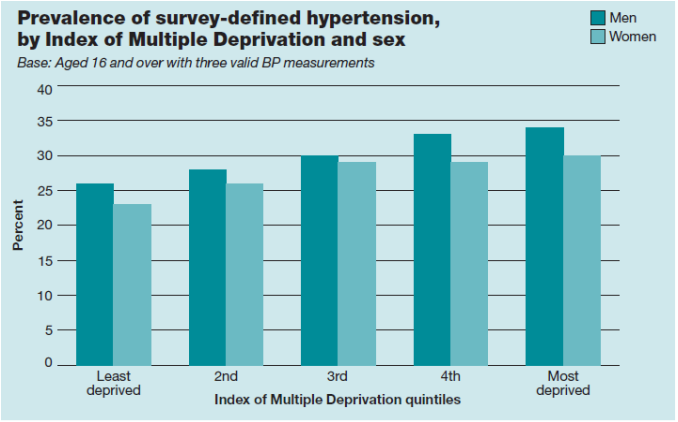
Over 24% of people in England are estimated to have high BP and it is one of the leading causes of premature death and disability in England. At least half of all heart attacks and strokes are associated with high BP and it is a major risk factor for chronic kidney disease, heart failure, stroke, myocardial infarction and vascular dementia.

Lowering blood pressure per se reduces risk for myocardial infarction by 20% - 25% [23].

High BP costs the NHS an estimated £2bn, while social care and productivity costs are likely to be much higher.

High BP is much more common in deprived communities. The Department of Health's 2010 'Health Survey for England' noted that prevalence increased from 26% of men and 23% of women in the least deprived fifth of the population to 34% and 30% respectively in the most deprived 20%.

**Figure 16: Prevalence of hypertension by Index of Multiple Deprivation (IMD) and sex (2011)**




*Source: NHS Digital: Health Survey for England (2011)*

# High blood pressure

For every ten people diagnosed with high BP, seven remain undiagnosed and untreated - this is more than 5.5 million people in England. Those in more deprived communities are less likely to have high BP detected though with the introduction of the quality scheme this gap has reduced [24,25]. In addition we can see the percentage of those in treatment and also adequately controlled reduces with increasing deprivation [25].

**Figure 17: High Blood Pressure**

| Income level | n | Aware (%) | Treated (%) | Controlled (%) |
|---|---|---|---|---|
| High | 6263 | 49.0 | 46.7 | 19.0 |
| Upper Middle | 18123 | 52.5 | 48.3 | 15.6 |
| Lower Middle | 23269 | 43.6 | 36.9 | 9.9 |
| Low | 10185 | 40.8 | 31.7 | 12.7 |
| | | | | |
| Total | 57840 | 46.5 | 40.6 | 13.2 |

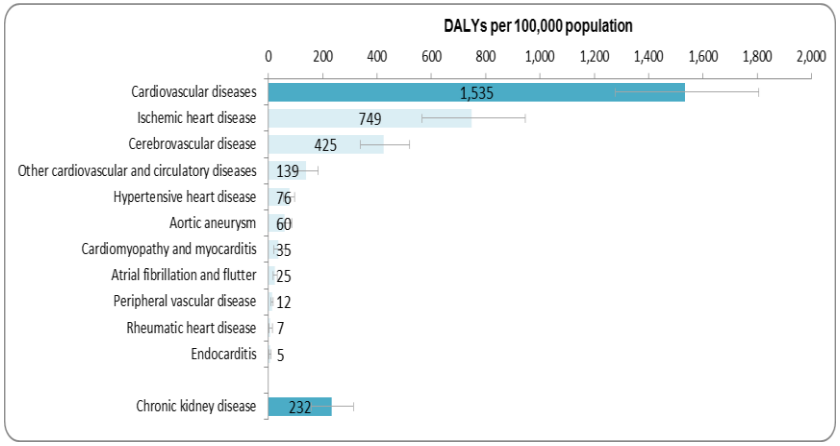
*Source: PHE: Health matters: combating high blood pressure*

13.1% of all deaths in South East England were attributable to high blood pressure [14].

7.2% of all disability-adjusted life years (DALYs) in the South East Region were attributable to high blood pressure in 2013 (1,766 per 100,000 population).

The largest number of DALYs attributable to high blood pressure were for cardiovascular diseases and chronic kidney disease. Within the cardiovascular diseases group, ischemic heart disease and cerebrovascular disease had the largest number of DALYs attributable to high blood pressure.

**Figure 18: DALYs attributable to High Blood Pressure in South East England (2013)**




*Source: Global Burden of Disease (GBD)*

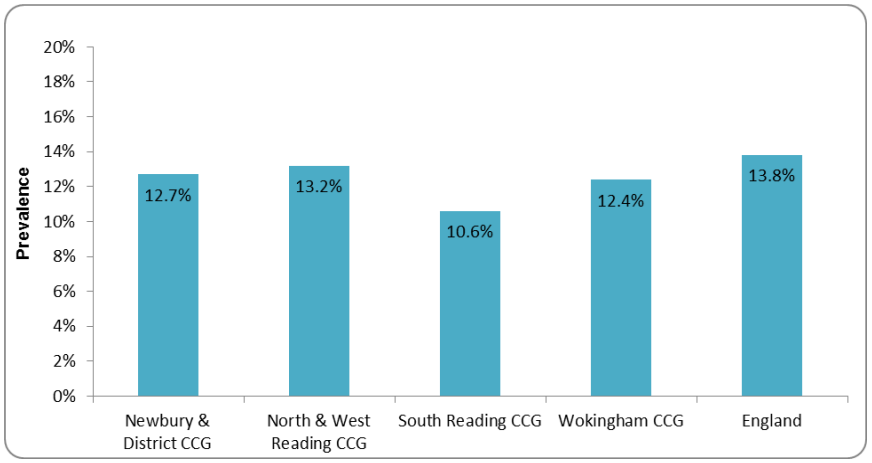
For all cardiovascular events high systolic BP accounts for 43% DALYs; 1,535 per 100,000.

In reviewing premature deaths (deaths before age 75) West Berkshire fares well with regards to heart disease and stroke being ranked 7th out of 150 authorities, with 53 deaths per 100,000 (2013-2015) and ranked 14 out of 16 in comparison to similar local authority areas [26].

# High blood pressure - Impact

Across the Newbury and District CCG, there are estimated to be 26,300 people with high blood pressure, with 14,900 currently being treated. This means that there are 11,500 people unaware of their high BP.

**Figure 19: High Blood Pressure Prevalence by CCG**




*Source: NHS Digital: Quality and Outcomes Framework 2014/15*

In addition, of those that are being treated by their GP not all are achieving target BP control: 505 patients [27].

Locally it is possible to measure the impact high BP has on disease and deaths but we can also estimate the impact of reducing high BP by 10 mm Hg in those with this condition in Newbury and District CCG . Every 10 mmHg reduction in systolic BP reduces the risk of major cardiovascular events by 20%.

Thus it is possible to calculate the impact of this improvement on Cardiovascular disease locally.

**Figure: 20**

| Condition | Current number of events | Current number if treated | Reduction in number of deaths |
|---|---|---|---|
| Stroke | 71 | 52 | 19 |
| Heart failure | 56 | 40 | 16 |
| Cardiovascular disease | 148 | 123 | 25 |
| Deaths | 837 | 728 | 109 |

*Source: British Heart Foundation: How can we do better?*

However, treatment is not simply reliant on medication. Across the long term conditions, more than half of all patients do not take their medication as prescribed. Modification of lifestyle factors can have a major impact on high BP with no side effects (and additional positive health impacts).

Studies show this impact and in one, the clear results were that in those who changed lifestyle behaviour for a period of 10 weeks a significant percentage achieved a 10 mmHg reduction in BP: [28]

- Weight reduction 40%
- Increased physical activity 30%
- More relaxation 25%
- Reduced alcohol intake 30%
- Reduced salt intake 25%

Advice given during the consultation for high BP is likely to be acted upon. Compared with those who did not recall being given advice, adults with high BP who recalled being given advice were more likely to change their eating habits, reduce salt, exercise and reduce alcohol consumption [29].

Indeed lifestyle modification is indicated for all patients with high BP, regardless of drug therapy, because it may reduce or even abolish the need for antihypertensive drugs.

# High blood pressure - Intervention

High blood pressure management in the community from a long term perspective is focussed on reducing the risk factors within the population; obesity, physical inactivity, smoking and high salt intake. However in the short and medium term there are clear programmes that can reduce the impact of high BP [21].

A clear priority is to reduce the number of patients with known high blood pressure for whom treatment is not adequate. This can be achieved by annual audits of GP practice registers to identify affected patients and develop the role of pharmacists and other professionals to maximise achievement of treatment goals through lifestyle changes and drug therapy. A 20% improvement in blood pressure control can be cost saving within 5 years.

Another key priority is the wider use of self-monitoring by patients. They can be encouraged to develop the skills and understanding to monitor their blood pressure in their daily lives to minimise false readings.

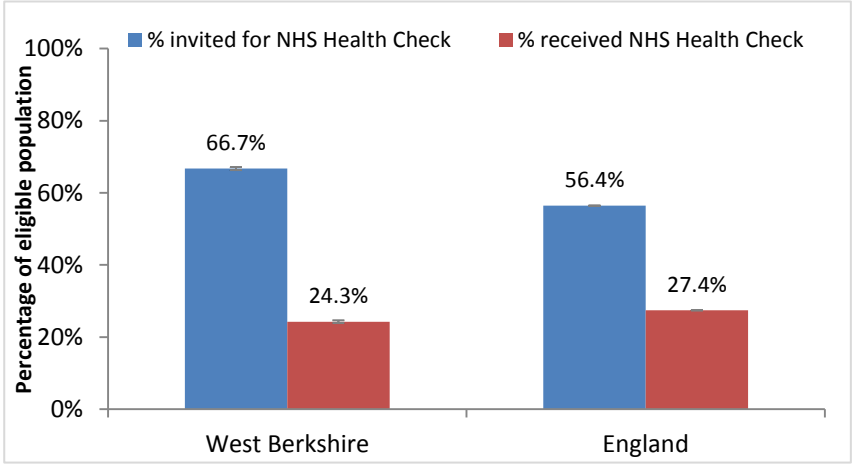
Of course it is also key to identify residents in the community who are unaware that they have high blood pressure. Programmes such as NHS Healthchecks identify those with high blood pressure and support them to make lifestyle changes or provide them with medical management will help to prevent longer term damage and reduce demands for more specialist health and social care.

**Figure: 21 The number of people who were invited/received an NHS Health Check from 1st April 2013 to 31st March 2016.**

| | Invited for NHS Health Check (2013/14 to 2015/16) | | Received NHS Health Check (2013/14 to 2015/16) | |
|---|---|---|---|---|
| | No. of people | % of eligible population | No. of people | % of eligible population |
| West Berkshire | 32,820 | 66.7% | 11,928 | 24.3% |
| England | 8,792,518 | 56.4% | 4,271,889 | 27.4% |

*This is cumulative, as part of the 5-year cycle of the programme.*

**Figure: 22 Percentage of eligible population who were invited/received an NHS Health Check from 1st April 2013 to 31st March 2016.**




*Source: PHOF 2017*

# Lifestyle - Alcohol

It is known that alcohol is harmful to health and the CMO guidelines to reduce risk state that it is safest for men and women not to drink more than 14 units a week on a regular basis. These should be spread over 3 or more days [29,30].

Alcohol is measured in units - one unit is 10ml or 8g of pure alcohol. Since drinks differ in the proportion of alcohol the number of units varies. Alcohol drinks are often described as alcohol by volume percentage e.g. some wines are 11% ABV - this means that a 1 litre bottle contains 11 units .

Therefore one 125ml glass contains 1.64units, a 175 ml glass has 1.9 units and a 250 ml glass has 2.5 units.
A pint of 4% beer has 2.3 units [30].

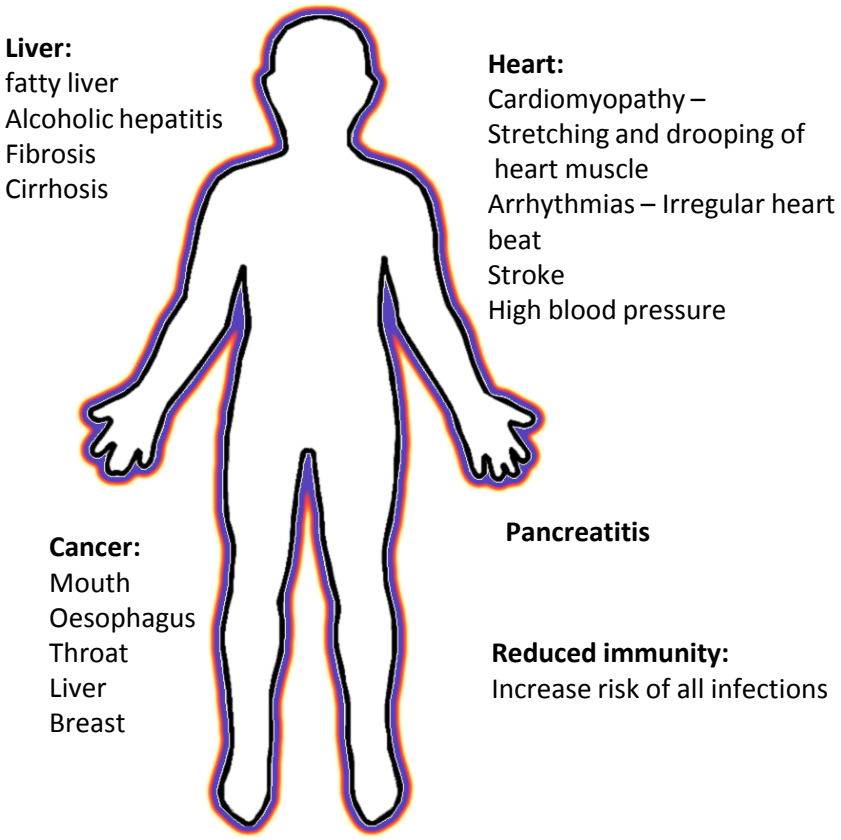
To keep to safe limits, an adult in a week should not drink more than

**Figure 23: Alcohol limits and unit guidelines**


*Source:* *Drinkaware.co.uk: Alcohol limits and unit guidelines*

Alcohol is the leading cause of death among 15 to 49 year olds and heavy alcohol use has been identified as a cause of more than 200 health conditions [31].

**Figure 24: Effects of Alcohol on the body**



# Alcohol - Impact

The burden of health, social and economic alcohol-related harm is substantial, with estimates placing the annual cost to be between 1.3% and 2.7% of annual GDP.

**Currently over 10 million people are drinking at levels that increase their risk of harm to their health.**

- 5% of the heaviest drinkers account for one third of all alcohol consumed

Alcohol caused more years of life lost to the workforce than from the 10 most common cancers combined. in 2015 there were 167,000 years of working life lost [32].

Among those aged 15 to 49 in England, alcohol is now the leading risk factor for ill-health, early mortality and disability.

With increasing consumption, there is increasing risk. For example, all alcohol-related cancers exhibit this relationship [33].

**Figure 25: Alcohol Harm Map**

| Condition | | |
|---|---|---|
| | 3 units of alcohol per day | 6 units of alcohol per day |
| **Liver disease** | 3 times | 7 times |
| **Mouth cancer** | 2.5 times | 5 times |
| **Throat cancer** | 1.8 times | 3 times |
| **Breast cancer** | 1.3 times | 2 times |
| **Hypertension** | 1.7 times | 3 times |
| **Ischaemic stroke** | No change | 2 times |
| **Haemorrhagic stroke** | 1.8 times | 3 times |
| **Pancreatitis** | 1.3 times | 2 times |

*Source: Alcohol Concern: Alcohol Harm Map*

The health and social harm caused by alcohol is determined by:

- the volume of alcohol consumed
- the frequency of drinking occasions
- the quality of alcohol consumed

In addition a number of individual risk factors moderate alcohol-related harm, such as [34]:

- age: children and young people are more vulnerable
- gender: women are more vulnerable
- familial risk factors: exposure to abuse and neglect as a child and a family history of alcohol use disorders (AUD)

Also in the English population, rates of alcohol-specific and related mortality increase as levels of deprivation increase and alcohol-related liver disease is strongly related to the socioeconomic gradient [32].

This despite the fact that lower socioeconomic groups often report lower levels of average consumption. This gives rise to what has been termed the 'alcohol harm paradox' whereby disadvantaged populations who drink the same or lower levels of alcohol, experience greater alcohol-related harm than more affluent populations. The reason for this is not known but may be due to a greater impact of alcohol due to lower resilience: possible higher rates of binge drinking or poorer access to services

Public Health England has estimated the increase on average life expectancy for men and women if all alcohol-related deaths were prevented. Nationally, this would be 12 months for men and 5.6 months for women (Source: Alcohol Concern, Alcohol Harm Map).

# Alcohol - Impact

**Figure 26:**

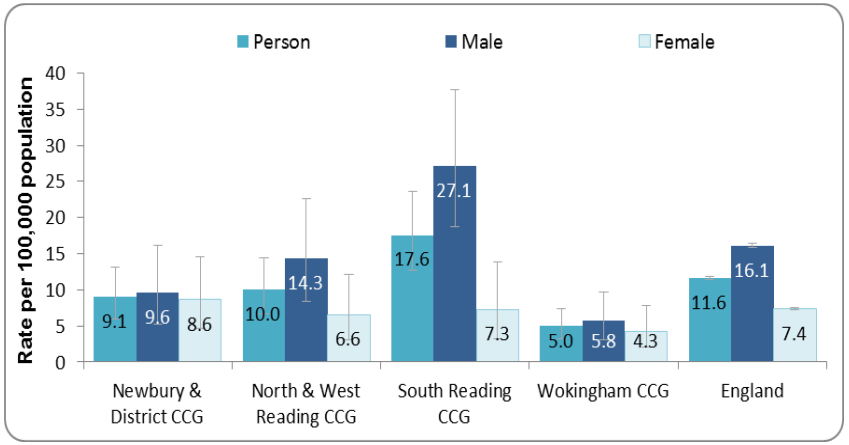
| Cause of death | No. of deaths | Average age at death |
|---|---|---|
| All causes (England & Wales | 501,424 | 77.6 |
| All alcohol-specific causes | 4,329 | 54.3 |
| Mental and behavioural disorders due to use of alcohol | 489 | 57.5 |
| Toxic effects of alcohol (unspecified) | 395 | 42.4 |
| Accidental poisoning by exposure to alcohol | 369 | 49.1 |

3.9% of all early death and poor health (DALYs) in the South East Region were attributable to alcohol use in 2013 (965 per 100,000 population).(12)

The largest number of DALYs attributable to alcohol use were for cancers, cirrhosis, mental and substance use disorders and unintentional injuries

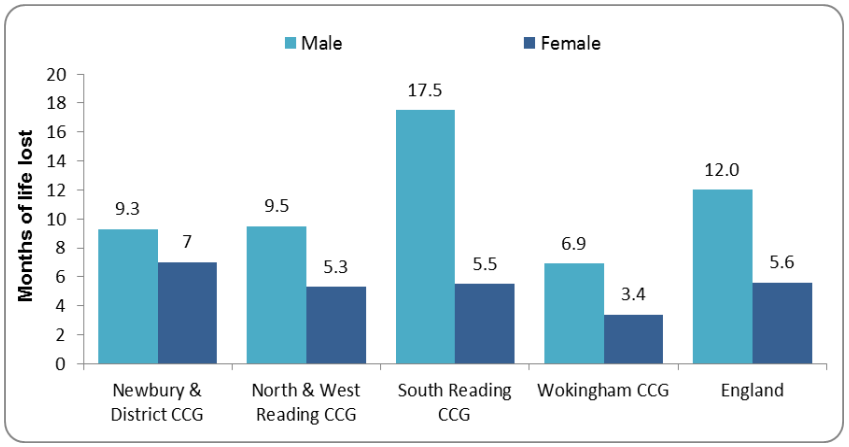
In 2012-14, 153 people died from alcohol-specific conditions in the Frimley Heath STP footprint, 75% of these were men. The rate of deaths per 100,000 population varied in the area from 9.1 per 100,000 population in Newbury & District CCG to 10.0 per 100,000 in North & West Reading CCG. (27)

**Figure 27: Alcohol-specific mortality per 100,000 population (2012-14)**




If we look at the months of life lost due to alcohol locally then we can see a similar picture where men in West Berkshire lose on average 9.4 months – (28).

**Figure 28: Months of life lost due to alcohol (2012-14)**



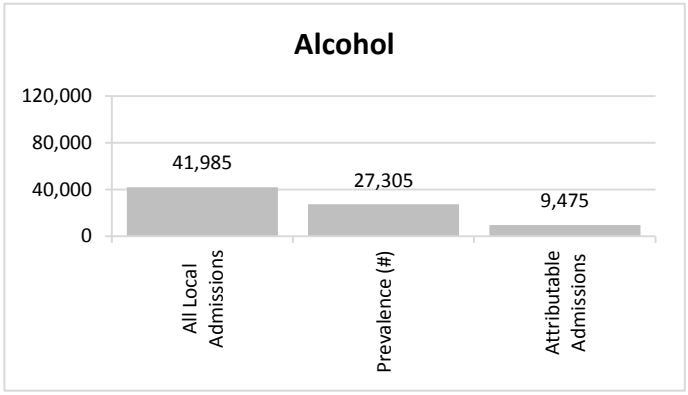

*Source: Public Health England (2016); Local Alcohol Profiles for England*

# Alcohol - Interventions

With such an impact on early death and illness alcohol has a significant impact on hospital use. Nationally alcohol related and attributable admissions have been rising: According to the broad measure, admissions for cardiovascular disease account for almost half of all alcohol-related admissions in 2014/15. For the narrow measure, hospital admissions for cancer represent the most common condition for admissions accounting for 23% of all alcohol-related conditions.

Within West Berkshire there are over 27,000 residents who consume alcohol and just over 9,000 admissions annually due to alcohol - not unexpected since alcohol accounts for 3% of all NHS costs [16].

**Figure 29: Alcohol figures**




*Source: LKIS 2017*

The impact of alcohol in our society is driven by a variety of factors including limited awareness of health risks from alcohol consumption, addictive nature of alcohol, failure of health professionals to address alcohol as a causal factor in patients' ill health and lack of local system join-up [34,31].

The public health ambition for alcohol is to reduce excessive alcohol consumption and therefore the associated burden on NHS and local authorities and the wider society [31].
This will result in:

- A reduction in alcohol-related hospital admissions, re-admissions, length of stay and ambulance call-outs
- A reduction in the burden on NHS, police and social care services from high volume service users
- A reduction in the impact of parental alcohol misuse on children

Much of the work on addressing alcohol needs to be done at a national level: continued media and awareness raising on safe alcohol consumption, national policy changes in minimum pricing, taxation and licensing of alcohol.

However there are further key actions that can be taken forward locally including:
Screening patients throughout health care settings to deliver a brief intervention, including giving advice to raise knowledge on safe alcohol levels, potential harm and ways to reduce alcohol intake [21].

The development of alcohol care teams, to support patients admitted to hospital through alcohol with specialised support , coupled with assertive outreach and case management for patients and residents in whom alcohol is causing repeated hospital admissions or use of other services.

# Lifestyle - Physical Activity

**Physical Activity is defined as any bodily movement produced by skeletal muscles that requires energy expenditure**

Physical activity levels can be measured either through asking people to report how much exercise they do, or by objectively measuring the amount of exercise a person is doing. Most reports use self reported activity.

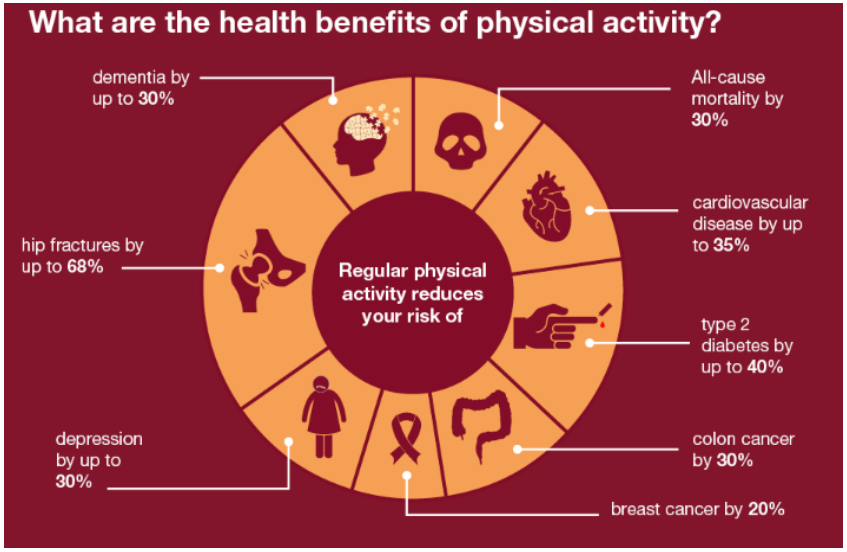
Physical inactivity is defined as less than 30 minutes of physical activity a week. The Chief Medical Officer guidelines for physical activity not only suggest recommended activity levels but also recommend the amount of time in which we are sedentary, and encourage weight bearing exercise [35] .

**Figure 30: Adult activity recommendation**


*Source: Health matters: getting every adult active every day*

The link between physical inactivity and obesity is well known, but physical activity is not just a way of addressing obesity.
Low physical activity is one of the top 10 causes of disease and disability in England.

**Figure 31: Health benefits of physical activity**




*Source: Health matters: getting every adult active every day*

UK studies have estimated that around 1% of cancers in the UK (around 3,400 cases every year) are linked to people doing less than the recommended 150 minutes of physical activity each week.

1 in 8 women in the UK are at risk of developing breast cancer at some point in their lives. By being active every day they could reduce their risk by up to 20% [36].

Physical activity is also important for people diagnosed with cancer and cancer survivors. Not only increasing ability to manage recovery but also reducing rate of recurrence in key cancers.

Macmillan has estimated that in the 2 million cancer survivors in the UK - 1.6 million do not meet the recommended levels of physically active [37].

# Physical Activity

One in four women and 1 in 5 men are inactive. Only 24% of women and 34% of men do muscle strengthening exercises twice a week. Men are more likely to be sedentary for more than 6 hours a Day [36].

Levels of activity are reducing. People in the UK are around 20% less active now than in the 1960s. This pattern is also seen in children and young people with the proportion who met the weekly physical activity guidelines falling between 2008 and 2012 [36].

People living in in the least prosperous areas are twice as likely to be physically inactive as those living in more prosperous areas [38].

South East England has the highest proportion of both men and women meeting recommended levels of physical activity, while North West England has the lowest.



### *Age*

Physical activity declines with age to the extent that by 75 years only 1 in 10 men and 1 in 20 women are sufficiently active for good health.

### *Disability*

Disabled people are half as likely as non-disabled people to be active. Only 1 in 4 people with learning difficulties take part in physical activity each month, compared to over half of people without a disability.

### *Race*

Only 11% of Bangladeshi women and 26% of and Bangladeshi men are sufficiently active for good health, compared with 25% of women and 37% men in the general population.

### *Sex*

Men are more active than women in virtually every age group, with 6 in 10 women not participating in sport or physical activity [38].

### *Sexual orientation and Gender Identity*

Over a third of lesbian, gay, bisexual and transgender youth do not feel they can be open about their gender identity in a sports club [26].

Lack of physical activity is costing the UK an estimated £7.4 billion a year, including £0.9 billion to the NHS alone [36].

Inactivity causes 9% (range 5·1–12·5) of premature mortality, or more than 5·3 million of the 57 million deaths that occurred worldwide in 2008 [14].

Physical inactivity in developed countries is responsible for :
an estimated:

22-23% of CHD
16-17% of colon cancer
15% of diabetes
2-13% of strokes and
1% of breast cancer [16]

It is estimated that physical inactivity contributes to almost one in ten premature deaths (based on life expectancy estimates for world regions) from coronary heart disease (CHD) and one in six deaths from any cause.

Persuading inactive people (those doing less than 30 minutes per week) to become more active could prevent:
- one in ten cases of stroke and heart disease in the UK and
- one in six deaths from any cause [38].

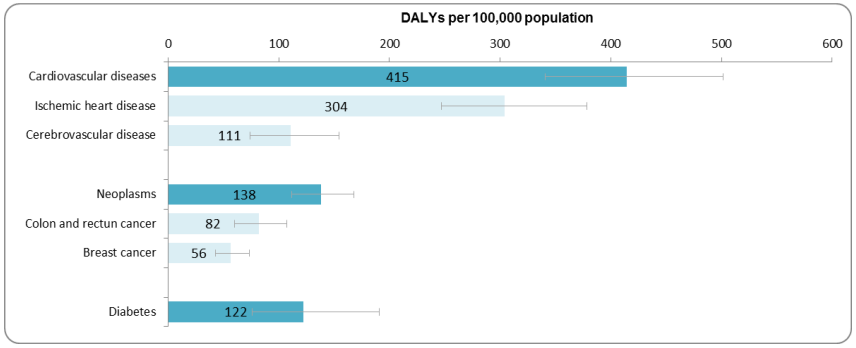
# Physical Activity - Interventions

In the UK the Global Burden of Diseases found physical inactivity to be the fourth most important risk factor in the UK for limiting illness and early death [14].

In the South East, 2.8% of all disability-adjusted life years (DALYs) in the South East Region were attributable to low physical activity in 2013 (675 per 100,000 population) [12].

The largest number of DALYs attributable to low physical activity were for cardiovascular diseases, neoplasms and diabetes

**Figure 32: DALYs attributable to low physical activity in South East England (2013)**




*Source: Global Burden of Disease (GBD)*

The Health Impact of Physical inactivity (HIPI) tool quantifies the impact of physical inactivity for people aged 40 – 79. Within West Berkshire each year If 100% of this group were active then:

- 83 out of 489 annual deaths (40-79) could be prevented
- 23 out of 119 annual cases of breast cancer could be averted
- 724 new cases of diabetes could be prevented

A body of evidence now exists that links physical inactivity to increasing risk of hospital admission - emergency and other use of health and social care [39].

In Scotland it was shown that minutes of moderate-to-vigorous physical activity (MVPA) per day predicted subsequent numbers of prescriptions: those with less than 25 minutes of moderate to vigorous physical activity per day had 50 per cent more prescriptions over the following four to five years.

Similarly the number of steps taken per day and MVPA also predicted unplanned hospital admissions. Those in the most active third of the sample were at half the risk of emergency hospital admissions than those in the low active group [40].

The solution is clear: Everybody needs to become more active, every day [36]. Physical activity does not need to be strenuous, it can be 30 minutes of brisk walking, a swim, gardening or dancing .

Each ten minute bout that gets the heart rate up has a health benefit. Being active is not just about moving more, we need to build our muscle strength and skills.

In addition adults need twice a week muscle strength and stability improvements which helps prevent the development of musculoskeletal disease.

A number of common characteristics are apparent in effective action to increase population levels of physical activity. These include two common factors: persistence and collaboration [40].

Four areas of action are identified by Public Health England, at national and local level.

- active society: changing our attitude to physical activity
- moving professionals: professionals across all sectors promoting activity in their work
- active lives: creating environments that make activity easy
- moving at scale: scaling up interventions that make us active

# Lifestyle - Obesity

Being overweight or obese is when a person has more body fat than is optimally healthy. Poor diet and physical inactivity are causal factors of obesity with excess weight being caused by an imbalance between energy consumed and energy expended.

**In the UK obesity is estimated to affect around one in every four adults and around one in every five children aged 10 to 11.**

The annual costs associated with obesity to the NHS and social care systems are estimated to be £6.1 billion a year and £352 million respectively [41].

For most adults, BMI measures are :

- healthy weight 18.5 to 24.9 kg/$m_2$
- overweight 25 to 29.9 kg/$m_2$
- obese 30 to 39.9 kg/$m_2$
- severely obese 40 or above kg/$m_2$

Another simple measure of excess fat is waist circumference. Normal waist size values are for men - 94cm (37in) or more
For women - 80cm (31.5in). If these measures increase an individual is more likely to develop obesity-related health problems.

Obesity prevalence increased steeply between 1993 and 2000. Rates of obesity and overweight were similar in 2013 to recent years. *Health Survey for England 2013* [41].

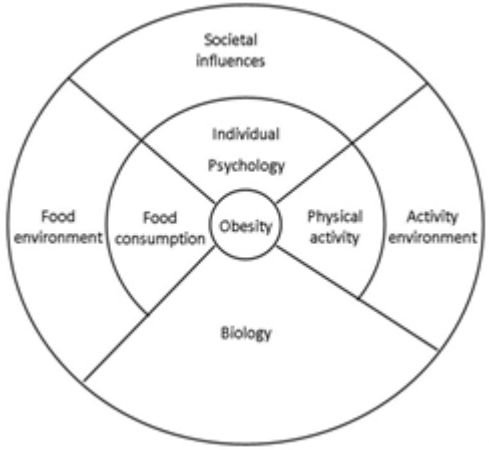
## Mortality

9.0% of all deaths in South East England were attributable to a high body-mass index (GBD2013) . This was the 3rd most important risk after smoking and high blood pressure (12).
The impact of weight on life expectancy is linked to the levels of excess weight.

**People with a BMI of 22 – 25 kg/$m_2$ have the best life expectancy:**
**obese individuals live 2 – 4 years less**
**People with BMI of over 40 live 8 – 10 years less** [42]

Increased mortality is as a result of higher rates of cardiovascular disease, high BP and type 2 diabetes and hormone sensitive cancer - e.g. breast .

**Figure 33: Foresight Obesity Systems Map (2007)**

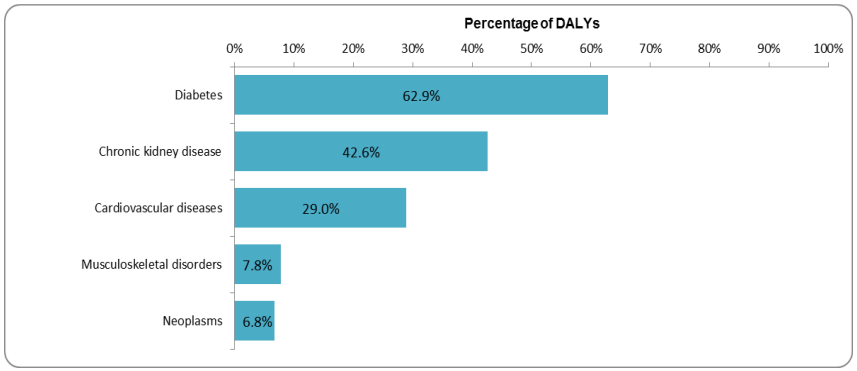



*Source: Foresight Systems Map (2007)*

# Obesity – local impact

Obesity causes 9% of all DALYs lost in the South East of England, with most overall impact being seen through cardiovascular disease and diabetes. But its impact as a cause of diabetes (63%), chronic kidney disease and cardiovascular disease due to high BP (56%) is very stark [14].

**Figure 34: Percentage of DALYs attributable to High BMI in South East England by cause (2013)**




*Source: Global Burden of Disease (GBD)*

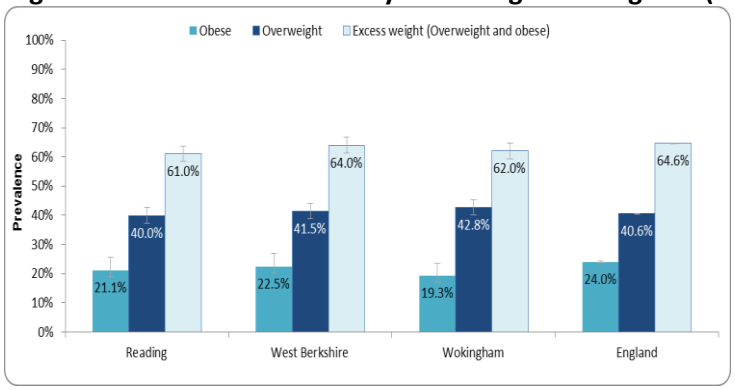
Obesity levels in the population vary with a variety of factors e.g. obesity levels increase until late middle age and then reduce in old age. More women in communities with higher deprivation are obese (NICE guidelines 2014).

Women from the higher socioeconomic groups have the lowest prevalence of obesity while those in the lowest groups consistently have the highest prevalence of obesity [42,43]. This is not seen in men, though for both men and women obesity is significantly reduced in those with a degree or equivalent.

Prevalence of obesity is highest in women from Black African, Black Caribbean and Pakistani ethnic groups.

Locally in West Berkshire we can see that we are below the national average with regards to obesity levels, however we exceed the national average for percentage of residents who are overweight. Whilst obesity has more adverse health effects, maximum life expectancy is seen with a normal BMI.

**Figure 35: Prevalence of obesity and being overweight in (2012-14)**




*Source: Active People Survey (2012-14)*

In our children the figures are a concern. In West Berkshire in 2015/16 18.7% of children in reception were measured as overweight or obese, rising to 26.6% in year 6 (England figures were higher at 22.1% and 34.2% respectively).

We know that obesity is linked to health conditions and so impact on hospital admissions. We would therefore expect that with our lower rates of obesity, this would have less of an impact on our adult hospital admissions. However even with our lower than average obesity levels approximately 700 admissions in West Berkshire have obesity recorded as part of the record each year, with just over 5000 admissions being attributable to obesity [16].

# Obesity - Interventions

Interventions to reduce obesity are less visible and accepted than others such as smoking cessation. There are a number of ways that can be adopted to reduce the burden of obesity for the individual and the community.

Our environments tend to promote obesity: encouraging high calorie food intake and physical inactivity. Local government partners, employers and communities can work together to change this. Promoting active travel and ensuring healthy food options in work are two examples of work to address our environment.

In addition we need to ensure our weight management services are evidence based and cost effective. However the first step is for professionals to consistently raise the issue of weight at every opportunity. There is evidence that professionals believe programmes to have no lasting impact. However the evidence from published research is that interventions do work, with community based approaches being more effective than those based in primary care (44). Primary care can increase the effectiveness of community based approaches through discussion and referral. People referred via primary care had greater weight loss [45] - 50%, but even just mentioning weight loss as part of a consultation results in weight loss still seen at 2 years [45].

**A brief intervention, resulting in 1.5 kg weight loss, delivered once a year to all eligible people visiting their GP, could halve the prevalence of obesity by 2035 (Jebb 2017).**

One other reason given for reluctance to refer is the belief that impact is short lived, whilst weight does gradually increase weight loss is still seen at 2 years and crucially even in patients who regain their weight the incidence of diabetes is significantly reduced at 10 years - the impact of the weight loss outlives the actual weight loss [47].

Furthermore Health professionals do not routinely address weight loss issues as some voice concern about the impact of the topic on the clinical relationship. However research on patients receiving weight loss advice showed that less than 2% found it to be unacceptable or unhelpful and over 40% very helpful. Moreover 77% accepted the referrals to weight management services with nearly 50% completing the course [47].

It should be remembered that weight management interventions aim to have lifelong benefits. In Berkshire in the second year of a locally developed intervention, Eat for Health, 529 people have attended courses with more than 50% losing more than 3% of their original body weight. 197 people with high BP attended and 55 (28%) lost weight with a resultant return to normal levels in their BP, needing no on-going medication and achieving significant on going health benefits.

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Berkshire West
Accountable Care System

# Berkshire West
## Accountable Care System





An Introduction to the Berkshire West Accountable Care System

April 2017

# Background & Context

- Delivery of the BOB STP will ensure that NHS organisations operating within the region can best deliver the 'Triple Aim' of the NHS 5 Year Forward View (5YFV):
    - Improved health and wellbeing
    - Transformed quality of care delivery
    - Sustainable finances
- Whilst BOB development continues, Berkshire West are seeking to implement a local Accountable Care Systems (ACS) and have been identified by NHSE/I as an exemplar area
- The Berkshire West ACS will be an 'evolved' version of an STP that is working as a locally integrated health system and will comprise the following organisations:
    - 4x Berkshire West CCGs
    - Royal Berkshire Hospital Foundation Trust
    - Berkshire Healthcare Foundation Trust
    - 3x Local Authorities in Berkshire West
    - GP Alliances
- The ambition of all parties also includes the addition of social care with local authorities as full members at a mutually agreeable pace. Wokingham Borough Council are joining the ACS Programme in April 2017.
- We envisage an end state whereby commissioners and providers operate under a single capitated budget (often referred to as a 'System Control Total') based on collaboration and built on a combination of both formal (statutory) governance and agreements such as the Berkshire West ACS Memorandum of Understanding.



Berkshire West
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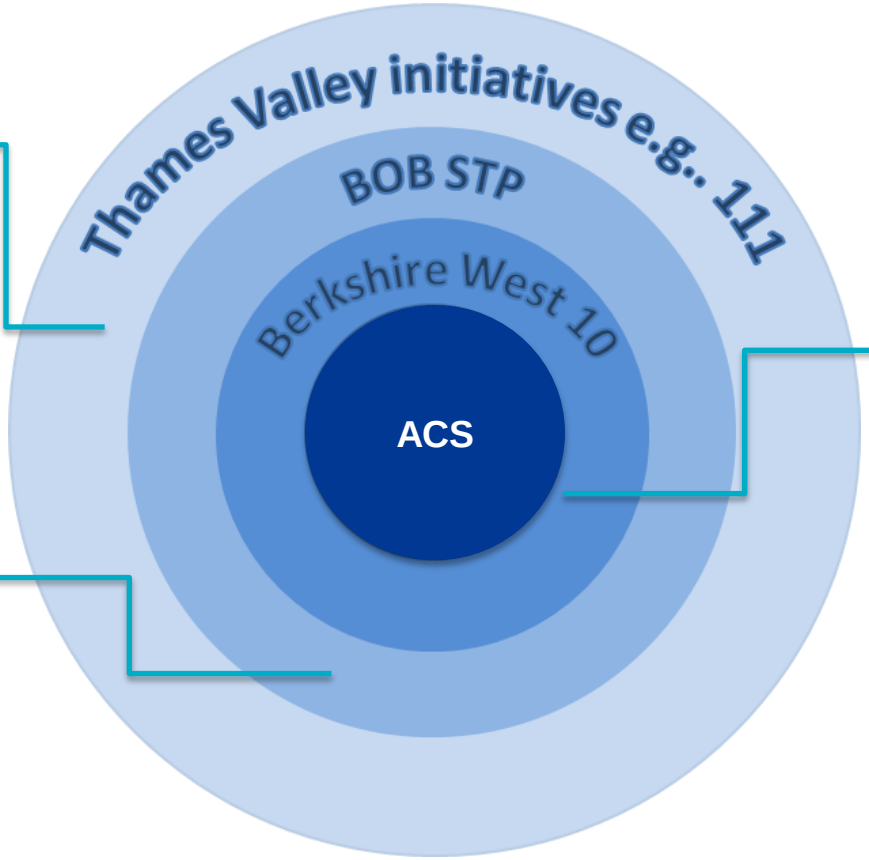
# What is an Accountable Care System?

- ACSs will be an ‘evolved’ version of an STP that is working as a locally integrated health system.
- They are systems in which NHS organisations (both commissioners and providers), often in partnership with local authorities, choose to take on clear collective responsibility for resources and population health.
- They provide joined up, better coordinated care.  In return they get far more control and freedom over the total operations of the health system in their area; and work closely with local government and other partners to keep people healthier for longer, and out of hospital.

# The ACS programmes fit with other initiatives in our region

We will continue our work with partner organisations to plan for and deliver services effectively at larger scales

Our individual ACS members are an engaged and active part of the Buckinghamshire, Oxfordshire and Berkshire West STP




The ACS compliments the well established health and social care integration programmes which oversees joint investments and improved system working



Berkshire West
Accountable Care System

# ACS objectives and what will be achieved

| Objectives | Success will look like…. | |
|---|---|---|
| **Develop a preventative model of working** | Promotion of primary and preventative care through reduction of more costly care | Patients seen in most appropriate settings of care – not necessarily in hospital |
| **Improve patient experiences and outcomes** | Optimised patient pathways across all areas e.g: planned care, mental health, maternity, LTC, frail elderly, EoL, urgent and emergency care | Streamlined pathways that provide: integrated care across all health and social care providers; a positive experience for patients; a cost reduction for the system |
| **Deliver financial stability for the system** | New finance and payment mechanisms put in place between the parties to optimise allocation of resources | Resource is allocated to support delivery of optimised care pathways, incentivise their achievement and share risk |



Berkshire West
Accountable Care System

# The ACS will deliver better financial value for the NHS

To unlock this value and bring our whole system into financial balance we will:

- Embed new ways of delivering our services which reward treating patients in the right place, at the right time and at the lowest cost e.g. through the Berkshire West Outpatients Transformation Programme

- Cover the challenge of lower real-terms allocations and deliver the efficiencies needed to run a balanced local health economy by taking shared investment and planning decisions

- Ensure each organisation has a stake in the system financial position rather than each constituent standing alone. For 17/18, The Berkshire West ACS has requested a "**System Control Total**" from NHS England to assist with this aim which will cover its whole ACS

- Better position the NHS for wider 'pooling' opportunities with Local Authorities, particularly as we continue to explore the opportunities arising from BCF 'Graduation'



Berkshire West
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# ACS partners have established ‘High Value Opportunity’ projects for immediate delivery

A number of improvement schemes which could deliver the highest clinical and financial benefits have been prioritised.

The 17/18 clinical priorities agreed by the ACS Partners are as follows:

- High Intensity Users
- Integrated Community Respiratory service
- Exploring an ‘MSK Prime Provider’ model
- Transformation of Outpatients
- Joint prescribing opportunities and best value medicines management for both products and processes



In parallel, the ACS will also oversee the delivery of improved system working opportunities:

- System wide bed modelling and redesign
- Consolidation of Back Office / Support Services
- Estates Optimisation: One Public Estate via Berkshire Property Partnership

Further, additional in-year opportunities are being explored such as the opportunities around ED front door screening

Berkshire West
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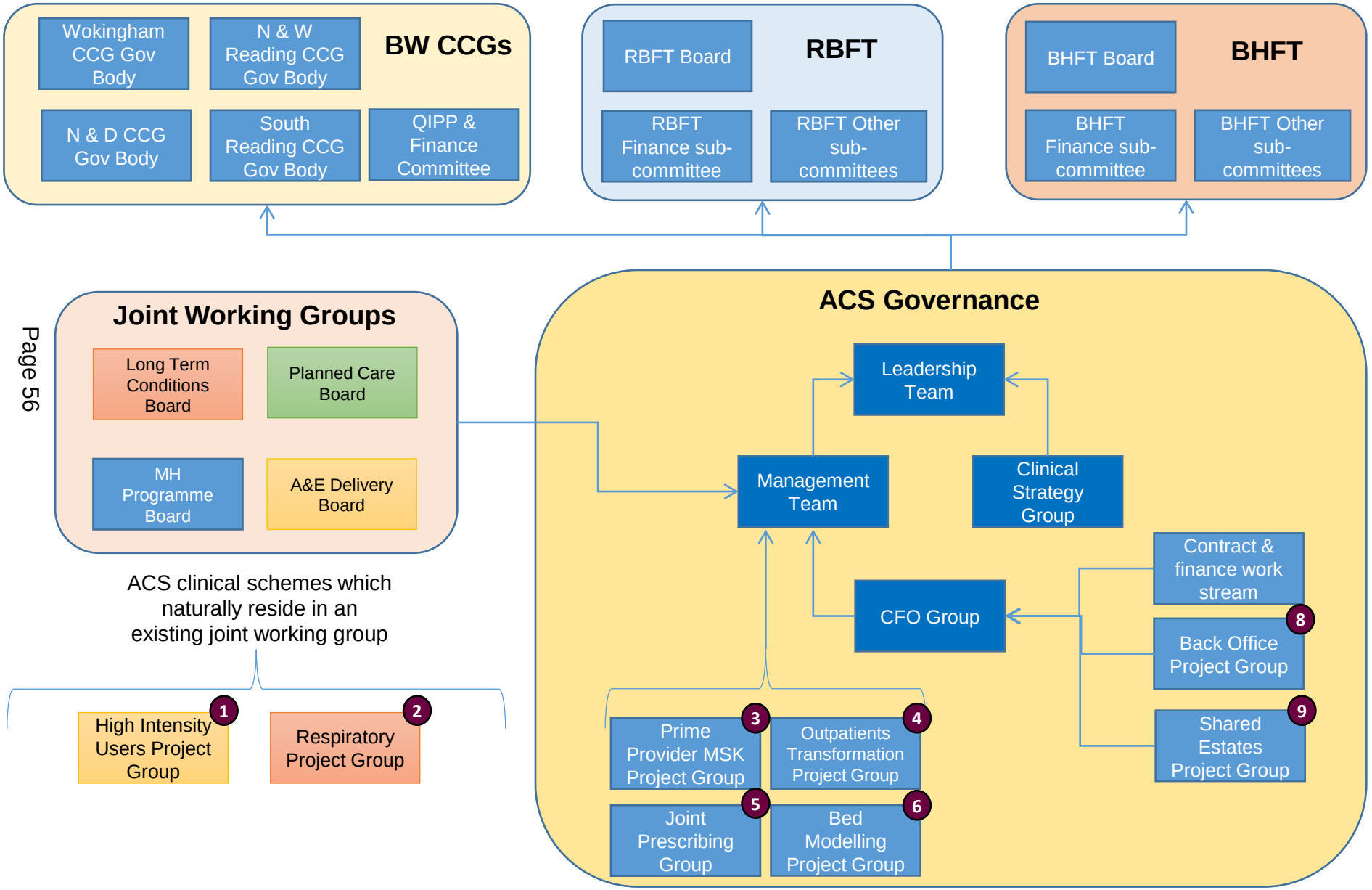
# Berkshire West has established a joint governance structure which will facilitate the delivery of our priority projects



# The Berkshire West ACS is nationally recognised and supported by the Five Year Forward View Delivery Plan

- NHS England are developing contracts which support the establishment of ‘New Models of Care’
- These new contractual forms provide opportunities for local systems which are able to work more closely together – both ACS programmes will be well placed to take advantage of this
- If these are advantageous to each ACS then local discussions will take place in order to accelerate the deployment of these
- These contracts seek to bolster the role of the out-of-hospital sector, supported by operational clusters of integrated community and social care – “The Healthcare Framework”
- The Five Year Forward View Delivery Plan which was published in March 2017 references Berkshire West as an exemplar ACS which will receive national support and expertise during implementation



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# Delivering the Health and Wellbeing Strategy (Delivery Plans) - Summary Report

| | |
|---|---|
| **Committee considering report:** | Health and Wellbeing Board |
| **Date of Committee:** | 25 May 2017 |
| **Portfolio Member:** | Cllr James Fredrickson |
| **Report Author:** | Jo Reeves |

## 1. Purpose of the Report

The purpose of this report is to outline the activities that will be completed by the Health and Wellbeing Board's sub-groups to deliver measurable progress towards the aims and objectives in the Health and Wellbeing Strategy. It also highlights objectives in the Strategy which do not have any additional activities being completed.

## 2. Recommendation

The Health and Wellbeing Board approve the delivery plans.

## 3. Implications

| | | |
|---|---|---|
| 3.1 | **Financial:** | The resourcing of delivering the Health and Wellbeing Strategy is being met from existing budgets. |
| 3.2 | **Policy:** | None |
| 3.3 | **Personnel:** | None |
| 3.4 | **Legal:** | None |
| 3.5 | **Risk Management:** | None |
| 3.6 | **Property:** | None |
| 3.7 | **Other:** | None |

## 4. How the Health and Wellbeing Board can help

The Health and Wellbeing Board can help by:

(1) Determining whether it would like to take any action regarding the objectives which do not have delivery plans

(2) Identifying the outcomes it would most like to achieve a difference on

| | | |
|---|---|---|
| **Will the recommendation require the matter to be referred to the Executive for final determination?** | Yes: ☐ | No: ☒ |

# Executive Summary

## 5. Introduction / Background

- The West Berkshire Joint Health and Wellbeing Strategy 2017-2020 was adopted by the Health and Wellbeing Board in November 2016,
- Under each of the five strategic aims, objectives specify what the Board wants to do to achieve its aims. The Board has chosen two of the objectives which sit under the aims to be their priorities for 2017. These are to reduce alcohol related harm and increase the number of community conversations.
- The Board has asked its sub-groups to identify actions that they will complete and measures that they will monitor to ensure their work is having an impact.

## 6. Proposal

- The Health and Wellbeing Board are invited to consider the delivery plans included in the supporting information.
- The Board should also consider whether it would to take any action regarding the objectives which do not have action plans for activity over and above the usual work of the Board's member organisations.

## 7. Conclusion

- The delivery plans specify the actions that the Board's sub-groups are focusing on in the short and medium term. The progress will be monitored by the Steering Group and the measures to monitor the progress of these actions will form the Board's new performance dashboard. The Steering Group considered that these delivery plans present the outputs that the sub-groups are seeking to achieve but they do not go far enough to explain the outcomes for West Berkshire's residents that are to be improved.
- The report identifies objectives in the Health and Wellbeing Strategy which have no additional work being undertaken that go above and beyond business as usual activities. It is also clear that some groups' delivery plans are more advanced than others and this is due in part to the lengths of time the groups have been operating. The Board should however be concerned that there is no delivery plan as yet for the aim to 'support mental health and wellbeing throughout life'. It should also give attention to the aims to 'build a thriving environment in which communities can flourish' and 'reduce premature mortality by helping everyone live healthier lives' which at present have no limited activity.
- Whilst the Board needs to balance the desires to focus its attention on areas where its involvement can be most effective, it also needs to ensure the delivery of the Health and Wellbeing Strategy in its entirety. At present there is no delivery plan for any objectives under the aim to 'support mental health and wellbeing throughout life' and the Board should investigate the barriers which have lead to the slow progress here.

## 8. Appendices

8.1 Appendix A – Supporting Information

8.2 Appendix B – Health and Wellbeing Programme Delivery Plan

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**Appendix A**

# Delivering the Health and Wellbeing Strategy (Delivery Plans) – Supporting Information

## 1. Introduction/Background

1.1 The West Berkshire Joint Health and Wellbeing Strategy 2017-2020 was approved by the Health and Wellbeing Board (the Board) on 24 November 2016 and adopted by the Council on 2 March 2017.

1.2 The Strategy sets out two priorities for 2017. The Board intends to achieve progress against these objectives to be achieved by the end of 2017. These are:

(1) Reduce alcohol related harm for all age groups

(2) Increase the number of Community Conversations through which local issues are identified and addressed

1.3 The Strategy sets out five strategic aims that the Board is working towards. Under each aim, three to five objectives specify what the Board wants to do to achieve its aims. Two objectives have been chosen as the Board's priorities for 2017 (above). The Health and Wellbeing Board wants to achieve measurable progress against these aims by the end of the period covered by the Strategy (2020). The aims are:

(1) Give every child the best start in life

(2) Support mental health and wellbeing throughout life

(3) Reduce premature mortality by helping everyone live healthier lives

(4) Build a thriving and sustainable environment in which communities can flourish

(5) Help older people maintain a healthy, independent life for as long as possible

1.4 When the Strategy was written, the author intended that the full list of objectives would encapsulate the aspects of health and wellbeing which had been identified as significant issues following analysis of the District Needs Assessment. The aims group these objectives which *should* inform the usual business of the Council, Clinical Commissioning Group and other partner organisations of the Health and Wellbeing Board. The author also intended that the Health and Wellbeing Board would choose annually a small number of objectives to be its priorities for the forthcoming year.

1.5 So that the Board can achieve measurable outcome change against the aims and objectives in their Strategy it has asked its sub-groups to identify actions that they will complete and measures that they will monitor to ensure their work is having an impact.

1.6 The purpose of this report is to outline the activities that will be completed by the sub-groups to deliver measurable progress towards the aims and objectives in the Health and Wellbeing Strategy. Measures have been developed to monitor the progress of these actions and will be reported to the Steering Group on a quarterly basis. These are available in the appendix.

1.7 The report also identifies objectives where work is under taken as 'business as usual', with no current additional work under the Board's 'banner'. The Board should reflect on its oversight of outcome improvement on objectives without delivery plans.

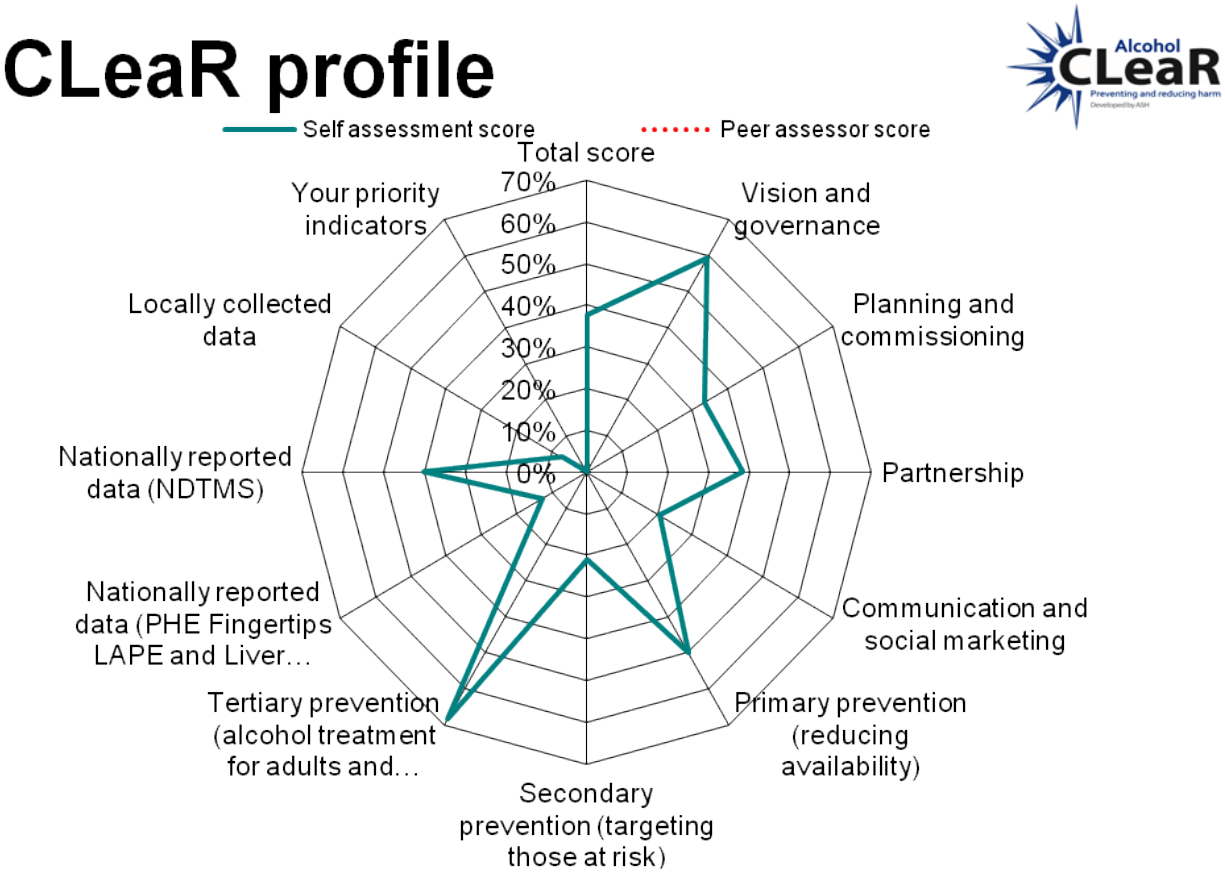
## 2. Priority for 2017: Reduce Alcohol Related Harm for all Age Groups

2.1 Reducing alcohol related harm has been chosen by the Board as a priority following the emergence of the issue at a number of partnership forums. The Board felt that they could be more effective by working together, rather than separately in their organisations, to reduce alcohol related harm for all age groups.

2.2 The Alcohol Harm Reduction Partnership (AHRP) has been set up to be responsible for delivering measurable change within 2017 on behalf of the Board.

2.3 The AHRP has used the CLeaR self assessment toolkit to identify the strengths of current services and the areas for improvement. The findings are below in Figure 1.

**2.4 Figure 1: West Berkshire CLeaR Profile (March 2017)**




2.5 The CLeaR assessment identified that in West Berkshire there is strong tertiary prevention (treatment), a strong vision and strong governance around alcohol.

2.6 Areas of improvement were identified as secondary prevention (targeting those at risk) and communication and social marketing. West Berkshire has performance below the national average on some key indicators.

2.7 The result of this assessment was that two projects have been identified to be delivered in 2017; a 'Blue Light' project and an Identification and Brief Advice (IBA) project.

**Blue Light Project**

2.8 West Berkshire's rate of alcohol specific mortality is below the national average but it is not falling and its performance is rated as amber (warning) under the Local Alcohol Profiles for England (Public Health England). There are an estimated 46 people in West Berkshire who are long-term alcohol dependent and are expensive to services, in addition to being at greater risk of alcohol related mortality.

2.9 The Blue Light project has been identified by the AHRP to target those most at risk of alcohol related mortality. It follows Alcohol Concern's national initiative to develop alternative approaches and care pathways for treatment resistant drinkers who place a burden on public services. It is supported by Public Health England and 23 local authorities across the country.

2.10 Drawing on both motivational and harm reduction approaches it provides non-specialist and specialist workers with tools they can use and pathways they can follow which help to manage the risk and directly reduce associated problems such as domestic abuse, fire deaths and health problems.

2.11 The actions associated with the Blue Light project are:

| **Alcohol Harm Reduction Partnership Action Plan (Blue Light Project) SRO: Debi Joyce** | | | |
|---|---|---|---|
| **Action** | **Start date** | **Measure** | **Target** |
| Monitor training in the Blue Light approach | Mar-18 | Number of Blue Light (BL) project training sessions and 'train the trainer' sessions delivered | 7 |
| | May-18 | Number of health, social care, housing and criminal justice staff who have attended Blue Light (BL) training | (Not targeted) |
| Develop and agree action plans to support treatment resistant drinkers in the Blue Light (BL) | May-18 | Number of identified treatment resistant drinkers on Blue Light project, with an agreed action plan | 15 |
| Reduce the cost to other WBC services for ongoing support by engaging treatment resistant drinkers in the Blue Light approach | May-18 | £ cost saved per client (at end of project) | (Not targeted) |

## Identification and Brief Advice

2.12 The CLeaR self-assessment identified that West Berkshire needed to strengthen secondary prevention. The focus of secondary prevention services is on lowering consumption in those drinking at risk. Large-scale delivery of targeted brief advice and early interventions aimed at individuals in at-risk groups can help make people aware of the harm they may be doing and can prevent extensive damage to health and wellbeing.

2.13 Identification and Brief Advice (IBA) is an alcohol brief intervention which typically involves:

(1) **Identification**: using a validated screening tool to identify 'risky' drinking.

(2) **Brief Advice**: the delivery of short, structured 'brief advice' aimed at encouraging a risky drinker to reduce their consumption to lower risk levels

2.14 IBA can be initiated by front line health and social care roles wherever they have a good opportunity. It is prevention rather than a treatment approach to helping at-risk drinkers make an informed choice about their drinking.

2.15 The actions associated with the IBA project are:

| Alcohol Harm Reduction Partnership Action Plan (Identification and Brief Advice) SRO: Debi Joyce | | | |
|---|---|---|---|
| **Action** | **Start date** | **Measure** | **Target** |
| Monitor uptake of Identification & Brief Advice (IBA) training | Jun-17 | Total number of WBC staff, GP staff, volunteers and staff from Lifestyle Intervention Providers trained in Identification & Brief Advice (IBA) | 1000 (Jun 18) |
| Monitor how many staff incorporate Identification & Brief Advice (IBA) into their practice | Jun-18 | Proportion of IBA trained people who have used training (3 month survey) | 75% (Jun 18) |
| Improve knowledge and confidence of those receiving Identification & Brief Advice (IBA) training | Jun-18 | Proportion of participants who report an increase level of confidence of IBA on training evaluation form (Identification & Brief Advice (IBA)) | 75% (Jun 18) |

2.16 The AHRP will also work closely with the Board's Patient and Public Engagement Group to improve communication regarding alcohol. It has already overseen the production of an article which was published in the Newbury Weekly News on 16th March 2017.

2.17 These are new projects and will be resourced by the Council's Public Health team. It is the intention that while Public Health will front the cost of the projects, there should be a system wide benefit to both the pressure on emergency services in the short term and the pressure on the health and wellbeing system in the long term.

## 3. Priority for 2017: Increase the number of Community Conversations through which local issues are identified and addressed

3.1 Community Conversations have been developed by the Building Communities Together programme with the aim to develop a community led restorative approach. The Peer Review in March 2016 recommended that the Board gain more oversight of this work and it was chosen as a priority during the development work following the Peer Review.

3.2 A Community Conversation is a form of engagement which seeks to enable communities to find solutions to problems that they have identified, without the need to bring in public services. Communities can be self-selecting or might be 'communities of interest' which are heavily reliant on public services and/or experience inequalities in their health outcomes compared to other West Berkshire communities.

3.3 The Building Communities Together (BCT) Partnership was established in May 2017 following the merger of the Safer Communities Partnership and the Brilliant West Berkshire Programme Board. The BCT Team formed on 1st April 2017 and includes officers from the Council and Thames Valley Police. The team is responsible for continuing and developing the work on community conversations, alongside a number of other areas, and is expected to deliver measurable change within 2017 on behalf of the Board.

3.4 Susan Powell, the team manager, completed a review of community conversations which was presented to the Board at its meeting on 30 March 2017. The key findings were:

(1) The range of issues identified during conversations has been diverse and some community orientated solutions identified.

(2) Volunteers have been forth coming with approximately 110 currently engaged in Community Conversations.

(3) A professional's forum has arisen from one Community Conversation.

(4) Restorative Approaches and Problem Solving have underpinned the conversations with residents and partner working together to identify issues and solutions.

(5) Engagement needs to be improved particularly with young people and hard to reach groups/communities.

(6) Restorative Approaches need to be sustained.

(7) SARA Problem Solving is a useful tool within Community Conversations.

3.5 The following actions were identified as the next steps of developing Community Conversations:

| Building Community Together Action Plan (Community Conversations) SRO: Susan Powell | | | |
|---|---|---|---|
| **Action** | **Start date** | **Measure** | **Target** |
| Conduct an audit of Community Conversations currently underway to clarify outputs, outcomes and impacts during 2016/17 and to celebrate success | May-17 | Number of identified Communities that have started new Community Conversations | >10 (Mar-18) |
| Identify existing community forums and activities that have potential to become 'new' Community Conversations | Sep-17 | % of identified communities that have mapped their assets within 3 months (where there is a requirement to do so) | 100% (Mar-18) |
| Conduct Community Engagement activities to support the development of 'new' Community Conversations and to identify local community based issues | Mar-18 | % of identified communities that have been trained in problem solving methodology (where there is a requirement to do so) | 100% (Mar-18) |
| Develop a Project Management Structure for Community Conversations | Jun-17 | % of identified communities that have agreed what actions will be undertaken to address locally identified issues | 100% (Mar-18) |
| Use data to support individual Community Conversations in identifying issues and, where, appropriate, to monitor change | Ongoing | | (Not targeted) |

3.6 This area of work is now resourced by bringing together a team of officers from the Council and Thames Valley Police (joining in June 2017) who are working together in a different way to support the use of Community Conversations. The West Berkshire Volunteer Centre Project Officer continues to provide support for Community Conversations working closely with the BCT Team Manager and Community Anchors.

## 4. Strategic Aim: Give Every Child the Best Start in Life

4.1 The aim to give every child the best start in life carries the following objectives:

(1) Decrease the educational attainment gap between children on free school meals and the rest

(2) Reduce childhood obesity

(3) Improve educational and health outcomes for Looked After Children

(4) Support the health and wellbeing of young carers

4.2 Much work in support of these objectives is business as usual for the Council's Education, Children and Family and Public Health teams. The Health and Wellbeing Board received a report at its meeting in November 2016 which outlined the work of the School Improvement Team to helps schools to improve educational attainment of children from vulnerable families and/or receiving free school meals. Children's health and wellbeing is particularly high profile, in the light of West Berkshire's Children and Family Services Ofsted 'inadequate' rating in 2015.

4.3 The Children's Delivery Group is responsible for delivering measurable change by 2020 on behalf of the Board. Its membership includes officers from Council's Education, Children and Family and Public Health teams, in addition to officers from the Berkshire West CCGs.

4.4 The Children's Delivery Group is also responsible to the Local Safeguarding Children's Board (LSCB).

4.5 The Children's Delivery Group has identified that they can add value to work regarding the following:

| **Children's Delivery Group Action Plan**<br>**SRO: Andrea King** | | | |
|---|---|---|---|
| Action | Start Date | Measure | Target |
| Organise a conference event for West Berkshire schools on managing autistic types of behaviours in school - promoting inclusion | Ongoing | Number of schools that attended the conference | TBC Summer 17 |
| | Ongoing | % of schools that are implementing the techniques for managing autistic types of behaviour | TBC Mar-18 |
| Schools promote inclusion with focus on managing autistic types of behaviour | TBC | Reduce the number of exclusions due to autistic types of behaviour | TBC Mar-18 |
| Support the physical health of Looked After Children | Ongoing | Percentage of LAC with completed health assessments on time | TBC |
| Increase the number of LAC who have had a mental health assessment | Ongoing | % of LAC aged 4-16 in care for 12 months+ with a with a SDQ (Strengths and Difficulties Questionnaire) assessment within the last year | 100% |
| | Ongoing | Reduce the Average Difficulties (SDQ) Score | <17 |
| Increase the number of young carers that have been identified and receive support | Ongoing | Number of Young Carers being supported | Increase nos |
| | Ongoing | Number of Young Carers engaged with support service | |

| | | | |
|---|---|---|---|
| Helping children, young people and families find support for emotional well-being earlier, faster and more easily | Ongoing | Number of referrals to the Emotional Health Academy triage | TBC |
| | Ongoing | Number of children that worked with the Emotional Health Academy professionals | TBC |
| | Ongoing | % of children and young people that improved their outcomes following support from the Emotional Health Academy | TBC |

4.6 These areas of work will have no new resource and will depend on the partner members of the Children's Delivery Group prioritising their time and service budgets to support its activities.

4.7 Recent external assessment has shown that excellent progress is being made in respect of the Council's Children and Family Services Team. This is also backed up by significant improvements in a number of key performance indicators in relation to child protection. Mindful of the role of the LSCB, the Board should reflect on its oversight of outcome improvement on objectives not covered by the Children's Delivery Group action plan.

## 5. Strategic Aim: Support mental health and wellbeing throughout life

5.1 The aim to support mental health and wellbeing throughout life carries the following objectives:

(1) Promote the emotional health and wellbeing of children

(2) Promote positive mental health and wellbeing for adults

(3) Prevent suicide and self-harm for adults and young people

(4) Decrease social isolation

(5) Ensure early assessment of and good provision of care for those with dementia

5.2 The Council's Public Health Team, Berkshire West CCG Federation, Berkshire Healthcare Foundation Trust and Berkshire's Shared Public Health Team conduct a variety of activities on Berkshire-wide, Berkshire West and West Berkshire footprints in support of the above objectives. At the meeting of the Health and Wellbeing Board on 30 March 2017, the Board received presentations from a number of speakers to outline some of these activities.

5.3 The Mental Health Collaborative is responsible for delivering measurable change by 2020 on behalf of the Board. The Collaborative is also a sub-group of the West Berkshire Mental Health Forum, formed as a meeting of a variety of professionals with an interest in mental health. The Mental Health Collaborative is currently writing their Strategy and when developing its action plan will need to identify where it can add value and not duplicate work being done already, with a particular focus on uniquely West Berkshire issues.

5.4 The Mental Health Collaborative is aiming to have its delivery plan prepared by June 2017. The Board should investigate the barriers which have prevented faster progress being made.

## 6. Strategic Aim: Reduce premature mortality by helping everyone live healthier lives

6.1 The aim to reduce premature mortality by helping everyone live healthier lives carries the following objectives:

(1) Reduce alcohol related harm across the district for all age groups

(2) Increase uptake of NHS Health Checks

(3) Support residents to stop smoking and reduce substance misuse

(4) Support residents to be more physically active, achieve a healthy weight and eat a healthy diet

6.2 The Alcohol Harm Reduction Partnership is responsible for delivering measurable change in 2017 on behalf of the Board. The actions that they will be completing to reduce alcohol related harm have been reported above.

6.3 The Council's Public Health Team and the Berkshire West CCG Federation, as part of the Accountable Care System, are responsible for business as usual activities in support of objectives (2), (3) and (4).

6.4 At present, the activities which the Board is overseeing in support of the aim to 'reduce premature mortality...' is limited to reducing alcohol related harm. The Board should reflect on its oversight of outcome improvement on objectives not covered by the Alcohol Harm Reduction Partnership action plan.

## 7. Strategic Aim: Build a thriving and sustainable environment in which communities can flourish

7.1 The aim to build a thriving and sustainable environment in which communities can flourish carries the following objectives:

(1) Increase the number of Community Conversations through which local issues are identified and addressed

(2) Ensure that housing is of good quality, accessible and affordable.

(3) Improve rural access to services

(4) Decrease levels of air pollution in areas that need it

(5) Increase the number of reports of Domestic Abuse and repeat incidents of abuse reported to Thames Valley Police

7.2 The Building Communities Together (BCT) Partnership and Team are responsible for delivering measurable change within 2017 on behalf of the Board regarding objective (1), increase the number of Community Conversations through which local issues are identified and addressed, and their associated actions have been reported above.

7.3 The BCT Partnership and Team are also responsible for business as usual activities to support objective (5), increase the number of reports of Domestic Abuse and repeat incidents of abuse reported to Thames Valley Police.

| **Building Community Together Action Plan (Domestic Abuse)**<br>**SRO: Susan Powell/ Jim Boden** | | | |
|---|---|---|---|
| Action | Start Date | Measure | Target |
| Run events to raise awareness of Domestic Abuse | Mar-17 | Number of Domestic Abuse awareness events held | 3 events (Mar 18) |
| Monitor uptake of Domestic Abuse, Stalking and Harassment (DASH) and Multi-agency Risk Assessment Committee (MARAC) | Mar-17 | Number of WBC staff, volunteers and partner agency staff trained in Deliver Domestic Abuse, Stalking and Harassment (DASH) and Multi-agency Risk Assessment Committee (MARAC) | 150 (Mar 18) |
| Conduct visits to schools to promote the issue of unhealthy, abusive relationships and the links to Child Sexual Exploitation | Mar-17 | Number of schools visited to promote the issue of unhealthy, abusive relationships and the links to Child Sexual Exploitation | Not targeted |
| Monitor the number of calls to both Thames Valley Police and West Berks Domestic Abuse Helpline | Mar-17 | Number of calls to both Thames Valley Police and West Berks Domestic Abuse Helpline | Not targeted |
| Monitor number of repeat incidents of Domestic Abuse reported to Thames Valley Police | Mar-17 | Number of repeat incidents of Domestic Abuse reported to Thames Valley Police | Not targeted |

7.4 The Council's Housing Team is responsible for business as usual activities to support objective (2), ensure that housing is of good quality, accessible and affordable.

7.5 The Council's Transport Team is responsible for business as usual activities to support objective (3), improve rural access to services.

7.6 The Council's Public Health Team and Environmental Health Team, together with the Highways and Transport service are responsible for business as usual activities to support objective (4), decrease levels of air pollution in areas that need it.

7.7 Mindful of the Board's new expanded membership and its ambition to take a broader role in the wider determinants of health the Board, again, should reflect on its oversight of outcome improvement on objectives not covered by the Building Community Together action plan.

## 8. Strategic Aim: Help older people maintain a healthy, independent life for as long as possible

8.1 The aim to help older people maintain a healthy, independent life for as long as possible carries the following objectives:

(1) Prevent falls and ensure integrated care for those who have sustained a fall

(2) Maximise independence for older people and those with long-term conditions

(3) Ensure good end of life care is available and residents are able to die where they choose

8.2 The Ageing Well Task Group (AWTG) is responsible for activities to support objective (1), prevent falls and ensure integrated care for those who have sustained a fall. The Board resolved to set up the Task Group in July 2016 following a Hot Focus Session on Falls Prevention on 23 April 2016. The AWTG considered the NICE guidance in evaluating the services available in West Berkshire and identified the following actions to deliver measurable change by 2020.

| **Ageing Well Task Group Action Plan**<br>**SRO: April Peberdy** | | | |
|---|---|---|---|
| **Action** | **Start Date** | **Measure** | **Target** |
| Increase the number of people aged over 65 who are at risk of a fall who have attended a Steady Steps class | Ongoing | Increase the proportion of people aged 65+ at risk of falling who take part in a 'Fall Prevention' class (Steady Steps) (At risk 35% of population aged 65-84 = 7,188 45% of population aged 85+ = 1389 ) | tbc |
| Increase the number of people aged over 65 who are at risk of a fall who have attended a Tai Chi course | Ongoing | Increase the proportion of people aged 65+ at risk of falling who take part in a Tai Chi for Falls Prevention class (At risk 35% of population aged 65-84 = 7,188 45% of population aged 85+ = 1389) | tbc |
| Conduct campaigns to increase public awareness of falls and how to prevent falls. | Ongoing | Number of Falls Prevention Awareness Campaigns | tbc |
| Deliver training to WBC staff, NHS Staff and volunteers on the Falls Prevention Pathway to increase knowledge of available services and the recommended approach. | Jan-17 | Number of Falls Prevention Awareness Training sessions delivered | tbc |
| Develop and implement a multi-factorial falls risk assessment tool (FRAT) | May-17 | Number of risk assessments conducted using FRAT tool | tbc |
| Conduct an Early Intervention Project to identify those most at risk of falls. | Sep-17 | Number of people aged over 65 identified as at risk of falls. | tbc |
| Conduct a Home Safety Check Pilot with RBFRS | 2018 | Number of Home Safety Checks | tbc |

8.3 The Council's Adult Social Care service and the Berkshire West CCG Federation are responsible for business as usual activities in support of objective (2), maximise independence for older people and those with long-term conditions and objective (3), ensure good end of life care is available and residents are able to die where they choose.

8.4 The Board should reflect on its oversight of outcome improvement on objectives not covered by the Ageing Well Task Group action plan.

## 9. Integration

9.1 Integration is a cross cutting theme across the priorities, aims and objectives in the Health and Wellbeing Strategy and each sub-group needs to pursue integrated ways of working.

9.2 The Health and Wellbeing Steering Group is responsible for supporting the Health and Wellbeing Board's development as they make decisions about what integration will look and feel like for the patients, service users and residents of West Berkshire.

9.3 There is also a Berkshire West 10 Integration Board (BW10) which includes representation from the health authorities and local authorities in Berkshire West (Reading, West Berkshire and Wokingham). The BW10 is committed to pursuing more integrated care for the patients, service users and residents of Berkshire West. The BW10 monitor the overarching performance of the Better Care Fund projects.

9.4 The West Berkshire Locality Integration Board (LIB) is linked to the BW10 governance and oversees the performance of the Better Care Fund (BCF) projects locally. There has been a delay in the publication of the national guidance however it is known that there will be four national conditions that the BCF must be used for:

(1) Delayed transfers of care

(2) Non-Elective Admissions (general and acute)

(3) Admissions to residential and care homes

(4) Effectiveness of reablement

9.5 The LIB is responsible for activities to support the above conditions and will provide this information once the Better Care Fund Plan is finalised.

## 10. Conclusion

10.1 The above delivery plans specify the actions that the Board's sub-groups are focusing on in the short and medium term. The progress will be monitored by the Steering Group and the measures to monitor the progress of these actions will form the Board's new performance dashboard. The Steering Group considered that these delivery plans present the outputs that the sub-groups are seeking to achieve but they do not go far enough to explain the outcomes for West Berkshire's residents that are to be improved.

10.2 The report identifies objectives in the Health and Wellbeing Strategy which have no additional work being undertaken that go above and beyond business as usual

activities. It is also clear that some groups' delivery plans are more advanced than others and this is due in part to the lengths of time the groups have been operating. The Board should however be concerned that there is no delivery plan as yet for the aim to 'support mental health and wellbeing throughout life'. It should also give attention to the aims to 'build a thriving environment in which communities can flourish' and 'reduce premature mortality by helping everyone live healthier lives' which at present have no limited activity.

10.3 Whilst the Board needs to balance the desires to focus its attention on areas where its involvement can be most effective, it also needs to ensure the delivery of the Health and Wellbeing Strategy in its entirety. At present there is no delivery plan for any objectives under the aim to 'support mental health and wellbeing throughout life' and the Board should investigate the barriers which have lead to the slow progress here.

## 11. Consultation and Engagement

11.1 Nick Carter, Health and Wellbeing Steering Group

**Background Papers:** West Berkshire Joint Health and Wellbeing Strategy 2017-2020

**Strategic Aims and Priorities Supported:**

The proposals will help achieve the following Council Strategy aims:

☒ **BEC – Better educated communities**
☒ **P&S – Protect and support those who need it**
☒ **HQL – Maintain a high quality of life within our communities**
☒ **MEC – Become an even more effective Council**

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

☒ **BEC1 – Improve educational attainment**
☒ **BEC2 – Close the educational attainment gap**
☒ **P&S1 – Good at safeguarding children and vulnerable adults**
☒ **HQL1 – Support communities to do more to help themselves**
☒ **MEC1 – Become an even more effective Council**

**Officer details:**

| | |
|---|---|
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# Health and Wellbeing Strategy Delivery Plan

| HWB Strategy Priority/ Strategic Aim | Objective Reference | HWB Strategy Objective | Ref. | Action | SRO | Start Date | Ref. | Measure | Latest Data | Target | Narrative |
|---|---|---|---|---|---|---|---|---|---|---|---|
| **2017/18 Priority: Reduce alcohol related harm across the district for all age groups** | | | A3/10.ac1 | Monitor uptake of Identification & Brief Advice (IBA) training | Debi Joyce (AHRP) | Jun-17 | | Total number of WBC staff, GP staff, volunteers and staff from Lifestyle Intervention Providers trained in Identification & Brief Advice (IBA) | | 1000 (Jun 18) | Procurement process currently underway. Commencement date likely to be end of June 2017 |
| | | | | | Debi Joyce (AHRP) | | A3/10.m1 | Number of WBC staff trained in Identification & Brief Advice (IBA) | | (Not targeted) | |
| | | | | | Debi Joyce (AHRP) | | A3/10.m2 | Number of GP practices trained in Identification & Brief Advice (IBA) | | (Not targeted) | |
| | | | | | Debi Joyce (AHRP) | | A3/10.m3 | Number of volunteers trained in Identification & Brief Advice (IBA) | | (Not targeted) | |
| | | | | | Debi Joyce (AHRP) | | A3/10.m4 | Number of Lifestyle Intervention Providers trained in Identification & Brief Advice (IBA) | | (Not targeted) | |
| | | | A3/10.ac2 | Monitor how many staff incorporate Identification & Brief Advice (IBA) into their practice | Debi Joyce (AHRP) | Jun-17 | A3/10.m5 | Proportion of IBA trained people who have used training (3 month survey) | | 75% (Jun 18) | Indicative target set at 75% in recognition that not all those who are trained might have the opportunity to put their training into practice. |
| | | | A3/10.ac5 | Improve knowledge and confidence of those receiving Identification & Brief Advice (IBA) training | Debi Joyce (AHRP) | Jun-17 | A3/10.m8 | Proportion of participants who report an increase level of confidence of IBA on training evaluation form (Identification & Brief Advice (IBA)) | | 75% (Jun 18) | Indicative target set at 75% in recognition that not all those who are trained might achieve a higher level of confidence to deliver IBA. |
| | | | A3/10.ac6 | Monitor training in the Blue Light approach | Debi Joyce (AHRP) | Mar-17 | A3/10.m9 | Number of Blue Light (BL) project training sessions and 'train the trainer' sessions delivered | | 7 | Procurement process currently underway. Commencement date likely to be end of May 2017 |
| | | | | | Debi Joyce (AHRP) | May-18 | A3/10.m10 | Number of health, social care, housing and criminal justice staff who have attended Blue Light (BL) training | | (Not targeted) | Data will be collected upon commencement of training. |
| | | | A3/10.ac8 | Develop and agree action plans to support treatment resistant drinkers in the Blue Light (BL) | Debi Joyce (AHRP) | May-18 | A3/10.m12 | Number of identified treatment resistant drinkers on Blue Light project, with an agreed action plan | | 15 | |
| | | | A3/10.ac9 | Reduce the cost to other WBC services for ongoing support by engaging treatment resistant drinkers in the Blue Light approach | Debi Joyce (AHRP) | May-18 | A3/10.m13 | £ cost saved per client (at end of project) | | (Not targeted) | Baseline for each client required. |
| **2017/18 Priority: Increase the percentage of communities where community conversations have successfully run and local action plans have been jointly developed** | | | A4/1.ac1 | Conduct an audit of Community Conversations currently underway to clarify outputs, outcomes and impacts during 2016/17 and to celebrate success | Susan Powell (BCT) | May-17 | A4/1.m1 | Number of identified Communities that have started new Community Conversations | | >10 (Mar-18) | |
| | | | A4/1.ac2 | Identify existing community forums and activities that have potential to become 'new' Community Conversations | Susan Powell (BCT) | Sep-17 | A4/1.m2 | % of identified communities that have mapped their assets within 3 months (where there is a requirement to do so) | | 100% (Mar-18) | |
| | | | A4/1.ac3 | Conduct Community Engagement activities to support the development of 'new' Community Conversations and to identify local community based issues | Susan Powell (BCT) | Mar-18 | A4/1.m3 | % of identified communities that have been trained in problem solving methodology (where there is a requirement to do so) | | 100% (Mar-18) | |
| | | | A4/1.ac4 | Develop a Project Management Structure for Community Conversations | Susan Powell (BCT) | Jun-17 | A4/1.m4 | % of identified communities that have agreed what actions will be undertaken to address locally identified issues | | 100% (Mar-18) | |
| | | | A4/1.ac5 | Use data to support individual Community Conversations in identifying issues and, where, appropriate, to monitor change | Susan Powell (BCT) | Ongoing | | | | | |

# Health and Wellbeing Strategy Delivery Plan

| HWB Strategy Priority/ Strategic Aim | Objective Reference | HWB Strategy Objective | Ref. | Action | SRO | Start Date | Ref. | Measure | Latest Data | Target | Narrative |
|---|---|---|---|---|---|---|---|---|---|---|---|
| HWB Strategic Aim: Give every child the best start in life | Objective 1 | Decrease the educational attainment gap between children who are eligible for Pupil Premium Grant and the rest | | Organise a conference event for West Berkshire schools on managing autistic types of behaviours in school - promoting inclusion | Andrea King (CDG) | Summer 17 | | Number of schools that attended the conference | N/A | TBC | We need to use this input measure this year as the impact on exclusions is expected towards the end of the year and longer term. |
| | | | | | Andrea King (CDG) | Mar-18 | | % of schools that are implementing the techniques for managing autistic types of behaviour | N/A | TBC | We need to use this output type measure as an evaluation of the input activity above and because the impact on exclusions is expected towards the end of the year and longer term. |
| | | | | Schools promote inclusion with focus on managing autistic types of behaviour | Andrea King (CDG) | Mar-18 | | Reduce the number of exclusions due to autistic types of behaviour | TBC | TBC | Impact on this measure is expected over the medium and longer term<br>Data is not available in Capita system to report on this but Andy Cordell / Cathy Burnham are using a separate tracking tool. |
| | Objective 2 | Reduce childhood obesity | | | | | | No measure is included here as a decision is being finalised if this objective is delivered by the entire subgroup or only by the Public Health | | | |
| | Objective 3 | Improve educational and health outcomes for Looked After Children | | Support the physical health of Looked After Children | Andrea King (CDG) | | | Percentage of LAC with completed health assessments on time | 100% (Feb 2017) | TBC | Target will be confirmed as part of the service target setting process. For 2016/17 the target was >90% (part of C&F service plan) |
| | | | | Increase the number of LAC who have had a mental health assessment | Andrea King (CDG) | | | % of LAC aged 4-16 in care for 12 months+ with a with a SDQ (Strengths and Difficulties Questionnaire) assessment within the last year | 100% (Feb 2017) | 100% | |
| | | | | | Andrea King (CDG) | | | Reduce the Average Difficulties (SDQ) Score | 17 (Feb 2017) | <17 | An alternative measure for this to be used is: 'reduction of SDQ scoring at subsequent assessments'. Availability of this information is being explored. |
| | Objective 4 | Support the health and wellbeing of young carers | | Increase the number of young carers that have been identified and receive support | Andrea King (CDG) | | | Number of Young Carers being supported | 45 (Feb 2017) | Increase nos | Data Source: Data Zone Children's Services |
| | | | | | Andrea King (CDG) | | | Number of Young Carers engaged with support service | | | |
| HWB Strategic Aim: Support mental health and wellbeing throughout life | Objective 5 | Promote the emotional health and wellbeing of children | | Helping children, young people and families find support for emotional well-being earlier, faster and more easily | Andrea King (CDG) | | | Number of referrals to the Emotional Health Academy triage | TBC | TBC | |
| | | | | | Andrea King (CDG) | | | Number of children that worked with the Emotional Health Academy professionals | TBC | TBC | |
| | | | | | Andrea King (CDG) | | | % of children and young people that improved their outcomes following support from the Emotional Health Academy | TBC | TBC | |
| ivving and sustainable unities can flourish | | | | Run events to raise awareness of Domestic Abuse | Jim Boden (BCT) | Mar-17 | A4/18.m 1 | Number of Domestic Abuse awareness events held | | 3 events (Mar 18) | |
| | | | | Monitor uptake of Domestic Abuse, Stalking and Harassment (DASH) and Multi-agency Risk Asssessment Committee (MARAC) | Jim Boden (BCT) | Mar-17 | A4/18.m 2 | Number of WBC staff, volunteers and partner agency staff trained in Deliver Domestic Abuse, Stalking and Harassment (DASH) and Multi-agency Risk Asssessment Committee (MARAC) | | 150 (Mar 18) | |

# Health and Wellbeing Strategy Delivery Plan

| HWB Strategy Priority/ Strategic Aim | Objective Reference | HWB Strategy Objective | Ref. | Action | SRO | Start Date | Ref. | Measure | Latest Data | Target | Narrative |
|---|---|---|---|---|---|---|---|---|---|---|---|
| HWB Strategic Aim: Build a thr environment in which comm | Objective 18 | Increase reporting of domestic abuse and decrease repeat incidents of domestic abuse | | Conduct visits to schools to promote the issue of unhealthy, abusive relationships and the links to Child Sexual Exploitation | Jim Boden (BCT) | Mar-17 | A4/18.m 3 | Number of schools visited to promote the issue of unhealthy, abusive relationships and the links to Child Sexual Exploitation | | 3 per school year | |
| | | | | Monitor the number of calls to both Thames Valley Police and West Berks Domestic Abuse Helpline | Jim Boden (BCT) | Mar-17 | A4/18.m 4 | Number of calls to both Thames Valley Police and West Berks Domestic Abuse Helpline | | 10% increase | |
| | | | | Monitor number of repeat incidents of Domestic Abuse reported to Thames Valley Police | Jim Boden (BCT) | Mar-17 | A4/18.m 5 | Number of repeat incidents of Domestic Abuse reported to Thames Valley Police | | <25% in a year | |
| HWB Strategic Aim: Help older people maintain a healthy, independent life for as long as possible | Objective 19 | Prevent falls and ensure integrated care for those who have sustained a fall | A5/19.a c1 | Increase the number of people aged over 65 who are at risk of a fall who have attended a Steady Steps class | April Peberdy (AWTG) | Ongoing | A5/19.m 1 | Increase the proportion of people aged 65+ at risk of falling who take part in a 'Fall Prevention' class (Steady Steps) (At risk 35% of population aged 65-84 = 7,188 45% of population aged 85+ = 1389 ) | | tbc | |
| | | | A5/19.a c2 | Increase the number of people aged over 65 who are at risk of a fall who have attended a Tai Chi course | April Peberdy (AWTG) | Ongoing | A5/19.m 2 | Increase the proportion of people aged 65+ at risk of falling who take part in a Tai Chi for Falls Prevention class (At risk 35% of population aged 65-84 = 7,188 45% of population aged 85+ = 1389) | | tbc | |
| | | | A5/19.a c3 | Conduct campaigns to increase public awareness of falls and how to prevent falls. | April Peberdy (AWTG) | Ongoing | A5/19.m 3 | Number of Falls Prevention Awareness Campaigns | | tbc | |
| | | | A5/19.a c4 | Deliver training to WBC staff, NHS Staff and volunteers on the Falls Prevention Pathway to increase knowledge of available services and the recommended approach. | April Peberdy (AWTG) | Jan-17 | A5/19.m 4 | Number of Falls Prevention Awareness Training sessions delivered | | tbc | |
| | | | A5/19.a c5 | Develop and implement a multi-factorial falls risk assessment tool (FRAT) | April Peberdy (AWTG) | May-17 | A5/19.m 5 | Number of risk assessments conducted using FRAT tool | | tbc | Due for implementation in May 2017. |
| | | | A5/19.a c6 | Conduct an Early Intervention Project to identify those most at risk of falls. | April Peberdy (AWTG) | Sep-17 | A5/19.m 6 | Number of people aged over 65 identified as at risk of falls. | | tbc | Due for implementation in September 2017. |
| | | | A5/19.a c7 | Conduct a Home Safety Check Pilot with RBFRS | April Peberdy (AWTG) | Jan-18 | A5/19.m 7 | Number of Home Safety Checks | | tbc | Due for implementation in 2018. |

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# Alcohol Harm Reduction Partnership Update – Summary Report

| | |
|---|---|
| **Committee considering report:** | Health and Wellbeing Board |
| **Date of Committee:** | 25 May 2017 |
| **Portfolio Member:** | Councillor James Fredrickson |
| **Report Author:** | Debi Joyce |

## 1. Purpose of the Report

1.1 To inform the Health and Wellbeing Board of what has been achieved so far by the Alcohol Harm Reduction Partnership in support of the Health and Wellbeing Strategy priority for 2017 to 'reduce alcohol related harm for all age groups'.

## 2. Recommendation

2.1 The Health and Wellbeing Board note the 'quick wins' that have been achieved and support the next steps that have been identified.

## 3. Implications

| | | |
|---|---|---|
| 3.1 | **Financial:** | The cost of the AHRP's two projects will be met from within the existing budget of the Public Health Team.<br><br>If a shared Community Alcohol Partnership Officer is shared with Reading, the cost will be met by Public Health England. |
| 3.2 | **Policy:** | None |
| 3.3 | **Personnel:** | If a shared Community Alcohol Partnership Officer is shared with Reading, the cost will be met by Public Health England. |
| 3.4 | **Legal:** | None |
| 3.5 | **Risk Management:** | None |
| 3.6 | **Property:** | None |
| 3.7 | **Other:** | None |

## 4. How the Health and Wellbeing Board can help

4.1 Commit to attending Identification and Brief Advice training and ask managers in their organisations to encourage staff to attend the IBA training upon completion of the commissioning process.

4.2 Support the launch of the Community Alcohol Partnership once the date is known.

| | | |
|---|---|---|
| **Will the recommendation require the matter to be referred to the Executive for final determination?** | Yes: ☐ | No: ☒ |

# Executive Summary

## 5. Introduction / Background

- The Health and Wellbeing Board identified that one of its priorities for 2017 would be to 'reduce alcohol related harm for all age groups. The purpose of this report is to provide an update on what has been achieved so far.

## 6. Proposal

- That the Health and Wellbeing Board note that the following 'quick wins' have been achieved since the Alcohol Hot Focus Session in October 2016:
    - There is now a strategic approach to reducing alcohol related harm in West Berkshire through the establishment of a multi-agency Alcohol Harm Reduction Partnership (AHRP).
    - Analysis of young people's concerns on cannabis rather than alcohol has lead to the establishment of a sub-group to the AHRP to develop and implement a combined drug and alcohol strategy, with support from the Children's Delivery Group.
    - Data analysis has demonstrated that West Berkshire is the 3rd best performing local authority area for alcohol-related admissions.
    - Secondary prevention and communication have been identified as key areas of improvement following the completion of the Alcohol CLeaR tool to 'stock take' West Berkshire services. West Berkshire's rating on the CLeaR tool benefitted significantly from the establishment of a partnership group.
    - The Alcohol CLeaR tool was peer-reviewed and found to be robust.
    - Two projects (Identification and Brief Advice and the Blue Light Project) have been identified for implementation in 2017. The Public Health team's budget had been realigned to commission these projects.
    - The AHRP have decided to establish West Berkshire as a Community Alcohol Partnership (CAP) area and are looking into a shared Community Alcohol Partnership Officer with Reading Borough Council, funded by Public Health England.
- That the Health and Wellbeing Board note that the following next steps have been identified for the remainder of 2017:
    - Implementation and delivery of the IBA and Blue Light projects (currently being commissioned).

- Data sharing between partners to identify wards/ areas with greatest need (Summer 2017).
- Launch the Community Alcohol Partnership (August 2017).
- Publication and implementation of the Children and Young People's Drug and Alcohol Strategy (tbc 2017.)

## 7. Conclusion

- Considering that in October 2016 there was no strategic oversight of alcohol related harm and services in West Berkshire, the Alcohol Harm Reduction Partnership have made considerable progress in implementing a framework to build on West Berkshire's good performance around alcohol.
- The next step is to demonstrate the improved outcomes for West Berkshire residents that the Alcohol Harm Reduction Partnership can achieve by working together.

## 8. Appendices

8.1 Appendix A – Supporting Information

8.2 Appendix B – Slides from CAP presentation

8.3 Appendix C - Draft IBA training programme-for information only

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**Appendix A**

# Alcohol Harm Reduction Partnership Update – Supporting Information

## 1. Introduction/Background

1.1 The Health and Wellbeing Board determined that reducing alcohol related harm would be a priority for 2017 within the Health and Wellbeing Strategy. The Board expressed its intention to make measurable progress to reduce alcohol related harm over a 12 month period.

1.2 The Alcohol Harm Reduction Partnership (AHRP) was established in November 2016. It is now a fully functioning group consisting of a mix of Council services, Health, Police, voluntary sector representatives, charities and service providers. This group acts as the alcohol operational group to the Health and Wellbeing Board.

1.3 Following completion of the Alcohol CleaR tool and subsequent presentation to peers at a regional level, the areas I which West Berkshire is performing well were highlighted in addition to areas for improvement. The areas of good performance were prevention work in schools for young people. The areas for improvement were communication and social marketing, plus secondary prevention (lowering consumption in those drinking at risk).

1.4 The need to improve our communication and social marketing in relation to alcohol will be undertaken in partnership with other agencies. The focus will be informed by local intelligence. PHE asks for LA to utilise already available national resources. NHS Creative have been asked to support the AHRP in its communication concerning alcohol.

1.5 In order to address the need to improve secondary prevention two projects will be implemented over the next year. These are: Identification and Brief Advice (IBA) and the Blue Light Project.

## 2. Supporting Information

### Alcohol Harm Reduction Partnership

2.1 The Alcohol Harm Reduction Partnership (AHRP) meets monthly and is chaired and coordinated presently by Debi Joyce, Senior Officer Public Health and Wellbeing.

2.2 The initial work of the AHRP has been to complete the CLeaR tool, which identified areas for focus. The outcomes of the self-assessment have informed the AHRP's action plan for 2017. Following feedback, the AHRP will focus reporting on the two projects of IBA and Blue Light.

2.3 When considering measurable progress within 12 months, one needs to be realistic. Premature mortality rate from alcoholic liver disease in West Berkshire is 7.2 per 100,000, which is just below the national average (8.7 per 100,000). The trend data for alcoholic liver disease in West Berkshire is not reducing over time, nor are alcohol specific mortality rates (WB rate 9.8 per 100,000; England rate 11.5.) These

two rates have an impact on alcohol related hospital admissions. Achieving improvements to these rates will take a number of years to materialise. The Blue Light Project will focus on identifying a small cohort of clients at risk of premature mortality caused by alcohol.

### Identification and Brief Advice (IBA)

2.4 Work has to be conducted by refocusing a treatment orientated budget to encompass prevention. This has enabled funding of the Identification and Brief Advice (IBA) training project to a range of partners. Currently this initiative is confined to GP practices. Large-scale delivery of brief advice and early interventions can help people to become aware of the harm they may be doing to their health.

2.5 Now that the IBA budget total has been identified, the procurement of this service can be conducted. In order to comply with Local Authority commissioning processes, three companies need to be invited to quote. Three companies have been identified. The Chair of the AHRP has requested all three provide details of their training packages, in order to provide a full assessment of the quality and content. Direct training and train-the-trainer training will be delivered to ensure the programme is sustainable. E learning packages will also be available . The AHRP will monitor training uptake and IBA delivery by a range of partners. It is envisaged the IBA training will commence end June 2017.

2.6 IBA will be included in all lifestyle intervention contracts, in order to embed IBA.

2.7 IBA recipients who are found to be drinking at levels harmful to health will be signposted to a range of sources of support including self help via apps and websites. People who wish to discuss their alcohol will be directed to Drink line who triage people to the appropriate service. This is an attempt to ensure that local services are not overwhelmed. How the numbers from the West Berkshire areas contacting Drink Line can be feedback to the AHRP is being explored.

2.8 The principle aim of the IBA project is that, by the end of June 2017, 1,000 people from a range of organizations will have received training on alcohol awareness and IBA techniques.

### Blue Light Project

2.9 The Blue Light project is Alcohol Concern's national initiative to develop alternative approaches and care pathways for treatment resistant drinkers who place a burden on public services.

2.10 Initial discussions have occurred within the AHRP to see how the Blue Light Project can dovetail with other local initiatives in order to make the best use of resources and to prevent duplication.

2.11 Alcohol Concern will begin the instigation of a local Blue Light Project by the end of May 2017. They will provide training for non-specialist staff on techniques of working with treatment resistive drinkers.

2.12 They will also scope the development of a multi-agency operational group to ensure identification and joint management of high impact clients.

### Subgroups of the AHRP:

2.13 The AHRP is working with Community Alcohol Partnership (CAP) to see if West Berkshire can become a member. There are advantages to this, as it enables access to free resources and initiatives for schools and retailers. The main focus for CAP is the prevention of underage drinking, through: Education; Enforcement work in partnership with trading standards; Public Perception; and Diversionary Activities. They are beginning to look at working with parents to dissuade parents from buying alcohol their children.

2.14 The AHRP is looking to identify two locations (one urban and one rural) to be the focus for CAP interventions for the coming year. Suggestions from the group were Hungerford, North Thatcham, Calcot and Greenham.

2.15 A subgroup to update the Young People's Harm Reduction Strategy, considering both direct and indirect harm has been formed and has had two meetings. The Local Children's Delivery Group will oversee this work-stream.

2.16 Ensure AHRP campaigns form part of the H&W Board's Communication strategy. NHS Creative will be working in collaboration with the AHRP and WB communications team to design a local alcohol campaign. There is a need to have a separate AHRP subgroup to look at communication and social marketing messages concerning alcohol. This is to ensure that focus on alcohol is communicated with West Berkshire residents, to enable them to feel the benefits of local work.

2.17 Due to the upcoming election, lobbying parliament for minimum price per unit alcohol has been postponed.

## 3. Conclusion

3.1 The Board will receive regular updates regarding the progress of the two projects and will be provided with an evaluation report upon completion. In order to have a strategic approach to alcohol, these two projects do not occur in a vacuum but are part of a much wider work-stream. These work-streams consider: the impact on young people of their own or parental alcohol misuse: education and diversional activities for all age groups: enforcement of licensing in order to control supply. In additional capacity issues within the specialist treatment services needs to be considered as a result of the roll out of a range of alcohol interventions.

## 4. Consultation and Engagement

4.1 Alcohol Harm Reduction Partnership, Jo Reeves, Health and Wellbeing Steering Group

**Background Papers:**

**Health and Wellbeing Priorities 2017 Supported:**

☒ Reduce alcohol related harm for all age groups
☐ Increase the number of Community Conversations through which local issues have been identified and addressed

**Health and Wellbeing Strategic Aims Supported:**

The proposals will help achieve the following Health and Wellbeing Strategy aim(s):

☐ Give every child the best start in life
☐ Support mental health and wellbeing throughout life
☒ Reduce premature mortality by helping people lead healthier lives
☐ Build a thriving and sustainable environment in which communities can flourish
☐ Help older people maintain a healthy, independent life for as long as possible

The proposals contained in this report will help to achieve the above Health and Wellbeing Strategy aim and priority by providing the Board with information regarding the activity to reduce alcohol related harm.

**Officer details:**


| | |
|---|---|
| Name: | Debi Joyce |
| Job Title: | Senior Programme Officer |
| Tel No: | 01635 519973 |
| E-mail Address: | Deborah.Joyce@westberks.gov.uk |


CAP
Community Alcohol Partnerships


WHY?

# CHIEF MEDICAL OFFICER

Drinking at a young age associated with:

- Physical or mental health problems
- Impaired brain development
- Increased risk of accident or injury
- Missing or falling behind at school
- Violent or anti-social behaviour
- Unsafe sexual behaviour

Cost of Ambulance call out
**£299**

Cost of Arrest
**£1668**

Cost of Intensive Care Unit bed per night
**£1509**

Cost of Hospital Bed per night
**£412**

Minor Operation
**£257**

# The Partnership

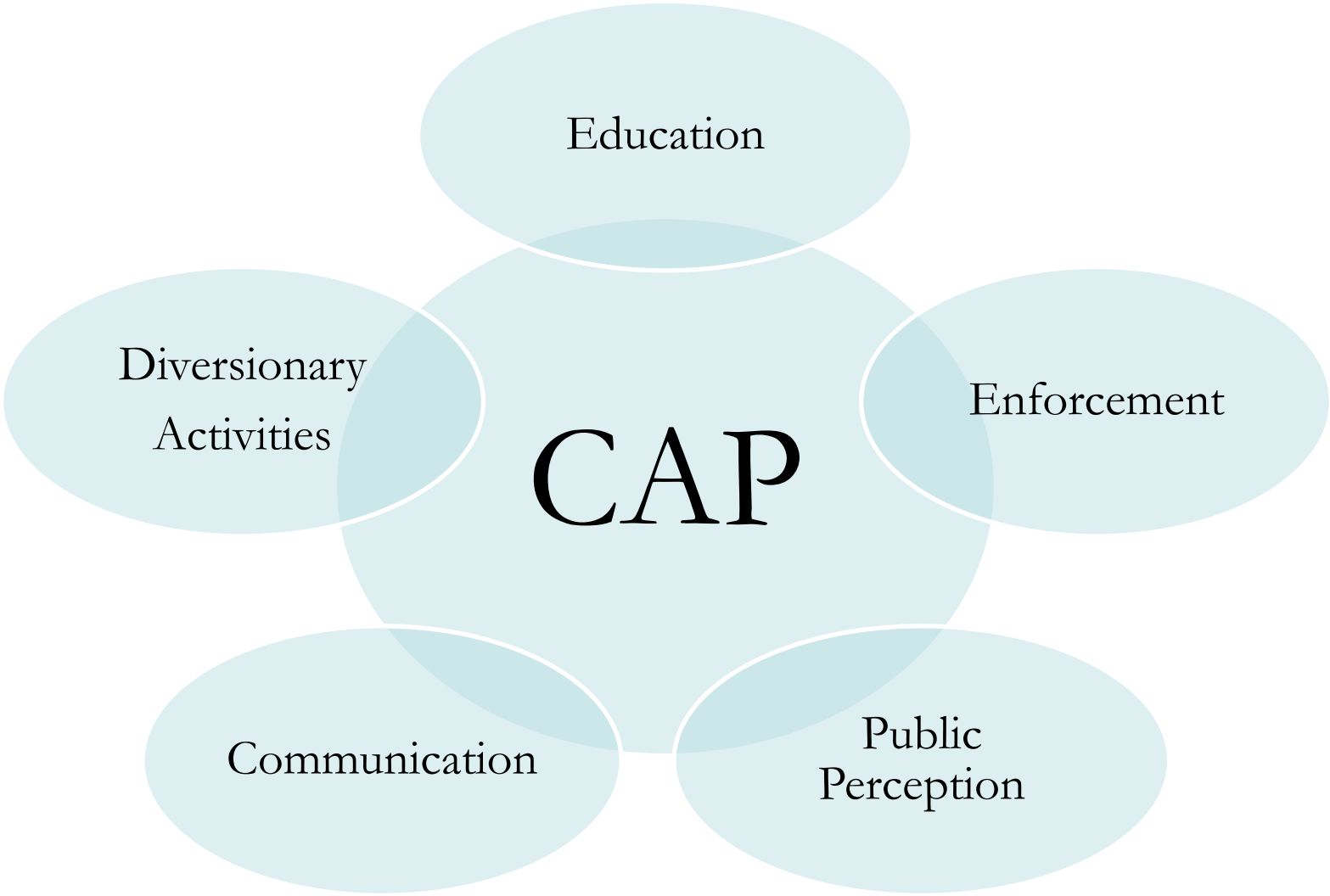
Trading Standards
Licensing
Police
Community Safety
ASB Team
Streetscene
Noise Enforcement

Public Health
Schools
Colleges
Councillors
Localities
Wardens
MPs
YOT
Youth Service
Fire Service
Housing Associations

Community Groups
Volunteers
Street Pastors
Parents
Young People
Sports Clubs

Retailers
Pubwatch
Drinkaware

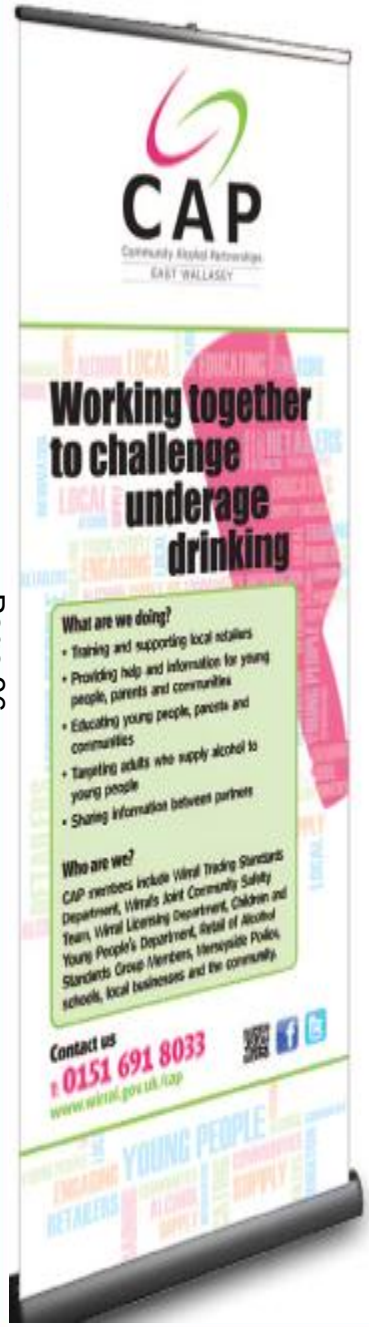
# What does a CAP look like?



# What we offer

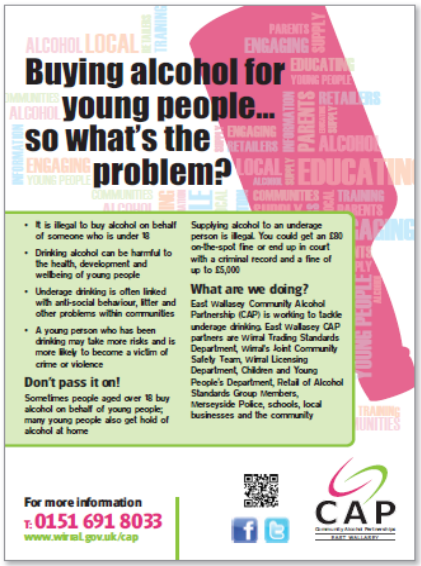





CAP
Community Alcohol Partnership
EAST WALLASEY
Working together to challenge underage drinking
What are we doing?
• Training and supporting local retailers
• Providing help and information for young people, parents and communities
• Educating young people, parents and communities
• Targeting adults who supply alcohol to young people
• Sharing information between partners
Who are we?
CAP members include Wirral Trading Standards Department, Wirral's Joint Community Safety Team, Wirral Licensing Department, Children and Young People's Department, Retail of Alcohol Standards Group Members, Merseyside Police, schools, local businesses and the community.
Contact us
t: 0151 691 8033
www.wirral.gov.uk/cap


UNDER 25?
please be prepared to show proof of age when buying alcohol
U25
drinkaware.co.uk
for the facts about alcohol
CAP


Buying alcohol for someone under 18?
Supplying alcohol to an underage person is illegal.
You could get an £80 on-the-spot fine or end up in court with a criminal record and a fine of up to £5,000.
For more information
What can you do to help?
CAP


Buying alcohol for young people... so what's the problem?
• It is illegal to buy alcohol on behalf of someone who is under 18
• Drinking alcohol can be harmful to the health, development and wellbeing of young people
• Underage drinking is often linked with anti-social behaviour, litter and other problems within communities
• A young person who has been drinking may take more risks and is more likely to become a victim of crime or violence
Don't pass it on!
Sometimes people aged over 18 buy alcohol on behalf of young people; many young people also get hold of alcohol at home
Supplying alcohol to an underage person is illegal. You could get an £80 on-the-spot fine or end up in court with a criminal record and a fine of up to £5,000
What are we doing?
East Wallasey Community Alcohol Partnership (CAP) is working to tackle underage drinking. East Wallasey CAP partners are Wirral Trading Standards Department, Wirral's Joint Community Safety Team, Wirral Licensing Department, Children and Young People's Department, Retail of Alcohol Standards Group Members, Merseyside Police, schools, local businesses and the community
For more information
t: 0151 691 8033
www.wirral.gov.uk/cap
CAP


Proud to be part of East Wallasey Community Alcohol Partnership
Working together to challenge underage drinking
For more information
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CAP


CAP
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Toolkit

# Baseline Data Examples

71% of 14 year olds had started drinking

30% of 14 year olds who already drink had been drunk in the last 4 weeks

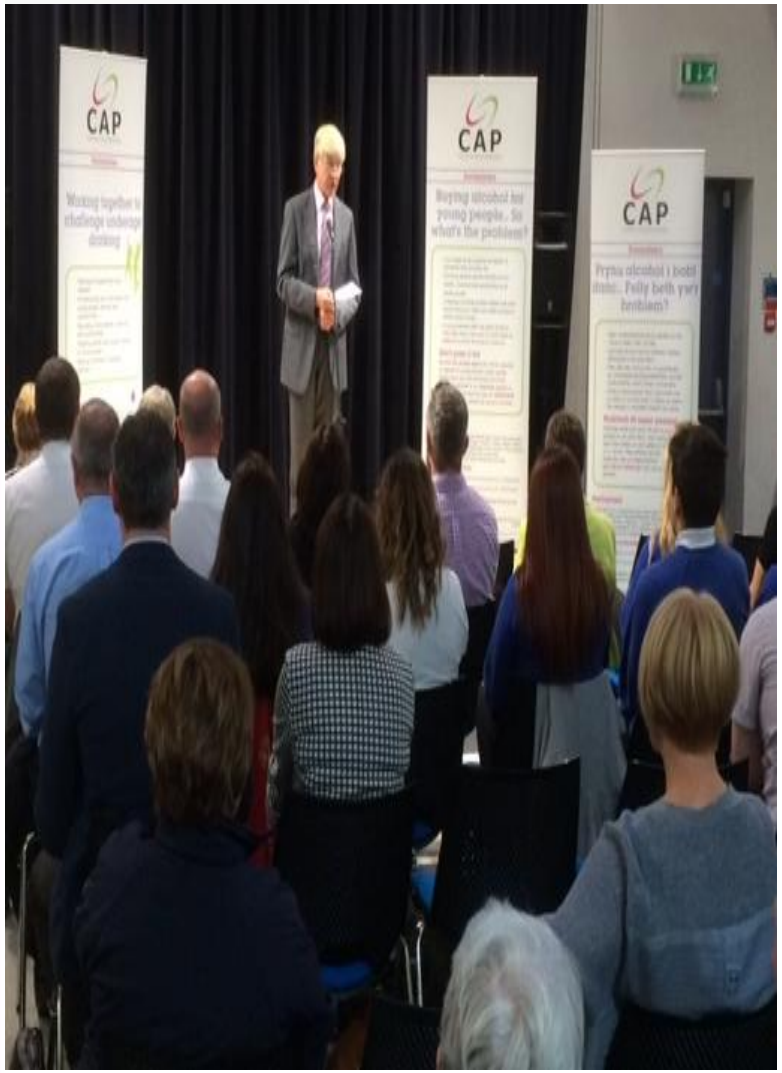
54% of 14 year olds say young people of their own age drink because friends pressure them into it

69% of residents said u18s drinking in public places was a very big (44%) or fairly big problem (25%)

75% of residents rated alcohol-related litter in public places as a very big (44%) or fairly big problem (31%)

63% of residents thought there were not enough things to do for under 18s that didn't involve drinking alcohol

# Official Launch





# Projects


# School Action Day




# Russell Sharland

## CAP Partnership Officer

## South-West England & Wales

## 07882 731 728

russell@communityalcoholpartnerships.co.uk

# Identification and Brief Advice

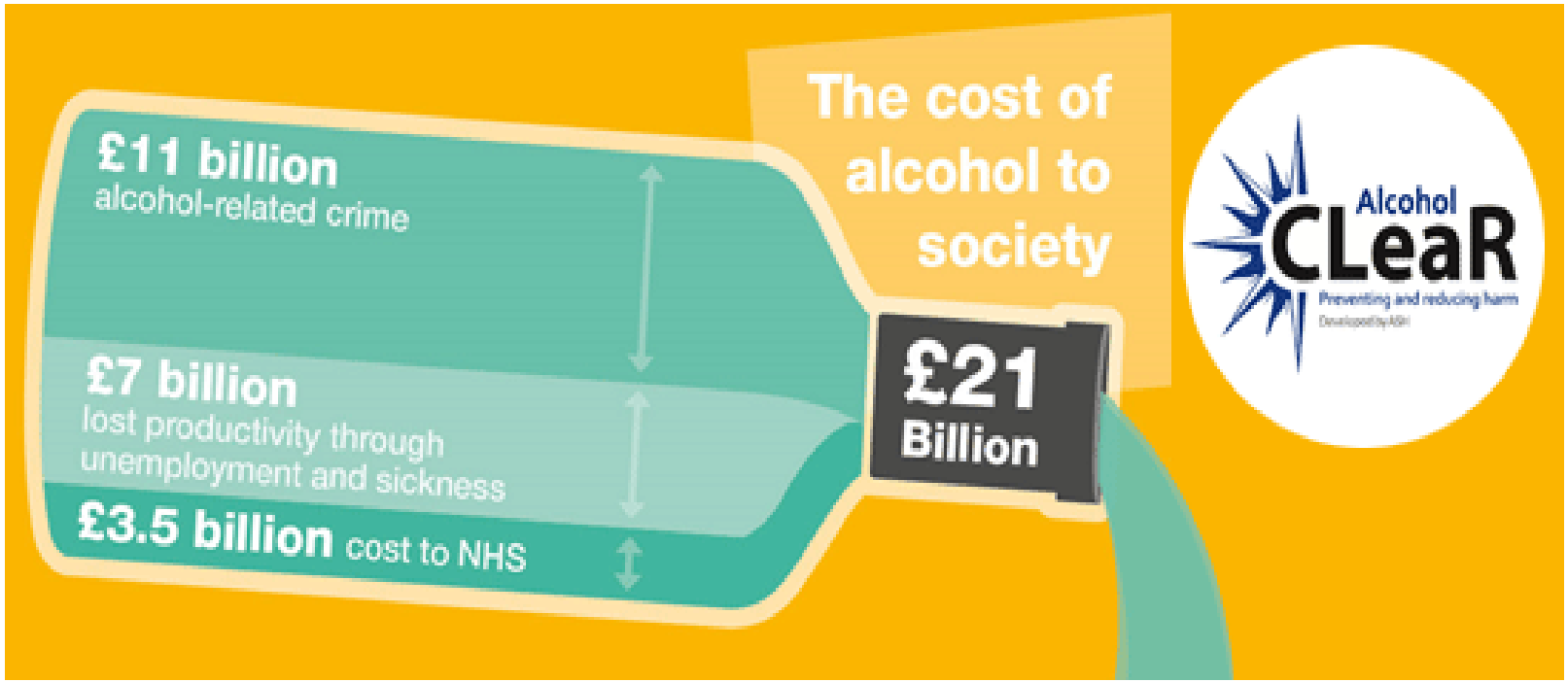
# Purpose

At the end of the session you'll:

- be aware of the importance of screening service users
- know how the body absorbs alcohol and the effects of alcohol
- be able to calculate a unit of alcohol
- know about the different types of drinking behaviours
- be aware of the screening tools you can use
- know how to approach the issue of alcohol
- understand the principles of delivering (identification and brief Advice (IBA)
- be aware of the referral pathways

# Ground rules /Expectations

- Respect each other
- Respect everyone's diversity and individual needs
- Respect everyone's views
- Listen and contribute
- Turn mobiles to silent or vibrate
- Respect confidentiality



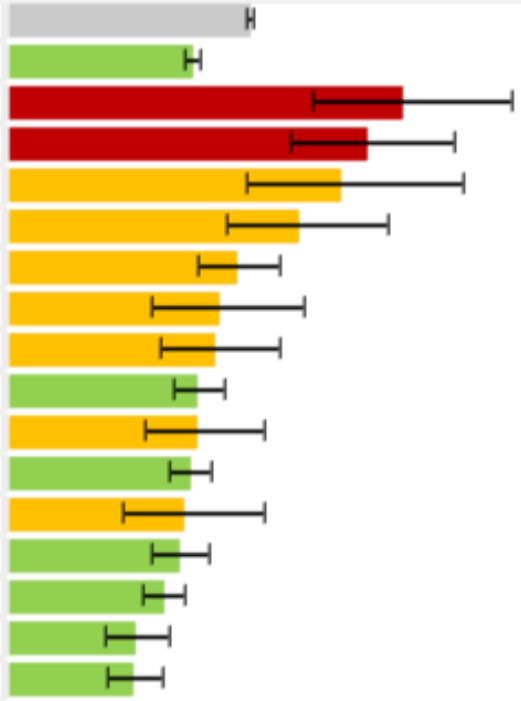

Source: PHE (2016)

# Facts and Figures

- **Alcohol related mortality per 100,000**
- **National 45.5**
- Reading 51.3
- Wokingham 32.2
- West Berkshire 43.5
- 
- **Rate per 100,000 alcohol specific hospital admissions**
- **National 364**
- Reading 327
- Wokingham 158
- West Berkshire 215

Rate of Under 75 mortality from alcoholic liver disease per 100,000 population.

| Area | Value | Lower CI | Upper CI |
|---|---|---|---|
| **England** | 8.6 | 8.4 | 8.7 |
| South East region | 6.6 | 6.2 | 6.9 |
| Portsmouth | 14.0 | 10.8 | 18.0 |
| Brighton and Hove | 12.7 | 10.0 | 15.9 |
| Reading | 11.9 | 8.4 | 16.2 |
| Southampton | 10.4 | 7.7 | 13.6 |
| East Sussex | 8.1 | 6.7 | 9.7 |
| West Berkshire | 7.5 | 5.1 | 10.6 |
| Medway | 7.3 | 5.4 | 9.7 |
| Surrey | 6.7 | 5.8 | 7.7 |
| Milton Keynes | 6.7 | 4.8 | 9.1 |
| Kent | 6.5 | 5.7 | 7.3 |
| Isle of Wight | 6.2 | 4.0 | 9.2 |
| West Sussex | 6.1 | 5.1 | 7.2 |
| Hampshire | 5.5 | 4.8 | 6.3 |
| Buckinghamshire | 4.5 | 3.4 | 5.7 |
| Oxfordshire | 4.4 | 3.5 | 5.5 |
| Wokingham | * | - | - |
| Windsor and Maidenhead | * | - | - |
| Slough | * | - | - |
| Bracknell Forest | * | - | - |



*Source: Public Health England (based on ONS source data)*

# Modern Drinking Habits

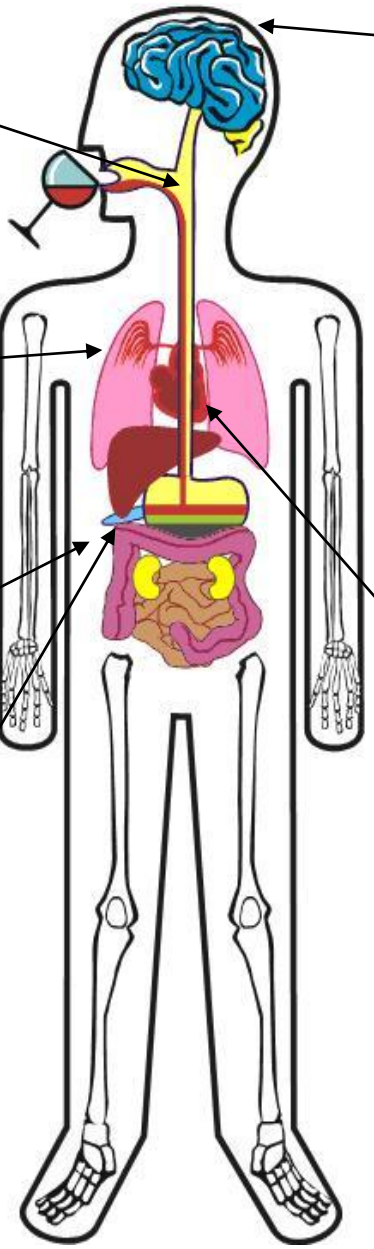
- Wine glasses in pubs are larger than 10 years ago
- People use larger glasses at home where they are less likely to monitor their drinking
- People are drinking more at home in preference to going to pubs
- Most common types of alcohol e.g.  beers and wine are now in higher strengths
- Younger age groups are more likely to report binge drinking and mid-life age groups are more likely to regularly drink too much (HSCIC, 2015).

## Throat
- Inflammation
- Painful swallowing
- Haemorrhage
- Swollen veins

## Lungs
- Lowered resistance to infection

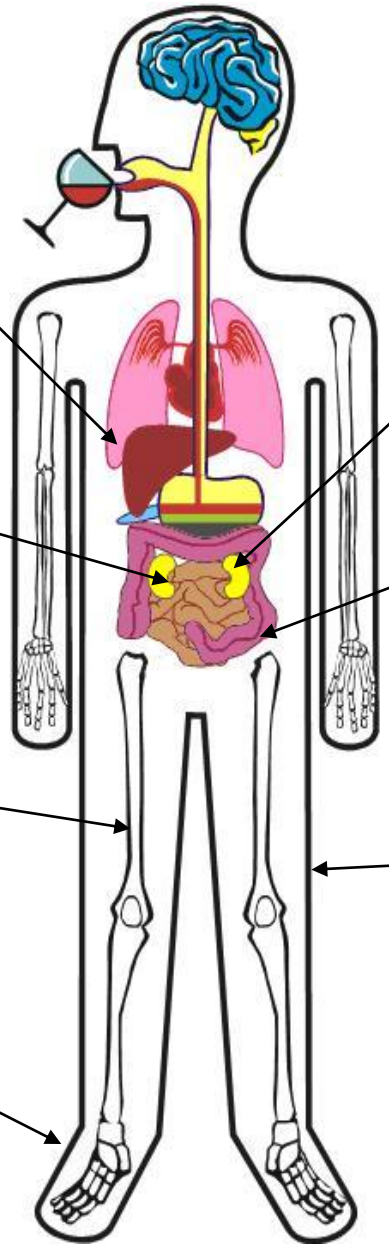
## Liver
- Hepatitis - inflammation
- Cancer
- Fatty liver
- Cirrhosis
- Decrease in blood clotting factor

## Stomach
- Peptic ulcer
- Bleeding lesions
- Poor appetite
- Irritation



## Brain and central nervous system
- Depression
- Aggression
- Slowed reactions
- Memory loss
- Blackouts
- Epileptic fits
- Poor problem solving
- Anaesthesia
- Permanent brain damage
- Respiratory failure
- Death

## Heart/blood
- High blood pressure
- Heart disease
- Increased risk of stroke
- Other drugs made more/less effective



**Pancreas**
- Pancreatitis
- Diabetes

**Kidneys**
- Impaired function
- Infection

**Intestines**
- Irritation
- Vitamin deficiency
- Nausea
- Ulcers
- Diarrhoea
- Cancers

**Reproduction**
- Infertility
- Men = impotence
- Women = increased risk of breast cancer

**Bones**
- Decrease in ability to absorb calcium

**Skin**
- Broken veins
- Rashes
- Itchiness
- Bruising

**Feet and hands**
- Tingling
- Loss of sensation (peripheral neuritis)

# Units- group activity


In your groups pour out what you believe to be 1 unit of:

- Beer
- Spirits
- Wine

# Calculating units

- Formula for calculating units
- (Volume mml/1000) x % alcohol by volume

| Female | Male |
| --- | --- |
| **14** | **14** |
| units per week | units per week |


## This is what 14 units looks like:

6 pints of 4% beer

6 glasses of 13% wine

175ml glasses of wine

**BUT** don't 'save up' your 14 units, it's best to **spread evenly** across the **week** & have **regular drink-free days**


Note: 175ml 13% ABV wine and 4% ABV beer

If you're **pregnant** you **shouldn't drink** alcohol **at all**

## Keep the short-term health risks low by:

- **limiting** the total amount of **alcohol** in **one session**
- **drinking** more **slowly**, alternating with **food** and/or **water**

# Current recommended alcohol limits

**Men**

Shouldn't regularly exceed 3 - 4 units a day.

**Women**

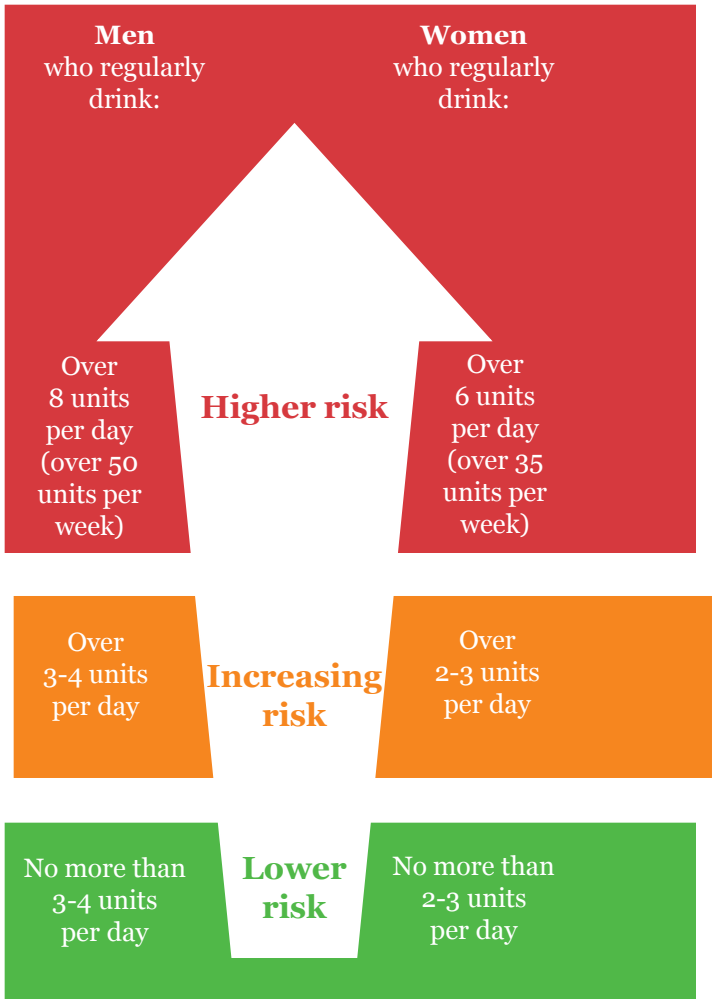
Shouldn't regularly exceed 2 - 3 units a day.

'Regularly' means most days or every day.

# DH Terms used for reflecting risk

- **Binge Drinking**: Drinking twice the recommended daily limit of alcohol in one session =6 units for women, 8 units men.
- **Lower risk:** Drinking within new guidelines of 14 units per week with regular drink free days.
- **Increasing risk:** Regularly drinking more than 2-3 units a day for a woman and 3-4 units for a man.
- **Higher risk**: Drinking over 6 units per day for women (over 35 units per week) and over 8 units a day for men ( over 50 units per week).
- **Alcohol dependence:** Develops with regular excessive drinking . Can be mild to severe physical and psychological symptoms

# Drinking risk levels



# Why brief interventions?

- 1 in 8 individuals drinking at increased or higher risk levels act on their worker's advice and moderate their drinking to low risk levels.
- This compares to 1 in 20 individuals offered smoking advice (1 in 10 when nicotine replacement is offered) (The Cochrane Library, 2011).
- Feeds into the NHS initiative 'Making every contact count'.

# Alcohol users Disorders Identification Test (Audit).

- Developed by the World Health Organisation (WHO) specifically for use in primary care
- Validated in more than 22 countries
- Seen as gold standard in screening tools
- Takes five minutes to complete, one minute to score
- Sensitivity 92% and specificity 94% to identify increased, higher risk and possible dependent drinking

# Audit Scores

| Score | PHE terminology | NICE terminology |
|---|---|---|
| 0-7 | Lower Risk | Lower Risk |
| 8-15 | Increasing Risk | Hazardous Drinking |
| 16-19 | Higher Risk | Harmful Drinking |
| 20-40 | Possible Dependence | Possible Dependence |

# Audit C and full Audit

- If a patient is identified as positive, scoring 5+ on AUDIT C, the remaining 7 questions of the ten question full AUDIT questionnaire should be used.

- The stepped care approach using the AUDIT tool provides a simple way of determining:
- A value should be added to a field associated with the code to record the score:
- **0-7** indicates lower risk drinking requiring low level action and information
- **8-15** indicates increasing risk drinking Service users who should be offered simple structured advice and information
- **16-19** indicates higher risk drinking. Service users who are appropriate for extended brief interventions dependent on time and practitioner knowledge of motivational interviewing.
- **20** and over indicates possible alcohol dependence. Service users who need more intensive interventions or referral due to possible dependence
- Referrals should be made electronically (wherever possible)

# Simple Brief intervention

Activity: in pairs deliver a brief intervention.

# Brief interventions

Primary goal of  simple brief interventions are to help the patient understand:

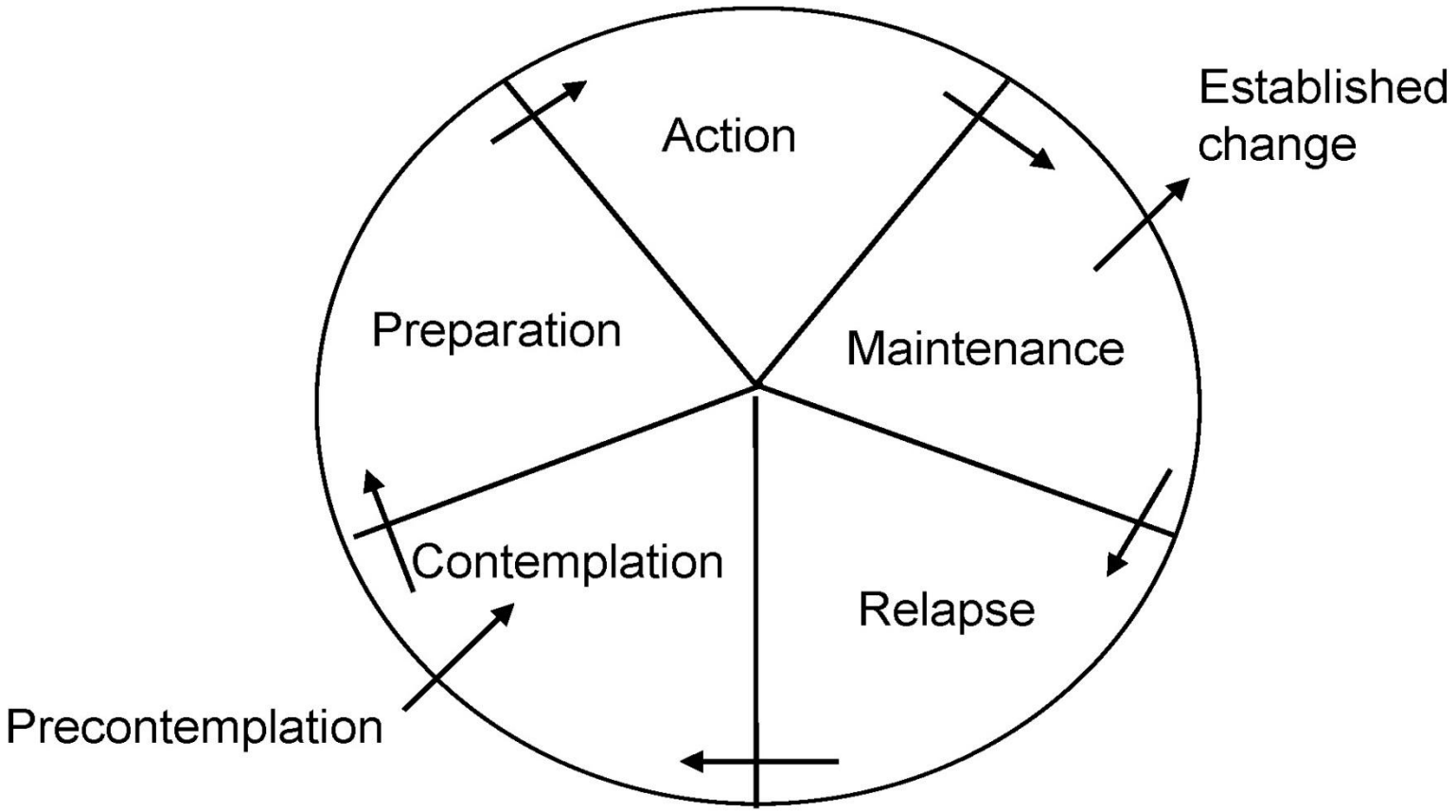
- What the consequences could be
- What they can do about it
- What help is available

# What is ‘simple brief advice’

- ‘Simple brief advice’ entails structured advice lasting 5-10 minutes, commonly delivered by non-alcohol specialists (i.e. as a tier 1 intervention)
- ‘Simple brief advice’ is known to be effective for increasing and higher-risk drinkers, but not dependent drinkers
- ‘Simple brief advice’ is not classed as a treatment but is part of an integrated alcohol care pathway. It will bring benefits at population level over time, as well as individual benefits.

# Motivation to change

# Stages of change




(based on Prochaska and DiClemente's model)

# Stage of change & brief intervention

- **Precontemplation** (unaware/unready)
  - intervention unlikely to succeed, give information about risks
- **Contemplation** (aware/ambivalent)
  - offer advice &/or motivational work to move patient along
- **Preparation** (planning)
  - set date, make plans, be specific, anticipate difficulties
- **Action** (ready to go)
  - encourage, support, offer to follow-up
- **Maintenance** (keeping it up)
  - reinforce success, advise on managing slips/relapse prevention

## This is one unit...

For more detailed information on calculating units see - www.nhs.uk/Livewell/alcohol/Pages/alcohol-units.aspx

Half pint of "regular" beer, lager or cider

1 very small glass of wine (9%)

1 single measure of spirits

1 small glass of sherry

1 single measure of aperitifs

How many units did you drink last week?

## ...and each of these is more than one unit


A pint of "regular" beer, lager or cider


A pint of "strong" or "premium" beer, lager or cider


Alcopop or a 275ml bottle of regular lager


440ml can of "regular" lager or cider


440ml can of "super strength" lager


250ml glass of wine (12%)


Bottle of wine (12%)

| Risk | Men | Women | Common Effects |
|---|---|---|---|
| Lower Risk | Both men and women should not regularly drink more than 14 units per week spread over three or more days | | • Increased relaxation<br>• Sociability<br>• Sensory enjoyment of alcoholic drinks |
| Increasing Risk | Regularly drinking 15-50 units per week | Regularly drinking 15-35 units per week | **Progressively increasing risk of:**<br>• Low energy<br>• Relationship problems<br>• Depression<br>• Insomnia<br>• Impotence<br>• Injury<br>• High blood pressure<br>• Alcohol dependence<br>• Liver disease<br>• Breast, mouth and throat cancers |
| Higher Risk | More than 8 units per day on a regular basis or more than 50 units per week | More than 6 units per day on a regular basis or more than 35 units per week | |

NHS

**There is no completely safe level of drinking and drinking even small amounts of alcohol can incur risk in certain circumstances**

**For example, with strenuous exercise, operating heavy machinery, driving or if you are on certain medications.**

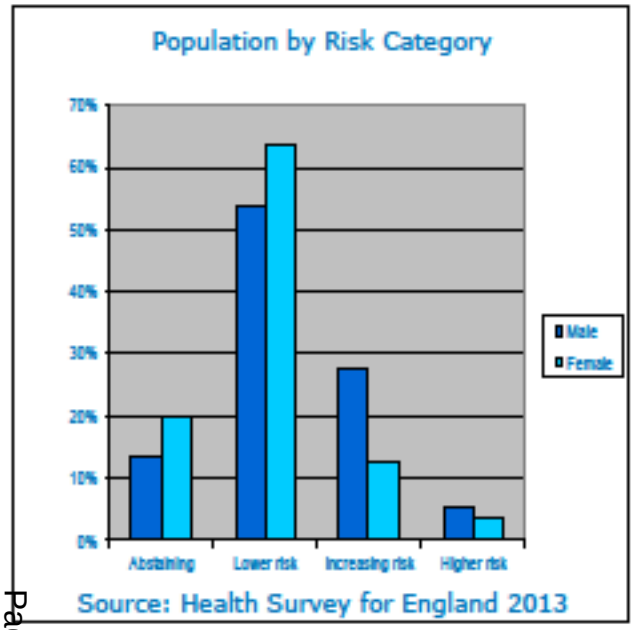
**If you are pregnant or planning a pregnancy, the safest approach is not to drink alcohol at all.**

**Drinking in pregnancy can harm the baby, with the more you drink the greater the risk.**

**The risk of harm to the baby is likely to be low if a woman has drunk only small amounts of alcohol before she knew she was pregnant or during pregnancy.**

More information is available from One You: www.nhs.uk/oneyou

## What's everyone else like?




Source: Health Survey for England 2013

## The potential benefits of cutting down

**Psychological/Social/Financial**

- Improved mood
- Improved relationships
- More time for hobbies and interests
- Reduced risks of drink driving
- Save money

**Physical**

- Sleep better
- More energy
- Lose weight
- Reduced risk of injury
- Improved memory
- Better physical shape
- Reduced risk of high blood pressure
- Reduced risk of cancer
- Reduced risks of liver disease
- Reduced risks of brain damage

## Making your plan

- Have several 'drink-free' days, when you don't drink at all
- When you do drink, set yourself a limit and stick to it
- Quench your thirst with non-alcohol drinks before and in-between alcoholic drinks
- Avoid drinking in rounds or in large groups
- Eat when you drink - have your first drink after starting to eat
- Switch to lower alcohol beer/lager
- Avoid going to the pub after work
- Plan activities and tasks at those times you would usually drink
- When bored or stressed do something physical instead of drinking
- Avoid or limit the time spent with "heavy" drinking friends

## What targets should you aim for?

**There is no completely safe level of drinking, but by sticking within these guidelines, you can lower your risk of harming your health:**

- **Adults are advised not to regularly drink more than 14 units a week**
- **If you do drink as much as 14 units in a week, spread this out evenly over 3 or more days.**

## What's your personal target?

NHS


ONE YOU

# DRINKS TRACKER

Drinking a bit too much can sneak up on you. Public Health England's free drinks tracker app makes it easy to keep an eye on the booze and take control with daily tips and feedback

www.nhs.uk/oneyou/apps

This brief advice is based on the **"How Much Is Too Much?"** Simple Structured Advice Intervention Tool, developed by Newcastle University and the Drink Less materials originally developed at the University of Sydney as part of a W.H.O. collaborative study.

Download this alcohol advice tool from http://www.alcohollearningcentre.org.uk/Topics/Browse/BriefAdvice/

# Brief Interventions – FRAMES

A structure of Brief Interventions

- Feedback (personalised)
- Responsibility (with patient)
- Advice (clear, practical)
- Menu (variety of options)
- Empathy (warm, reflective)
- Self-efficacy (boosts confidence)

# Key messages

- Facilitating self-efficacy: Can you think of any benefits reducing the amount of alcohol you drink would have for you?

- Empathy: It can be quite tricky to keep track of how much you're drinking when you are out with friends, can't it?

- Authoritative: It's recommended that you don't drink more than 2 to 3 units a day, on a regular basis. It is also recommended that you have at least 2 alcohol free days each week.

- Encouragement: By making some simple changes to your drinking, you could probably improve your quality of life quite quickly.

- In pairs practice super brief intervention

# Recording (read codes)

- **A plea:** please complete
- Assessment-
- Consumption- lower ,increasing, higher, dependent
- Brief intervention -
- Referral

# Extended brief interventions

- Extended' brief interventions are essentially 'brief motivational interviewing' approaches, sometimes referred to as 'brief lifestyle counselling'.

- An extended brief intervention  is usually delivered in one session, but unlike 'simple brief advice', is 20-30 minutes to allow for more  interaction and motivational enhancement.

# Motivational interviewing

Basic principles:

- Express empathy- seeing the world through the client's eyes.
- Support self efficacy- a client's belief that change is possible is an important motivator.
- Roll with resistance- clients are not reinforced for becoming argumentative.
- Develop Discrepancy- clients examine the discrepancies between their current behaviour and future goals

# Summary

- Be non judgmental – avoid making judgemental comments about patients' drinking revelations.
- Recommended approach is to be encouraging, empathetic, authoritative and aim to facilitate the patient’s decision making.
- If dealing with an angry question or response from a patient be assertive but calm, drawing the patient’s attention back to the structured advice tool.
- Addressing potential alcohol dependency is beyond the scope of the Brief Advice session, offer referral to a specialist service.

# Specialist Services

- Young people
- **The Edge**
- theedge@westberks.gov.uk
- **Tel:** (01635) 582002
- Adults
- **Swanswell Alcohol and Drug Recovery Service**
  wberksadmin@swanswell.org
- 0300 003 7025

# Additional learning

- http://www.alcohollearningcentre.org.uk/eLearning/IBA/platforms/ALC/
- https://www.drinkaware.co.uk/
- http://www.nhs.uk/livewell/alcohol/Pages/Alcoholhome.aspx
- https://www.drinkaware.co.uk/check-the-facts/health-effects-of-alcohol/effects-on-the-body/health-effects-of-alcohol-resources

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# Community Conversations - Summary Report

| | |
|---|---|
| **Committee considering report:** | Health and Wellbeing Board |
| **Date of Committee:** | 25 May 2017 |
| **Portfolio Member:** | Cllr James Fredrickson |
| **Report Author:** | Susan Powell |

## 1. Purpose of the Report

1.1 To provide an update on progress with the Board's priority for 2017 to 'increase the number of Community Conversations through which local issues are identified and addressed.'

## 2. Recommendation

2.1 That the Health and Wellbeing Board note the update.

## 3. Implications

| | | |
|---|---|---|
| 3.1 | **Financial:** | None |
| 3.2 | **Policy:** | Continuation and development of the Building Communities Together initiative |
| 3.3 | **Personnel:** | Phase 1 of the creation of the Building Communities Together Team commenced on 1st April 2017 with the collocation of West Berkshire Council officers. |
| 3.4 | **Legal:** | None |
| 3.5 | **Risk Management:** | None |
| 3.6 | **Property:** | None |
| 3.7 | **Other:** | None |

## 4. How the Health and Wellbeing Board can help

4.1

| | | |
|---|---|---|
| **Will the recommendation require the matter to be referred to the Executive for final determination?** | Yes: ☐ | No: ☒ |

# Executive Summary

## 5. Introduction / Background

- The previous report to the Board (30th March 2017) provided a summary of the instigation of Community Conversations and a review of their status as responsibly for their ongoing development passed to the Building Communities Together Team.

- This report provides a summary of work undertaken since that previous report was written and also briefly outlines some emerging plans for the future development of Community Conversations.

- Whilst responsibility for Community Conversation only passed to the Building Communities Together (BCT) Team at the beginning of April 2017 prior to that date the BCT Team Manager worked alongside the previous lead officer, colleagues from the West Berkshire Volunteer Centre and partner officers to gain an insight into their development, status and ideas for the future.

- Officers of the Safer Communities Partnership Team, who have now transferred into the BCT Team, were routinely attending Community Conversations and had strong working relationships with a wide range of officers participating in them and therefore had a good working knowledge on this initiative.

- As described in the previous report there had been a Learning Event and a Review Meeting in January 2017 the outcomes of both of these were very helpful in enabling the BCT Team to identify areas of work to consolidate and formulate some ideas for change.

## 6. Proposal

- That the Board note that:

    - Responsibility for Community Conversations has transferred to the newly formed and developing Building Communities Together Team.

    - Existing Conversations are being sustained and opportunities to start new Conversations are being explored.

    - Ways to bring young people's voices forward are being explored.

    - A Toolkit is to be developed and ways of supporting Community Anchors are being explored.

    - Performance Indicators have been included in relevant Action Plans and a Project Management Structure is to be developed.

## 7. Conclusion

- The Health and Wellbeing Board will routinely receive update reports on developments

## 8. Appendices

8.1 Appendix A – Supporting Information

8.2 Appendix B – Draft Communtiy Conversations Toolkit

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**Appendix A**

# Community Conversations – Supporting Information

## 1. Introduction/Background

1.1 The previous report to the Board (30th March 2017) provided a summary of the instigation of Community Conversations and a review of their status as responsibly for their ongoing development passed to the Building Communities Together Team.

1.2 This report provides a summary of work undertaken since that previous report was written and also briefly outlines some emerging plans for the future development of Community Conversations.

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1.4 Officers of the Safer Communities Partnership Team, who have now transferred into the BCT Team, were routinely attending Community Conversations and had strong working relationships with a wide range of officers participating in them and therefore had a good working knowledge on this initiative.

1.5 As described in the previous report there had been a Learning Event and a Review Meeting in January 2017 the outcomes of both of these were very helpful in enabling the BCT Team to identify areas of work to consolidate and formulate some ideas for change.

## 2. Building Communities Together Team

2.1 Phase 1 of the creation of the BCT Team commenced on 1st April 2017 with the co-location of West Berkshire Council (WBC) officers in the Contact Centre at WBC Market Street Offices. These officers occupy desks adjacent to those allocated to officers from the Community Rehabilitation Company and National Probation Service.

2.2 The WBC officers within the BCT Team are:

- Building Communities Together Team Manager (formerly Safer Communities Partnership Team Manager)
- Civil Contingencies Manager
- Principal Policy Officer (Communities)
- Anti-social Behaviour Coordinator
- Domestic Abuse Reduction Coordinator
- Emergency Planning Support Officer
- Crime Prevention Coordinator (post currently vacant)

2.3 From the 1st April the BCT Team Manager has reported to the Deputy Local Police Area Commander and as the Team develops other cross organisational reporting arrangements will be introduced.

2.4 Phase 2 of the development of this multi agency team will be in June 2017 when a Sergeant and 8 Police Constables from Thames Valley Police join the BCT Team. The Sergeant will report to the BCT Manager and the TVP officers will co-locate at Market Street offices..

## 3. West Berkshire Volunteer Centre

3.1 The West Berkshire Volunteer Centre Project Officer continues to provide support for Community Conversations working closely with the BCT Team Manager and Community Anchors.

3.2 The experience and knowledge of the Project Officer has been invaluable during the period of transition.

## 4. New Community Conversation in Newbury

4.1 The Community Anchor for Newbury undertook 3 days Restorative Practice Training in February 2017 and is now planning the first Newbury Community Conversations which will take place on Saturday 17th June 2017 in Newbury Baptist Church.

4.2 The BCT Team Manager and Project Officer are providing support and in addition the Newbury Community Anchor has been linked to the Calcot and Hungerford Community Anchors for peer support.

4.3 The Newbury Community Conversation will take place between 12noon and 2pm and will adopt a World Cafe format to:

- engage attendees
- gather information
- identify local strengths and assets
- identify local issues that the local community would like to address
- develop initial actions

4.4 The date for the first Newbury Community Conversation has been chosen to coincide with 'The Big Lunch' which is being promoted locally through Newbury Weekly News to hopefully benefit from this additional publicity and to attract a good number of participants.

4.5 The Big Lunch is a national initiative seeking to address social isolation and 're-connect communities' so there is a natural synergy with a Community Conversation.

## 5. Re-energised Community Conversation in Calcot

5.1 A 'new start' Community Conversation was held on Sunday 5th March 2017 at The Gate Church which was very well attended and skilfully facilitated by the new Community Anchor.

5.2 There were table/group exercises and discussions resulting in the identification of some action points that it is hoped will have a real impact in the community.

5.3 A follow up meeting with the Community Anchor to talk through the next steps to maintain momentum is planned at the beginning of May and as mentioned above the Anchor is assisting the Newbury Anchor with their planning for their own Conversation in June.

## 6. Community Conversation Toolkit

6.1 It was identified that a 'toolkit' to assist Anchors with initiating, facilitating and sustaining Community Conversations would be an extremely helpful resource and it was suggested that the Patient and Public Engagement Group could assist with its development.

6.2 The ideas captured at the Community Anchors Learning Event in January 2017 have been used to generate an initial draft of a Community Conversation Toolkit attached to this report as Annex A.

6.3 This draft document was discussed at the April meeting of the Patient and Public Engagement Group and it will be developed further in partnership with 'new' and 'established' Anchors and colleagues in communications and graphics.

6.4 The recent Community Conversation in Calcot and the planned Conversation in Newbury provide timely opportunities to refine the toolkit alongside the activity it is being developed to support.

## 7. Hungerford and Lambourn Community Conversations adopt a Multi Professional Lens approach

7.1 As highlighted in the previous report there is a highly effective Community Anchor in Hungerford who continues to facilitate very effective Community Conversations. A 'multi-professional lens' approach has been adopted with a wide range of officers coming together to provide support for each other and to work together to improve outcomes for families and children across Hungerford and the local area (Hungerford, Kintbury, Lambourn, Wickham, Shefford).

7.2 Regular thematic meetings are taking place and to date the following 'topics' have been discussed:

- Anti-social Behaviour
- Domestic Abuse
- Mental Health and Self Harm

7.3 The meetings are using a simplified version of the TVP Problem Solving Framework, SARA (described in the previous report), and discussions follow the following stages:

- Scanning
- Analysis
- Response (solutions/actions)

7.4 The Community Anchor is also providing peer support to new Community Anchor in Newbury.

## 8. Other existing Community Conversations and Community Anchor Meetings

8.1 Future Community Conversations in Thatcham will be coordinated under the Thatcham Vision and the multi agency work to address youth related anti-social behaviour described in the previous report continues using SARA problem solving and community engagement solutions.

8.2 Community Conversations in Burghfield and Mortimer have been very productive with some significant outcomes achieved as previously reported. Both communities benefit from robust communication mechanisms and volunteers. The BCT Team Manager and Project Officer are arranging to meet with Community Anchors to involve them in the development of the toolkit and to discuss further development of Conversations.

8.3 The BCT Manager is currently arranging to meet with all Community Anchors, including those within Schools and partner organisations, to strengthen links and explore options for coordinating and supporting their activities.

## 9. Young People's Voices

9.1 It has been identified that young people's voices need to be heard however to date Community Conversations have not been well attended by young people. It was highlighted by several participants at the January Review Meeting that young people may prefer to participate in other ways rather than 'attending a meeting in the local hall'.

9.2 Alternative ways of engaging with young people are therefore being explored including working with the network of Peer Mentors. The Peer Mentor Coordinators have agreed to have a Community Conversation at their annual Conference on 8th November 2017. All 10 mainstream secondary schools are invited to send Peer Mentor representatives to the Conference and it is anticipated, from previous experience, that there could be approximately 50 – 60 Peer Mentors attending.

9.3 The Health and Wellbeing in Schools Coordinator has been instrumental in creating the opportunity described above and is also working with members of the BCT Team to launch a Schools Arts Festival linked to on-line safety.

9.4 From 2006 to 2016 local secondary schools participated in the annual Schools Play Competition organised by Thames Valley Police and partner agencies under the Safer Schools Programme. Each year schools were invited to create an original play addressing a topical community safety related issue and the plays were performed at the Corn Exchange, Newbury.

9.5 In 2017 all secondary schools will be invited to participate in an Arts Festival where students will be encouraged to produce an original piece of art (dance, drama, music, spoken word) or multi- media item (exhibition, film, presentation,) related to on line safety.

9.6 The '#Protect your World' Arts Festival will hopefully engage young people and give them a way to join in with the potential for holding a symposium on cyber crime being considered for Autumn 2017.

9.7 Secondary and primary schools across West Berkshire continue to participate in Restorative Practice with further training planned for the Autumn.

## 10. Thematic and Targeted Community Conversations

10.1 To date Community Conversations have been primary 'geographic' with a community being identified through data analysis and subsequently instigated by an Anchor arising from that community.

10.2 During the Review Meeting in January and from discussions between colleagues it has become clear that the potential for developing conversations with 'communities of interest' should be explored.

10.3 One such conversation that is currently being explored is around Dementia. There are a number of communities where Dementia Friends initiatives are established and they are different communities to those that currently have Community Conversations underway. The potential to link up this work for the benefit of all communities, those living with dementia and those supporting them is being explored.

10.4 Taking the learning from the Hungerford Community Conversation there may be other opportunities for convening meetings of professional who through their work represent members of the community around a specific issue. This will be developed further by the BCT Team Manager and collagues.

10.5 It is important that Community Conversations are effective in bringing issues forward that generate the most demand on local services and that they also bring together professionals working with vulnerable individuals/communities.

## 11. Potential new Community Conversations

11.1 The West Berkshire Volunteer Centre is coordinating an event in Pangbourne in May 2017 which could be a catalyst for a Community Conversation and provide an opportunity to explore the potential with members of that community.

11.2 There are a significant number of Neighbourhood and other Watches across West Berkshire with volunteers actively engaged in the prevention and detection of crime. The potential to link these active citizens to Community Conversations will be explored by the BCT Team Manager who is making a presentation to the South West Newbury Neighbourhood Watch Coordinators meeting in August 2017.

11.3 In addition to Neighbourhood Watches there are a number of Neighbourhood Actions Groups and TVP are exploring establishing Community Forums all of which need to be effectively coordinated and further updates will be provide to the Health and Wellbeing Board in subsequent reports.

## 12. Restorative Practice Training and Restorative Approach/es

12.1 The Brilliant West Berkshire Programme Board agreed a recommendation for a 'Train the Trainer' approach to sustaining Restorative Practice. Potential Trainees are being approached for training in Summer 2017 to be able to deliver training in both Schools and for partner officers from Autumn 2017.

## 13. Performance and Project Management

13.1 Appropriate Performance Management Indicators relating to Community Conversations have been developed and incorporated into relevant Action Plans.

13.2 An audit of Community Conversations will, as recommended in the previous report, be completed during May 2017 to inform the development of output, outcomes and impacts. The audit will also inform the development of a Project Management Structure for Community Conversations which will be developed by the BCT Team during June 2017.

## 14. Conclusion

14.1 Responsibility for Community Conversations has transferred to the newly formed and developing Building Communities Together Team.

14.2 Existing Conversations are being sustained and opportunities to start new Conversations are being explored.

14.3 Ways to bring young people's voices forward are being explored.

14.4 A Toolkit is to be developed and ways of supporting Community Anchors are being explored.

14.5 Performance Indicators have been included in relevant Action Plans and a Project Management Structure is to be developed.

14.6 The Health and Wellbeing Board will routinely receive update reports on developments.

## 15. Consultation and Engagement

15.1 Nick Carter, Health and Wellbeing Steering Group

**Background Papers:**

**Health and Wellbeing Priorities 2017 Supported:**

☐ Reduce alcohol related harm for all age groups
☒ Increase the number of Community Conversations through which local issues have been identified and addressed

**Health and Wellbeing Strategic Aims Supported:**

The proposals will help achieve the following Health and Wellbeing Strategy aim(s):

☐ Give every child the best start in life
☐ Support mental health and wellbeing throughout life
☐ Reduce premature mortality by helping people lead healthier lives
☒ Build a thriving and sustainable environment in which communities can flourish
☐ Help older people maintain a healthy, independent life for as long as possible

The proposals contained in this report will help to achieve the above Health and Wellbeing Strategy aim and priority by providing the Board with information regarding the activity to increase the number of community conversations.

**Officer details:**

Name: Susan Powell
Job Title: Building Communities Together Team Manager
Tel No: 07881 856801
E-mail Address: Susan.Powell@westberks.gov.uk

# Community Conversations Toolkit

Building Community Together

## What is the purpose of a community conversation?

- Someone has approached you for help-about what?
- Look for the unexpected solutions-value different perspectives
- Everyone needs an opportunity to speak
- The spark of an idea taken forward by the community-'small seeds'
- To celebrate strengths and successes in communities

---

## Why should I have a community conversation?

### Priorities

- Is there a need
- Understand your community
- Look for the unexpected
- Where is the need
- Community conversations are not a quick win
- Celebrate strengths in the community and as professionals

### Pitfalls

- Starting a community conversation when there is already similar work occurring

# I want to start a community conversation in my local area and don't know where to start and what to avoid?

## Priorities

- Support people to have the confidence to speak and share their view/thoughts
- Ensure the environment for the conversations is welcoming-circle of chairs, food, the welcome you give people to your venue
- Develop a 'space' to help people articulate what they are thinking
- Ask 'what have you NOTICED in your community?'
- Prioritise when someone has a passion to do something, create a change in the community-harness people's passion/fire
- Assume a 'non-expert' position-everyone has the opportunity to speak
- Focus on relationships and building relationships-addressing power imbalance and pyramid conversations
- Avoid the word 'problem'/'issue' focus on strengths and solutions
- Consider different mechanisms for community conversations-web chats
- Widen the circle-increase attendance to a broader audience
- Use existing networks to develop community conversations-peer mentors, practice managers at GPs, PPGs etc
- Learn from others-Mortimer village partnership
- People are the experts in their situations
- Partnership between local people and professionals
- Children and young people have a voice
- Use websites, FB and social media
- Share a core set of values
- Position the conversations to work 'with' and not to or for
- Develop links with faith and voluntary sector
- Share the needs of the community with all partners and the faith/voluntary sector
- Develop trust in communities and within multi-agency relationships
- Involve vulnerable groups-AA, Loose ends etc. Face to face conversations, online opportunities, celebrating success, valuing others
- Focus on building solutions together
- Conversation based on trust
- Empower and work in partnership-people and communities design the 'curriculum'/ focus of the meetings
- They are organic
- Make sure it is not too big-not everyone needs to be involved
- Give space to come in and out
- It is not a destination, its a journey
- Communities win communities
- Inspire sustained change and empowering people to take responsibility

## Pitfalls

- Avoid duplication with NAGs and neighbourhood forums-There can be a strength in joining forces
- Attempt to have a balanced attendance and not just those who are already active in their communities or professionals in those communities
- Community conversations do not require everyone who is active in the community to attend. People can dip in and out

# West Berkshire Health and Wellbeing Board Annual Conference – 27 April 2017 – Summary Report

| | |
|---|---|
| **Report being considered by:** | Health and Wellbeing Board |
| **On:** | 25 May 2017 |
| **Portfolio Member:** | Councillor James Fredrickson |
| **Report Author:** | Jo Reeves |

## 1. Purpose of the Report

1.1 The aim of the Annual Health and Wellbeing Conference held on 27 April 2017 was for attendees to broaden their understanding of the community conversations approach by applying it to the issue 'How as system leaders do we move from cooperation to transformation?'

1.2 The purpose of this report is to summarise the content of the Conference and consider the next steps for the actions which arose.

## 2. Recommendation

2.1 The Health and Wellbeing Board approve and own the action plan at Appendix A.

## 3. Implications

| | | |
|---|---|---|
| 3.1 | **Financial:** | None |
| 3.2 | **Policy:** | None |
| 3.3 | **Personnel:** | None |
| 3.4 | **Legal:** | None |
| 3.5 | **Risk Management:** | None |
| 3.6 | **Property:** | None |
| 3.7 | **Other:** | None |

## 4. How the Health and Wellbeing Board can help

4.1 The action plan in Appendix B details the responsible parties for the identified actions and also the way in which Board members can support the delivery of the action plan.

| | | |
|---|---|---|
| **Will the recommendation require the matter to be referred to the Executive for final determination?** | Yes: ☐ | No: ☒ |

# Executive Summary

## 5. Introduction / Background

- The Health and Wellbeing Board held its third annual conference on 27 April 2017.
- The aim of the conference was for attendees to broaden their understanding of the community conversations approach by applying it to the issue 'How as system leaders do we move from cooperation to transformation?'

## 6. Proposals

- The Principal Policy Officer supporting the Board has adapted these actions into a set of SMART (Specific, Measurable, Achievable, Relevant and Time-bound) actions so the Steering Group and the Health and Wellbeing Board can monitor their implementation. The Steering Group approved the action plan at their meeting on 4 May 2017.

## 7. Conclusion

- The Health and Wellbeing Board are invited to approve and own the actions which arose from this year's conference, as outlined in the appendix.

## 8. Appendices

8.1 Appendix A – Supporting Information

8.2 Appendix B – Health and Wellbeing Conference Action Plan

**Appendix A**

# West Berkshire Health and Wellbeing Board Annual Conference – 27 April 2017 – Supporting Information

## 1. Introduction/Background

1.1 The Health and Wellbeing Board held its first conference in November 2015. The purpose was to identify opportunities for further cooperation between member organisations and assist to identify priorities for the Health and Wellbeing Strategy. Speakers from a range of public organisations were invited to give presentations about the key issues which would impact on their services going forwards. Although cooperative relationships between the Board's member organisations were strengthened, there was limited progress in achieving outcome change

1.2 The June 2016 conference was held in the wake of the Peer Review conducted by the Local Government Association (LGA) in March 2016 of the three Health and Wellbeing Boards in Berkshire West. The Peer Review recognised the strong cooperative relationships held between the Board's member organisations and suggested that the Board was ready to include other public sector organisations in its membership (such as Thames Valley Police, Royal Berkshire Fire and Rescue Service).

1.3 In response to the recommendations which arose from the Peer Review, the conference in June 2016 aimed to consider how the wider determinants of health could be incorporated into the Health and Wellbeing Strategy. This conference was successful in channelling the Board members' focus and the following priorities for the Strategy, published in March 2017, were identified:

(1) Reduce alcohol related harm for all age groups.

(2) Increase the number of community conversations through which local issues are identified and addressed.

1.4 The LGA facilitated further development work for the Board over the summer of 2016. The key outcome was that the Board members defined their role going forward as *system leaders*. System leadership means working together in a transformative way to place the user at the centre of service design; basically putting the customer first and the interests of the organisation after. The way in which this new way of working together, in transformation and not just in cooperation, would be implemented was not determined and Board members recognised that there would be barriers such as organisation's reducing resources to name just one.

1.5 A community conversation is a mechanism to solve a problem by identifying the strengths that already exist. Given the Board's focus on community conversations in 2017, the Principal Policy Officer supporting the Board recommended that this approach be used for the next conference. The aim of the Annual Health and Wellbeing Conference held on 27 April 2017 was for attendees to broaden their

understanding of the community conversations approach by applying it to the issue 'How as system leaders do we move from cooperation to transformation?'

## 2. Supporting Information

### Conference Agenda - State of the District

2.1 Dr Anees Pari, the Interim Head of Public Health and Wellbeing at West Berkshire Council, gave an introductory presentation which outlined some of the health inequalities in West Berkshire. He reported that in West Berkshire, performance was significantly above the national average for 84 measures form the Public Health Outcomes Framework. There were seven measures which had significantly worse performance.

2.2 Dr Pari summarised some of the key inequalities in life expectancy in different wards in West Berkshire. There is approximately a ten year difference in life expectancy between the least deprived wards (Bucklebury, Birch Copse) and the most deprived wards (Victoria, Thatcham North).

2.3 These inequalities also extend to hospital stays for alcohol related harm with Lambourn Valley at the top of the fifth quintile for Standard Admission Ratio.

2.4 Dr Pari concluded that while West Berkshire is a relatively affluent district, there are big differences between the health outcomes of different communities. There are excellent opportunities for working together to close the gaps between communities that are doing well and those that need help.

### Conference Agenda - Context Setting

2.5 Cllr Graham Jones and Dr Bal Bahia, Chairman and Vice-Chairman of the Health and Wellbeing Board, outlined that the main recommendations from the Peer Review were to accelerate local improvement to address health inequalities and incorporate the work around community conversations. These recommendations led to the Board identifying their vision as 'The Health and Wellbeing Board will enable communities to become healthier and stronger.'

2.6 They explained that in the development work following on from the Peer Review they came across a term 'system leaders'. This term means that organisations move beyond simple collaboration and work in partnership to transform services around the needs of the service user. They reported that Board members had come across the phrase 'a soup not a salad' which alludes to the way that from the perspective of service users, the public sector organisations want to 'blend' their boundaries we can make the most of the available resources.

2.7 Cllr Jones and Dr Bahia concluded by summarising the Board's new strategy and governance arrangements. The two priorities were identified as reduce alcohol related harm and increase the number of community conversations.

### Conference Agenda - Community Conversations

2.8 Rachael Wardell, Corporate Director – Communities at West Berkshire Council, introduced the topic of community conversations and outlined the elements that make an effective community conversation including the actions, practices and

leading energies. She also explained the ground rules and the different forms they could take.

2.9 The session took place in a fishbowl, which meant there was an inner and an outer circle of chairs. Only people sat in the inner circle of chairs were permitted to speak and moved to the outer circle once they had said what they wished.

2.10 Delegates were invited to consider the following:

(1) What are our strengths?

(2) What do we need?

(3) What gets in the way?

(4) What would "good" transformation look like?

(5) What actions do we propose?

(6) What can we commit to?

2.11 Conference attendees enjoyed an interesting session; feedback from the evaluation forms will be reported verbally at the Health and Wellbeing Board on 25 May 2017.

2.12 The actions that were proposed by the conference attendees to support the aim to move from cooperation to transformation were:

(1) Raise the profile of the Health and Wellbeing Board's work and strategy with existing place based groups such as Parish Councils/ Use the District Parish Conference.

(2) Amend the report template for Board meetings to invite authors to explain how the Board can support them.

(3) Update the Board on community activities which are creating the 'soup'.

(4) Make engagement with the Board easier.

(5) Look at the terminology and branding used by the Board.

(6) Incentivise attendance at community conversations

(7) Focus alcohol strategy on communities with the greatest need so we can have the greatest impact.

(8) Look at examples of good 'soups'.

(9) Write the recipe for 'soup' and assess how far along the salad to soup scale we are.

(10) Commit to putting our entire workforce and resources behind the two priorities.

(11) Increase the visibility of what's working to system leaders.

(12) Delivery Groups needs to be focussed on their impact and outcomes.

2.13 The Principal Policy Officer supporting the Board has adapted these actions into a set of SMART (Specific, Measurable, Achievable, Relevant and Time-bound) actions so the Steering Group and the Health and Wellbeing Board can monitor their implementation. The Steering Group approved the action plan at their meeting on 4 May 2017.

2.14 To adopt action (2) above, this report outlines explicitly how the Health and Wellbeing Board can help to support the content of this report in paragraph 3. The action plan itself also outlines the specific role of the Board members in enabling the implementation of each of the identified actions.

## 3. Conclusion

3.1 In the three years that the Health and Wellbeing Board's Annual Conference has been running, its purpose has evolved in recognition of the Health and Wellbeing Board's evolving role. The focus has matured from working in collaboration to building on the recognised strong relationships between organisations to transform services to meet the needs of service users.

3.2 Strong communication and engagement with the communities in West Berkshire will be essential to the success of working to meet needs of service users. The Board will need to ask them what their needs are and how they want their public services to meet those needs. The Board's Patient and Public Engagement Group will own many of the actions in the appended action plan and work with the Board's other sub-groups to coordinate effective consultation with West Berkshire's residents.

3.3 The Health and Wellbeing Board are invited to approve and own the actions which arose from this year's conference, as outlined in the appendix.

## 4. Consultation and Engagement

4.1 Health and Wellbeing Steering Group, Jenny Legge (Principal Policy Officer – Research, Performance and Consultation), Nick Carter, Rachael Wardell, Andrea King, Susan Powell

**Background Papers:**

**Health and Wellbeing Priorities 2017 Supported:**

☐ Reduce alcohol related harm for all age groups
☐ Increase the number of Community Conversations through which local issues have been identified and addressed

**Health and Wellbeing Strategic Aims Supported:**

The proposals will help achieve the following Health and Wellbeing Strategy aim(s):

☐ Give every child the best start in life
☐ Support mental health and wellbeing throughout life
☐ Reduce premature mortality by helping people lead healthier lives
☐ Build a thriving and sustainable environment in which communities can flourish
☐ Help older people maintain a healthy, independent life for as long as possible

The proposals contained in this report will help to achieve the above Health and Wellbeing Strategy aim and priority by

**Officer details:**

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|---|---|
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# Appendix A Health and Wellbeing Conference Action Plan

| Conference Action | SMART action | Support required from HWBB | Owner |
|---|---|---|---|
| Raise the profile of the Health and Wellbeing Board's work and strategy with existing place based groups such as Parish Councils/ Use the District Parish Conference. | Contact all Parish Councils to request a 20 minute slot at a meeting to explain the HWBB priorities and how PCs can support the HWBB's work (by July 2017) | Individual members to identify availability to represent the HWBB at Parish Council meetings. | PPE/ Jo Reeves |
| Amend the report template for Board meetings to invite authors to explain how the Board can support them. | Include the heading 'How the Health and Wellbeing Board can help' in the report template for Board meetings in time for the July meeting. | HWBB members to take a 'high support, high challenge' approach to considering reports. | Jo Reeves |
| Update the Board on community activities which are creating the 'soup'. | In each update report to the HWBB in 2017, include examples of activities which demonstrate an integrated approach. | HWBB members to identify and share good examples of integrated working with communities. | BCT |
| Make engagement with the Board easier. | Develop a HWBB web page, including a contact form for public to submit queries on any HWB issue. | Once developed, all HWBB members to promote the webpage by inclusion in email signatures. | PPE |
| Look at the terminology and branding used by the Board. | Develop a logo for the HWBB by September 2017 | Encourage colleagues to use the logo on appropriate material | PPE |
| Incentivise attendance at community conversations | Evaluate the potential effectiveness of monetary incentivisation for attendance at community conversations (by end of 2017) | HWBB members to influence organisations to resource this work. | BCT |
| Focus alcohol strategy on communities with the greatest need so we can have the greatest impact. | Cross reference data of all partners to identify areas with greatest alcohol need/ burden of services and prioritise delivery of IBA and Blue Light to those areas. | HWBB members to ensure organisations share data. | AHRP |
| Look at examples of good 'soups'. | By the end of the year, invite representatives from a good practice HWBB to a Problem Solving Session to identify what we can learn from them. | HWBB members to prioritise attendance at the session. | Jo Reeves |
| Write the recipe for 'soup' and assess how far along the salad to soup scale we are. | Give a presentation to the HWBB regarding current good practice and opportunities for development. | HWBB members to identify what their vision for integration is. | Steering Group/ Locality Integration Board |
| Commit to putting our entire workforce and resources behind the two priorities. | Identify strategies/ operational plans due to be updated that can be aligned to the HWB priorities and amend by March 2018. | All HWBB members to influence organisational priorities to support the HWB strategy. | HWBB |
| Increase the visibility of what's working to system leaders. | Forward Plan to include update from a sub-group to provide opportunity to share successes and identify areas of improvement. | HWBB members to feed back good practice examples. | Steering Group |
| Delivery Groups needs to be focussed on their impact and outcomes. | Sub-groups to include outcome targets and measures on Delivery Plan by end of May 2017. | HWBB members to challenge delivery plans with insufficient outcomes focus | Steering Group |

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# Berkshire West CCGs Cancer Framework 2016-2020 - Summary Report

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|---|---|
| **Committee considering report:** | Health and Wellbeing Board |
| **Date of Committee:** | 25 May 2017 |
| **Portfolio Member:** | Cllr James Fredrickson |
| **Report Author:** | Shairoz Claridge |

## 1. Purpose of the Report

1.1 To communicate to the Health and Wellbeing Board the plan for locally delivering the national cancer strategy and to confirm any involvement from Health and Wellbeing members especially around the prevention element of the framework.

## 2. Recommendation

2.1 Confirmation of involvement of Health and Wellbeing Board members in delivery of the strategy.

## 3. Implications

| | | |
|---|---|---|
| 3.1 | **Financial:** | None |
| 3.2 | **Policy:** | None |
| 3.3 | **Personnel:** | None |
| 3.4 | **Legal:** | None |
| 3.5 | **Risk Management:** | None |
| 3.6 | **Property:** | None |
| 3.7 | **Other:** | None |

## 4. How the Health and Wellbeing Board can help

4.1 Commit to delivering the strategy.

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|---|---|---|
| **Will the recommendation require the matter to be referred to the Executive for final determination?** | Yes: ☐ | No: ☒ |

# Executive Summary

## 5. Introduction / Background

- More than one in three people in the UK will develop cancer and half will now live for at least ten years – forty years ago the average survival was just one year. But for some cancers, patients are being diagnosed late so that some survival rates are below the European average. There is also variability in access to and experience of care across different areas.

- The National Audit Office has estimated cancer services cost the NHS approximately £6.1 billion per annum in 2012/2013. The Five Year Forward View projections indicate that this will grow by about 9% a year, implying a total of £13 billion by 2020/2021.

- In January 2015 NHS England announced that a new independent taskforce would be established to develop a five-year action plan for cancer services to improve survival rates and save thousands of lives.

- The taskforce were asked to deliver the vision set out in the NHS Five Year Forward View, which calls for action on three fronts: better prevention; swifter diagnosis; and better treatment, care and aftercare for all those diagnosed with cancer. In July 2015 the taskforce released their report “Achieving World Class Cancer Outcomes. A Strategy for England 2015-2020”.

- The Berkshire West framework has been jointly developed with stakeholders from Berkshire West Clinical Commissioning Groups, Royal Berkshire Foundation Trust, Public Health, Thames Valley Strategic Cancer Network, Macmillan and Cancer Research UK to improve the outcomes for people affected by cancer in Berkshire West. Through this framework it is intended to deliver the strategic priorities outlined in “Achieving World-Class Cancer Outcomes: A Strategy for England” and the national “must dos” in the Planning Guidance for 2017/2019.

- The framework includes a series of initiatives across the patient pathway emphasising the importance of earlier diagnosis and of living with and beyond cancer in delivering outcomes that matter to patients.

- Working with all the stakeholders the Berkshire West Cancer Steering Group have identified and prioritised work streams and expected outcomes that will be implemented to deliver the local strategic priorities.

- Detailed action plans and project groups have been developed for each of the work streams and the Berkshire West Cancer Steering Group has oversight on all the work streams and is accountable to the Planned Care Programme Board.

## 6. Conclusion

- Health and Wellbeing members are requested to review the information provided and consider if involvement is required from the Board members to support the prevention element of the framework.

## 7. Appendices

7.1 Appendix A – Berkshire West Cancer Framework

7.2 Appendix B – Berkshire West Cancer Framework Plan on a Page

7.3 Appendix C - Achieving World-Class Cancer Outcomes: A Strategy For England 2015-2020

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