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Date of issue: Tuesday, 15 March 2016

MEETING:	**SLOUGH WELLBEING BOARD** Councillor Rob Anderson, Leader Naveed Ahmed, Business Representative Ruth Bagley, Chief Executive Superintendent Simon Bowden, Thames Valley Police Iain Harrison, Royal Berkshire Fire and Rescue Service Councillor Sabia Hussain, Health & Wellbeing Commissioner Ramesh Kukar, Slough CVS Lise Llewellyn, Strategic Director of Public Health Dr Jim O'Donnell, Slough Clinical Commissioning Group Les O'Gorman, Business Representative Krutika Pau, Interim Director of Children's Services Colin Pill, Healthwatch Representative Rachel Pearce, NHS Commissioning Board Representative Alan Sinclair, Interim Director Adult Social Services
DATE AND TIME:	WEDNESDAY, 23RD MARCH, 2016 AT 5.00 PM
VENUE:	VENUS SUITE 2, ST MARTINS PLACE, 51 BATH ROAD, SLOUGH, BERKSHIRE, SL1 3UF
DEMOCRATIC SERVICES OFFICER: (for all enquiries)	NICHOLAS PONTONE 01753 875120

NOTICE OF MEETING

You are requested to attend the above Meeting at the time and date indicated to deal with the business set out in the following agenda.

RUTH BAGLEY
Chief Executive

sustainable forest

AGENDA ITEM	REPORT TITLE	PAGE	WARD

AGENDA

PART I

Apologies for absence.

CONSTITUTIONAL MATTERS

1. Declaration of Interest

   All Members who believe they have a Disclosable Pecuniary or other Pecuniary or non pecuniary Interest in any matter to be considered at the meeting must declare that interest and, having regard to the circumstances described in Section 3 paragraphs 3.25 – 3.27 of the Councillors' Code of Conduct, leave the meeting while the matter is discussed, save for exercising any right to speak in accordance with Paragraph 3.28 of the Code.

   The Chair will ask Members to confirm that they do not have a declarable interest.

   All Members making a declaration will be required to complete a Declaration of Interests at Meetings form detailing the nature of their interest.

2. Membership Update

   To welcome Iain Harrison to the Board representing RBFRS, and to formalise the membership of Alan Sinclair (Interim Director of Adult Social Services) and Krutika Pau (Interim Director of Children's Services) as statutory members.

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12.	Date of Next Meeting *11th May 2016*		

Press and Public

You are welcome to attend this meeting which is open to the press and public, as an observer. You will however be asked to leave before the Committee considers any items in the Part II agenda. Please contact the Democratic Services Officer shown above for further details.

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Slough Wellbeing Board – Meeting held on Thursday, 21st January, 2016.

Present:- Councillors Anderson (Chair) and Hussain, Naveed Ahmed, Ruth Bagley, Supt Bowden, Ramesh Kukar, Lise Llewellyn, Les O'Gorman, Dave Phillips and Sangeeta Saran (deputising for Jim O'Donnell

Apologies for Absence:- Rachel Pearce, Colin Pill and Jane Wood

PART 1

47. Declarations of Interest

No declarations were made.

48. Minutes of the last meeting held on 11th November 2015

Resolved – That the minutes of the meeting held on 11th November 2015 be approved as a correct record.

49. Slough Youth Parliament

The Board received a presentation from representatives of the Slough Youth Parliament about their campaign to reduce the stigma around young people's mental health needs.

The Youth Parliament had been established in January 2015 and comprised of 34 young people aged between 12-19 elected through schools and colleges. The Parliament had been involved in the development and consultation on a number of local strategies that effected children. They had co-ordinated the local response to the UK Youth Parliament's 'Make Your Mark' ballot that selected key priorities for young people and mental health had been identified as one of the priority campaigns for 2016 with a Slough Youth Parliament representative participating in a debate held in the House of Commons in November. Mental health was also included in the Slough Youth Parliament's manifesto that had been circulated with the report.

The campaign aimed to reduce stigma around young people's mental health needs. It was estimated that 1 in 10 children aged 5-16 suffered from a diagnosable mental health condition and half of all adults with mental health problems were diagnosed in childhood, but had often not received appropriate treatment. On average there were 120 referrals a week from GPs in Berkshire to the CAMHS common point of entry, with waiting times of at least a year for young people awaiting diagnosis for ASD & ADHD. Young people were working with the public health team on anti-stigma issues and had been consulted on the new THRIVE mental health programme.

The presentation highlighted a number of recommendations arising from the Youth Parliament's campaign:

- The need for counselling in Slough;
- Improved training in mental health for professionals working with young people;
- Introduction of Mental Health Champions in schools;
- Improved understanding and awareness of LGBT issues.

The Board congratulated the Youth Parliament on their work in a range of areas in the past year, including on mental health issues. It was recognised that the Board, and partners more generally, needed to better understand the perceptions of young people with regards to mental health. Members asked a range of questions about the support needs of parents and families. It was recognised that there was a need to educate and raise awareness amongst parents and it was suggested making greater use of parent's evenings in schools. Youth Parliament representatives confirmed that they were preparing a list of recommendations for the Slough Association of Secondary Heads and that funding for counselling services was a key issue. The Board also discussed the difficulties in tackling LGBT issues, particular given the prevalence of homophobic bullying. These issues were acknowledged but it was also indicated that young people were generally more willing to open up and champion such issues, for example there was an active LGBT group at the college.

The Board were asked to support the campaign for schools to train more staff in 'Mental Health First Aid'. It was reported that additional NHS and CCG funding had recently been secured for such activity and there was a comprehensive programme of activity as part of the wider CAMHS strategy.

At the conclusion of the discussion, the Board congratulated all of those involved in the Slough Youth Parliament for their achievements in the past year and particularly for their important campaign on mental health issues. The Board formally endorsed this work and noted the recommendations emerging from the campaign.

Resolved –

(a) That the work being undertaken by the Slough Youth Parliament in campaigning on young people's mental health issues be endorsed.

(b) That the recommendations arising from the Slough Youth Parliament's campaign be noted.

50. Mental Health Street Triage Pilot for East Berkshire

Chief Inspector Wong introduced a report regarding the introduction of a pilot mental health street triage service across Slough, Windsor, Ascot, Maidenhead and Bracknell from 1st April 2016. The proposal utilised the evidence base from the current street triage pilot operating in Oxfordshire and West Berkshire.

The proposed service consisted of a police officer and mental health practitioner able to provide a rapid response capability between 5.00pm and 1.00am, 5 days per week, to provide a triage assessment and signpost the most appropriate pathway for people with a mental health incident who came to the attention of the Police. The aim of the service was to avoid unnecessary detentions under s136 of the Mental Health Act, some of which resulted in people being detained in police cells which was recognised as not being appropriate for a person suffering from a mental health condition. The model adopted in the West Berkshire pilot area demonstrated improved care for individuals facing mental health crisis and time and savings costs across services. It was noted that East Berkshire was the only area in the Thames Velley without a street triage team. Demand for s136 provisions at Prospect Park had risen by 33% across Berkshire between 2013/14 and 2014/15 with 153 cases from East Berkshire. The proposed operation and business case, as set out in paragraphs 5.6 to 5.10 of the report was summarised, and the Board was asked for their support for the pilot to help secure the funding required from partners.

The Board asked a number of questions about the length and cost of the pilot and the relative benefits to partners in terms of cost savings. The pilot would last for a year and cost approximately £136k depending on the final model adopted. The benefits of the approach included a reduction in s136 detentions, reduced use of police custody, relieved pressure on AMHP service and s12 doctor demand and a reduction in police time spent on mental health incidents. Whilst it was difficult to accurately quantify the exact benefits in terms of cost savings across services it was recognised that early intervention resulted in better long term outcomes for patients and reduced demand for other services. One of benefits to Slough residents of the pilot would be to reduce transit to Prospect Park and treat people closer to their home where possible.

The Board recognised the likely benefits to individuals in mental health crisis and the potential cost savings to public sector partners in delivering services more efficiently. It was therefore agreed that the Board support the introduction of the street triage pilot in East Berkshire.

Resolved – That the Board support the introduction of a mental health street triage pilot scheme for East Berkshire to commence on 1 April 2016.

51. Cumberland Initiative

The Board received a presentation from Professor Terry Young on the work of the Cumberland Initiative whose vision was: “to transform the quality and cost of NHS care delivery through simulation, modelling and systems thinking”. The Initiative had set up a ‘living lab’ in Slough for clinicians and managers to simulate scenarios in a busy A&E department to help model and plan services.

The Board welcomed the work that the Cumberland Initiative was doing in Slough and suggested a number of potential opportunities to help model, design and plan health and wellbeing services locally. These included:

- Public health applications to model the different approaches and pathways that could be taken to better plan and deliver programmes e.g. the Global Burden of Disease modelling to understand back pain.

- Explore the potential to use shared health data and models to understand and improve services e.g. to investigate the determinants of longevity and help to shape future services by understanding the interventions that had the maximum impact.

- Utilising the expertise to assist with demand management analysis to design primary care and acute services in the most efficient way.

Partners agreed to consider the opportunities within their own organisations to work with the Initiative and it was noted that the CCG already had meetings planned. It was proposed and agreed that Lise Llewellyn take the lead on behalf of the Board in working with the Cumberland Initiative to explore these and any other opportunities.

Resolved –

(a) That Professor Young be thanked for his presentation and that the work of the Cumberland Initiative in Slough be welcomed.

(b) That further consideration be given to identifying the practical opportunities for the Cumberland Initiative and Slough Wellbeing Board to work together to improve the planning, design and efficiency of health and wellbeing services.

(c) That Lise Llewellyn lead the exploration of practical opportunities to work with the Cumberland Initiative and that the Board be informed of progress in due course.

52. Slough Borough Council Five Year Plan 2016/20

The Board received an information report on Slough Borough Council's revised Five Year Plan 2016-20. The plan set a clear strategic direction for the Council and helped partners to understand its priorities for the future and links to the new Slough Joint Wellbeing Strategy which would also be refreshed during 2016.

Resolved – That the refreshed draft Council Five Year Plan as attached at Appendix A to the report be noted.

53. Slough Wellbeing Board's Annual Report 2015/16

An information report was received on the development of the Wellbeing Board's Annual Report which was attached at Appendix A to the report. The draft focused on 2015/16 but also included activity since the inception of the Board as its first full Annual Report. The document would be circulated amongst partners and the Priority Delivery Groups and any comments should be provided to the Council policy team. A number of suggestions were made including the inclusion of case studies e.g. BCF, and the need for a succinct, plain English summary to clearly communicate the work of the Board.

Resolved –

(a) That the report be noted.

(b) That Board Members provide any drafting suggestions or further points for inclusion to Council policy team as soon as possible after the meeting.

54. Six Month Review of the Wellbeing Board's Overarching Information Sharing Protocol and it's Protocol with the Slough Local Children's and Adult's Safeguarding Boards

An information report was received setting out progress over the past six months of the Board's Overarching Information Sharing Protocol (OISP) and its protocol with the children's and adults safeguarding boards. It was considered that the arrangements were working well since being formally adopted by the Board in July 2015, however, some partners had not yet formally signed the OISP. The Board agreed that information sharing was crucial to successful partnership working and it was agreed that those partners who had not signed the document should do so as soon as possible.

Resolved –

(a) That the six month update be noted.

(b) That the four partners that had yet to formally sign the protocol agreed by the Board in July 2015 do so as an urgent priority.

55. Action Progress Report and Future Work Programme

The Board considered the Action Progress Report and Future Work Programme and were invited to suggest any improvements to the current format of the report. A number of comments were made including the use of RAG ratings and a clearer focus on priority outcomes or actions that were outstanding.

Resolved – That the Action Progress Report and Future Work Programme be noted and the suggestions for improvement be considered.

56. Attendance Report

Resolved – That the attendance record 2015/16 be noted.

57. Date of Next Meeting

Dave Phillips indicated that this would be his final Board meeting as he would shortly be retiring from the Royal Berkshire Fire & Rescue Service. The Board thanked Dave Phillips for his contribution to the Slough Wellbeing Board and to local partnership working more widely. The new fire service representative would be confirmed in due course.

Resolved –

(a) That Dave Phillips be thanked for his contribution to the Slough Wellbeing Board.

(b) That the next meeting be confirmed as 23rd March 2016.

Chair

(Note: The Meeting opened at 5.05 pm and closed at 6.48 pm)

SLOUGH BOROUGH COUNCIL

REPORT TO: Slough Wellbeing Board **DATE:** 23 March 2016

CONTACT OFFICER: Alan Sinclair, Interim Director of Adult Social Services
Mike Wooldridge, Better Care Fund Programme Manager

(For all Enquiries) (01753) 875752

WARD(S): All

PART I
FOR COMMENT & CONSIDERATION

BETTER CARE FUND (BCF) QUARTERLY REPORT AND INTEGRATION STRATEGY

1. Purpose of Report

The purpose of this report is to update the Slough Wellbeing Board (SWB) on developments of the Better Care Fund (BCF). It summarises:

i) The position of the 2015/16 programme at the end of the third quarter
ii) The planning requirements and proposal for Slough's 2016/17 BCF plan
iii) Requirements and first steps towards developing an integration strategy by March 2017

2. Recommendation(s)/Proposed Action

The SWB is asked to:

a) Note this progress report of the Better Care Programme for 2015/16 and

b) Approve the proposed outline plan for the BCF for 2016/17 and to

c) Give delegated authority to the BCF Joint Commissioning Board for sign off of the final plan to be submitted by 25 April 2016.

3. The Slough Joint Wellbeing Strategy, the JSNA and the Five Year Plan

3a. Slough Joint Wellbeing Strategy Priorities

The Better Care Fund programme being planned and managed between the local authority and CCG together with other delivery partners aims to improve, both directly and indirectly, the wellbeing outcomes of the people of Slough against all the priorities of the strategy but especially the Health priority.

3.1.2 It will do this through an approach that promotes people's wellbeing, empowering people and families in ways that will prevent and postpone the need for care and support, and put people in control of their lives so they can pursue opportunities underpinned by the theme of civic responsibility.

3.1.3 The BCF programme encompasses a range of activities which focus on diversion from A&E and increasing community based support services. These services improve health and wellbeing outcomes for people in Slough. The plan seeks to address key cross cutting themes such as prevention, early intervention and management of conditions which limit inclusion.

3b. Five Year Plan Outcomes

The Better Care programme will contribute towards the outcome of more people taking responsibility and managing their own health, care and support needs.

4. Other Implications

(a) Financial

The Better Care programme has financial implications for the Council and the CCG for the following reasons:

- BCF and its role in starting the delivery of a wider integration agenda is key in its contribution to managing ongoing financial and demographic pressures facing Councils and the NHS
- It combines CCG and SBC funding into a pooled budget which subsequently brings changes in governance and sharing risks related to the identified funds
- It links to delivery of elements of the Care Act and new health and social care responsibilities
- It aims to release funding from the hospital sector over the next 5 years through building capacity in 'out of hospital' community based services
- Costs arising from an escalation of non-elective admissions into the acute sector hospitals if not successful in delivering the above

The minimum BCF pooled budget for Slough in 2016/17 will be £9,034m of health and social care funding. This is an increase of £272k on last year's pooled budget of £8,762m. £5,728m of this expenditure is social care related services. The draft expenditure plan for 2016/17 is included in appendix one.

Building the evidence case and monitoring scheme activity to ensure they deliver financial benefits across the programme is an integral part of the governance process and so the expenditure plan is subject to change within the year under the agreement of the voting members of the Joint Commissioning Board.

(b) Risk Management

Risks to the programme are reviewed and managed within the risk register which is overseen and reviewed by the BCF Joint Commissioning Board with escalation to Slough Wellbeing Board, CCG Governing Body and SBC Cabinet as appropriate.

The BCF Plan has provisionally identified funding within the pooled budget as contingency to cover areas of risk. There is no Payment for Performance element to BCF in this year against non-elective (unplanned) admissions to hospital but instead a requirement to agree investment in NHS commissioned out of hospital services and/or put a proportion of the fund into a local risk sharing agreement. In the proposed draft the total value of the NHS commissioned out of hospital services is £2,640m together with £800k funding held as risk share to ensure value to the NHS.

Risk	Mitigating action	Opportunities
Legal	A Section 75 (Pooled Budget) agreement in place for 2016/17 by 30 June 2016.	Improved joint working and better value for money.
Property	None	None
Human Rights	Engage residents and service users in BCF development.	Improved wellbeing for residents and positive experience of services.
Health and Safety	None	None
Employment Issues	Full formal consultations will be carried out with staff over changes as and where required.	Improved joint working and better value for money.
Equalities Issues	EIA will be carried out in respect of individual projects and schemes and any proposed changes.	Improved wellbeing for all residents.
Community Support	Engage communities in the development of BCF related activities.	Improved joint working and better value for money.
Communications	Utilise communication functions to keep stakeholders up to date.	Better understanding of BCF and health and wellbeing in Slough.
Community Safety	Engage community safety services in development of BCF related activities.	Improved joint working and better value for money.
Financial	Robust risk and project management in place.	Improved joint working and better value for money.
Timetable for delivery	Timetable agreed with SWB, CCG and SBC. Programme managed to deliver on agreed milestones on time.	Improved joint working.
Project Capacity	BCF Programme Manager for Slough in post	Improved joint working and better value for money.
Acute Sector.	Acute sector representatives are part of planning and delivery of BCF activities.	Improved joint working and better value for money.

(c) Human Rights Act and Other Legal Implications

No Human Rights implications arise.

There are legal implications arising from how funds are used, managed and audited within a Pooled Budget arrangement under section 75 of the NHS Act 2006.

The Care Act 2014 provides the legislative basis for the Better Care Fund by providing a mechanism that allows the sharing of NHS funding with local authorities.

(d) Equalities Impact Assessment

The BCF aims to improve outcomes and wellbeing for the people of Slough through effective protection of social care and integrated activity to reduce emergency and urgent health demand. Impact assessments are undertaken as part of planning of any new scheme or project to ensure that there is a clear understanding of how various groups are affected.

(e) Workforce

There are significant workforce development implications within the programme as we move forward with integration which leads to new ways of working in partnership with others. Changes will be aligned together with other change programme activities such as that described in the New Vision of Care being led across the East of Berkshire and the Social Care reforms within SBC.

This will include moving towards a joint asset based approach to care planning and empowering individuals to actively participate and manage their care. Staff working in multidisciplinary teams will have greater understanding of their responsibilities and boundaries and that of other professionals they work alongside in order to use their expertise and other networks around the individual.

5. Supporting Information

5.1 National Policy context

A revised BCF Policy Framework has been published for 2016/17 which includes key changes for next year. These are:

- Payment for Performance Framework removed and replaced with 2 new National Conditions
    1. Requirement to use to monies previously allocated to 'Payment of Performance' for investment in NHS Out of Hospital Services (including Social Care)
    2. A jointly agreed system-wide action plan for reducing Delayed Transfers of Care
- A reduced amount of detail required for the assurance process

It is important also that BCF Plans are aligned with other programmes of work including new models of care which form part of the Sustainability and Transformation Plan, set out within the NHS Five Year Forward Plan and delivery of 7-day services.

The timetable for submission of plans has been tight between the issuing of the detailed technical guidance and templates and the deadlines for submission.

NHS Planning Guidance for 2016-17 issued	22 Dec 2015
Technical Annexes to the planning guidance issued	19 Jan 2016
BCF Planning Requirements; Planning Return template, BCF Allocations published	Feb 2016
First submission 9following CCG Operating Plan submission on 8 Feb) agreed by CCGs and local authorities	2 March 2016
Second submission following assurance and feedback to consist of: Revised BCF planning return High level narrative plan	21 March 2016
Assurance status of draft plans confirmed	By 8 April
Final BCF plans submitted, having been signed off by Health and Wellbeing Boards	25 April 2016
All Section 75 agreements to be signed and in place	30 June 2016

As for last year the BCF plans for 2016/17 need to:

- Be jointly agreed and signed off by the Health and Wellbeing Board by Monday 25 April 2016.
- Maintain provision of social care services (setting a level of protection for social care to ensure that changes do not destabilise the local social and health care system as a whole)
- Provide 7 day services that prevent unnecessary admissions and support timely discharge of patients
- Improve data sharing between health and social care based on the NHS number
- Ensure a joint approach to assessment and care planning
- Include agreement on consequential impact on providers predicted to be substantially affected by the plans
- Include agreement to invest in NHS commissioned out of hospital services (including a wide range of services, including social care)

Other key outcome measures remain the same as for 2015/16 although targets for each will be revised and there is opportunity for wellbeing board areas to review or revise their local performance metric and their locally defined patient experience metric.

Within the NHS Planning Guidance 'Delivering the forward view' 2016/17 – 2020/21 it sets out that overall 2020 goal is that areas will achieve better integration of health and social care in every area of the county and eventually 'graduate' from the BCF programme once they can demonstrate they have moved beyond its requirements. One of the required deliverables in 2016/17 is that each area will have an agreed action plan by March 2017 for better integrating health and social care.

5.2 Local position

5.2.1 Performance in Quarter 3 2015/16

Slough has performed well overall in its performance against both the national conditions and metrics for BCF.

At the end of Q3 (Oct-Dec 2015) non-elective admissions activity was only 340 above our 2015 target or 16,244 and this is 1.4% below the baseline set in 2014 (16,825).

Whilst achieving a reduction in NELs should have released contingency funding to invest in other jointly agreed activity this has not happened in this year due to a several factors which are being explored further in order to reconcile and understand. Part of this is that payments to acute hospital services are set by tariff and agreed in contracts well in advance of the beginning of the year and therefore reduction in activity does not necessarily reduce cost.

The programme has also continued to perform well against other metrics, including:

- Admissions to residential care which are on target to be at or below 77 (a rate of 552 per 100,000) against an increase in population.
- Discharge from hospital into reablement services continue to have a very high success rate on or near 100% still at home 91 days after discharge and also on track to meet target

Delayed transfers of care activity (DToCs) has been volatile with peaks and troughs through the year and in Q3 was 30% above planned activity, this being a total of 645 delayed days above the target figure of 496. This is still relatively small numbers of numbers of people and low in comparison with the national picture. Each wellbeing board is required to have an agreed plan for improvement for 2016/17 as part of the BCF submission and this is in development.

The BCF is on target in terms of its financial forecast and will come in on budget for this year. There has been some underspend identified within areas of the planned activity due to either delay in implementation (arising from capacity and complexity taking forward larger projects), or to business cases not being approved to take forward. This has led to some reinvestment of funds to support other pilot or project work in this year but also agreement to approximately £700k of underspend (not including the contingency) being split between CCG and SBC in contribution to offsetting overspends in both organisations in this year.

5.2.2 BCF Plan for 2016/17

The BCF delivery group used the BCF self-assessment tool to review and evaluate how schemes have progressed and delivered against the metrics in 2015/16 and so help plan towards 2016/17. Through this process we have:

- identified areas of activity that are performing well and how we want to build and develop these
- identified projects that have been slower to get off the ground and what might help in terms of resource and/or linking and scheduling with other planned project activity and
- identified areas which have not performed so well and are taking steps to further review, evaluate or redesign

Several of our projects have been evaluated in detailed impact on the individual cohorts of people and have demonstrated significant impact and return on investment. These include:

Paediatric Non-Elective admissions	Slough has focused in this area in recognition that significant NEL activity is from u18s, particularly around asthma and respiratory problems. Changes in the way that this are managed at practice level and supported by Community Respiratory Nurses have reduced by 14% from our April 2014 baseline. (YTD £268k saving)
Care Homes	There has been a pilot project of a bespoke programme for local Care Homes together with additional GP support which has delivered significant reductions in NEL from Care Homes (up to 50%) as well as providing improved quality of care and positive patient and family experience.(YTD saving 324k)

Telehealth	A small pilot project which has been targeted at patients with COPD and HF and has seen marked reduction in NEL and outpatient follow up. This is giving significant return on investment, as well as having positive feedback from patients and giving additional capacity community nursing staff as a result (delivered a return on investment and £8k saving)
Falls Prevention	This pilot project has been commissioned with Solutions for Health and whilst only operating a few months has started to demonstrate impact against admissions due to falls, currently 9% below our April 2014 baseline.

Where there has been some underspend from slippage in other areas of BCF some of this has been reinvested, through shared decision making of the Joint Commissioning Board, in order to pilot other areas of work in this year and into 2016/17. These include:

Complex Case Management	Using AGC tool to carry out risk stratification and support GPs in identifying and supporting those at risk. This is already showing to have an impact in the first two months of activity.
Responder service	Providing a quick response to people in need who use Care line services as an alternative to ambulance callouts

Within the programme there are also been areas of activity that have not performed so well and these we have either closed for reinvestment or redesigning. These include:

PACE (post acute reablement)	This service was closed in May 2015 and the money reinvested back in the pooled fund
PCICT(Primary Care Integrated Cluster Teams)	This service is being reviewed to remodel the referral pathways and criteria, linking in with our Complex Case Management and Telehealth schemes.

Looking ahead to 2016/17 the Slough BCF programme will continue broadly with its current programme of activity within the present governance structure and identified workstreams. We recognise that although there are some areas of integrated working within our projects and schemes we want to push onwards with some larger change projects within the ambition of our plan.

Our priority schemes within BCF for 2016/17 will see significant progress towards health and social care integration and will be designed and developed to the 'New Vision of Care' model within a co-ordinated and integrated system.

For this year this means BCF bringing focus on the following key areas:

- Establishing our integrated point of referral for professionals into short term services through the existing Health Hub
- Out of Hospital transformation through the integration of our Intermediate Care and short-term services.

These are being taken forward as separate, but linked projects, which together will ensure rapid access to a range of care and support out of hospital which are

accessed through a single route. This will include having a shared assessment and care planning process, a remodelling of PCICT, a shared plan for reducing DToC and exploring models of Discharge to Assess.

5.2.3 Towards integration

Slough hosted a workshop on 23 February inviting partner organisations and patient representatives from across the East Berkshire health and social care system to have shared discussions that will help start to inform our plans for integration by 2020.

The workshop set out the context in which we need to consider and build our integration plans which include not only BCF but the New Vision of Care Model developed across the East of Berkshire and our emerging Sustainability and Transformation Plans (STPs). In order to successfully integrate we will need to look to do this across a much wider footprint than that of the Wellbeing Board and in partnership with our community and health providers.

The workshop then had table discussions with groups of representatives to explore further questions of:

- What we mean by integration?
- Where we are now, and what are the barriers?
- What would a joint approach look like?

There was very good engagement and enthusiasm from all those present and this was recognised in the positive feedback. There was overall a joint recognition from all about what needs to be done in terms of shared objectives and outcomes, and a real willingness to do this together across the system. We are now looking at next steps to build on these first steps and the commitment to taking it forward together.

6. Comments of Other Committees

None

7. Conclusion

This report provides an update on the position of the Slough BCF programme for this year and outlines the approach and priorities being taking forward in the planning of the BCF programme in 2016/17.

Overall Slough has achieved improvements in reducing NEL activity in several schemes and overall against its planned targets for 2016/17. By 25 April we will have produced and updated a refreshed plan for 2016/17 which will build on what has been working well as well as taking forward the larger scale integration projects outlined within the initial plan in September 2014.

The plan will continue to be actively managed through the Joint Commissioning Board with regular progress updates to the Wellbeing Board.

We will continue to engage and plan together with our neighbouring areas in order to have an agreed plan for integration by March 2017.

8. **Appendices Attached**

‘A’ Template showing draft expenditure plan for BCF 2016/17

9. **Background Papers**

‘1’ Delivering the Forward View: NHS Planning Guidance 2016/17 – 2020/21

‘2’ 2016/17 Better Care Fund Policy Framework (Jan 2016)

‘3’ Better Care Fund Planning Requirements for 2016/17 (Feb 2016)

Template for BCF submission 1: due on 02 March 2016

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

Selected Health and Well Being Board:

Slough

	Expenditure									
Scheme Name	Scheme Type (see table below for descriptions)	Please specify if 'Scheme Type' is 'other'	Area of Spend	Please specify if 'Area of Spend' is 'other'	Commissioner	Provider	Source of Funding	2016/17 Expenditure (£)	New or Existing Scheme	Total 15-16 Expenditure (£) (if existing scheme)
Enhanced 7 day working	7 day working		Other	To be determined	CCG		CCG Minimum Contribution	£99,000	Existing	£99,000
Complex Case Management	Personalised support/ care at home		Primary Care		CCG	CCG	CCG Minimum Contribution	£60,000	Existing	£60,000
Falls Prevention	Personalised support/ care at home		Other	Independent provider	Local Authority	Private Sector	CCG Minimum Contribution	£50,000	Existing	£50,000
Footcare	Personalised support/ care at home		Other	Charity/voluntary sector	CCG	Charity/Voluntary Sector	CCG Minimum Contribution	£14,000	Existing	£14,000
Stroke	Personalised support/ care at home		Other	Charity/voluntary sector	Local Authority	Charity/Voluntary Sector	CCG Minimum Contribution	£50,000	Existing	£50,000
Dementia Care Advisor	Personalised support/ care at home		Other	Charity/voluntary sector	Local Authority	Charity/Voluntary Sector	CCG Minimum Contribution	£30,000	New	
Children's Respiratory Care	Personalised support/ care at home		Acute		CCG	NHS Acute Provider	CCG Minimum Contribution	£95,000	Existing	£88,000
Proactive Care (children)	Personalised support/ care at home		Other	To be determined	CCG		CCG Minimum Contribution	£177,000	Existing	£177,000
Single Point of Access	Integrated care teams		Community Health		CCG	NHS Mental Health Provider	CCG Minimum Contribution	£200,000	Existing	£50,000
Telehealth	Assistive Technologies		Social Care		Local Authority	Private Sector	CCG Minimum Contribution	£50,000	Existing	£25,000
Telecare	Assistive		Social Care		Local Authority	Private Sector	CCG Minimum	£62,000	Existing	£62,000

	Technologies						Contribution			
Disabled Facilities Grant	Personalised support/ care at home		Social Care		Local Authority	Private Sector	Local Authority Social Services	£775,000	Existing	£407,000
RRR Service (reablement and intermediate care)	Reablement services		Social Care		Local Authority	Local Authority	CCG Minimum Contribution	£2,184,000	Existing	£2,184,000
Joint Equipment Service	Personalised support/ care at home		Social Care		CCG	Private Sector	CCG Minimum Contribution	£793,000	Existing	£533,000
Nursing Care Placements	Improving healthcare services to care homes		Social Care		Local Authority	Private Sector	CCG Minimum Contribution	£400,000	Existing	£400,000
Care Homes - enhanced GP support	Improving healthcare services to care homes		Primary Care		CCG	CCG	CCG Minimum Contribution	£110,000	New	
Domiciliary Care	Personalised support/ care at home		Social Care		Local Authority	Private Sector	CCG Minimum Contribution	£30,000	Existing	£30,000
Integrated Care Services / ICT	Integrated care teams		Community Health		CCG	NHS Community Provider	CCG Minimum Contribution	£748,000	Existing	£748,000
Intensive Community Rehabilitation	Reablement services		Social Care		Local Authority	Local Authority	CCG Minimum Contribution	£82,000	Existing	£82,000
Intensive Community Rehabilitation	Reablement services		Community Health		CCG	NHS Community Provider	CCG Minimum Contribution	£170,000	Existing	£170,000
Responder Service	Personalised support/ care at home		Social Care		Local Authority	Private Sector	CCG Minimum Contribution	£60,000	New	
Out of Hospital Tranformation (integrated short term services)	Integrated care teams		Other	To be determined	Joint		CCG Minimum Contribution	£250,000	New	
Carers	Support for carers		Social Care		Local Authority	Charity/Voluntary Sector	CCG Minimum Contribution	£196,000	Existing	£196,000
EoL Night Sitting Service	Personalised support/ care at home		Community Health		CCG	Charity/Voluntary Sector	CCG Minimum Contribution	£14,000	Existing	£14,000
Community Capacity	Personalised support/ care at home		Social Care		Local Authority	Charity/Voluntary Sector	CCG Minimum Contribution	£200,000	Existing	£200,000
Programme Management Office &	Other	Program me Manage	Other	Various	Joint		CCG Minimum Contribution	£260,000	Existing	£260,000

Governance		ment costs								
Contingency (risk share)	Other	Contingency (risk share)	Other	To be determined	<Please Select>		CCG Minimum Contribution	£800,000	Existing	£867,000
Care Act funding	Personalised support/ care at home		Social Care		Local Authority	Local Authority	CCG Minimum Contribution	£296,000	Existing	£317,000
Additional Social Care protection	Personalised support/ care at home		Social Care		Local Authority	Local Authority	CCG Minimum Contribution	£600,000	Existing	£483,000
Digital roadmap - Connected Care	Integrated care teams		Other	Independent provider	Joint	Private Sector	CCG Minimum Contribution	£180,000	Existing	£208,000

SLOUGH BOROUGH COUNCIL

REPORT TO: Slough Wellbeing Board **DATE:** 23rd March 2016

CONTACT OFFICER: Jo Jefferies, Consultant in Public Health, Berkshire Shared Public Health Team

WARD(S): All

PART I
FOR COMMENT & CONSIDERATION

REVIEW OF ONLINE SEXUAL HEALTH SERVICE PROVISION

1. **Purpose of Report**

   To provide the board with evidence regarding the effectiveness and acceptability of online sexual health services available elsewhere in the UK, including ordering of postal home screening kits for sexually transmitted infections and notification of results by email, web, or SMS and to provide an update on plans for sexual health provision locally.

2. **Recommendation(s)/Proposed Action**

   The Board is requested to note the report

3. **The Slough Joint Wellbeing Strategy, the JSNA and the Five Year Plan**

The Slough Joint Wellbeing Strategy (SJWS) is the document that details the priorities agreed for Slough with partner organisations. The SJWS has been developed using a comprehensive evidence base that includes the Joint Strategic Needs Assessment (JSNA). Both are clearly linked and must be used in conjunction when preparing your report. They have been combined in the Slough Wellbeing Board report template to enable you to provide supporting information highlighting the link between the SJWS and JSNA priorities.

3a. **Slough Joint Wellbeing Strategy Priorities**

The board is asked to consider the information presented in relation to the key Slough Joint Wellbeing Strategy priority of **Health**.
Sexual and reproductive health, like physical and mental health is a key component of wellbeing, a healthy sex life and confidence and personal control over reproductive health are important.

One aim of the Slough Health and Wellbeing Strategy is to improve the sexual health of adults and young people, by enhancing uptake of effective sexual health screening and family planning services. Slough residents can play their part by taking up offers of health screening.

Access to high quality sexual and reproductive health information and services for all population groups is important for Slough to achieve good sexual and reproductive health.

Nationally, demand for sexual health services is increasing, the National Survey of Sexual Attitudes and Lifestyle indicates use of sexual health services has with three times as many women and 2.5 times as many men attending a clinic in the last year between the 1999-2001 and 2010-20121 surveys. Ensuring that health services are accessible to all residents and reducing health inequalities is particularly important when it comes to sexual health.

Cross cutting themes - Improving wellbeing and having access to high quality modern health services relates to the cross cutting theme of Improving the image of the town, while empowering individuals to take responsibility for their sexual health aligns with civic responsibility.

JSNA - The sexual health chapter of the Slough JSNA provides information on sexual health outcomes used in the Public Health Outcomes Framework the incidence of sexually transmitted infections and HIV, service use, teenage pregnancy and contraception for Slough residents.

In Slough rates of sexually transmitted infections have remained lower than the England rate over the past three years, the diagnosis rate of gonorrhoea (a marker of high levels of risky sexual activity) has decreased in the last two years and is now significantly lower than the national and comparator group rates, this is against the national trend.

Late HIV diagnosis is the most important predictor of HIV-related illness and short-term death and the proportion of late stage HIV diagnoses in Slough has reduced over the last four years, in line with the national picture.

There are still challenges to improving the sexual health of adults and young people in Slough;

- In 2014 there were 334 people living with HIV in Slough, this equates to a rate of 3.7 per 1000 which is significantly higher than the England rate of 2.2 per 1,000 and the rate of 2.7 per 1,000 in the comparator group of local authorities.

- Rates of new STIs rise with the level of deprivation across England, in Slough rates of new STI were highest in the most deprived fifth of the population

- Men who have sex with men and men and women of black African ethnicity continue to bear a disproportionate burden of HIV

3b. **Five Year Plan Outcomes**

Explain which of the Five Year Plan's outcomes the proposal or action will help to deliver. The outcomes are:

- **More people will take responsibility and manage their own health, care and support needs –** providing sexual health information and increasing access to some elements of sexual health service provision online has the potential to empower people to manage their sexual health and to free up time in specialist services for more complex cases, so that overall capacity can increase

- **Children and young people in Slough will be healthy, resilient and have positive life chances -** providing sexual health information and increasing access to some elements of sexual health service provision online in a way which is acceptable to young people regardless of gender, ethnicity or sexual orientation will enable
- **The Council will be a leading digital transformation organisation** – providing sexual health information and increasing access to some elements of sexual health service provision online will contribute to Sloughs ambition to become a leading digital transformation organisation.

4. **Other Implications**

(a) Financial

Report for information only - there are no financial implications

(b) Risk Management

Report for information only - not applicable

(c) Human Rights Act and Other Legal Implications

Report for information only - not applicable. There are no Human Rights Act Implications.

(d) Equalities Impact Assessment

Not applicable.

5. **Supporting Information**

5.1 Why is sexual and reproductive health important?
Sexual and reproductive health, like physical and mental health is a key component of wellbeing, a healthy sex life and confidence and personal control over reproductive health are important.

One aim of the Slough Health and Wellbeing Strategy is to improve the sexual health of adults and young people, by enhancing uptake of effective sexual health screening and family planning services. Slough residents can play their part by taking up offers of health screening.

Access to high quality sexual and reproductive health information and services for all population groups is important for Slough to achieve good sexual and reproductive health.

Nationally, demand for sexual health services is increasing, the National Survey of Sexual Attitudes and Lifestyle (1) indicates use of sexual health services has with three times as many women and 2.5 times as many men attending a clinic in the last year between the 1999-2001 and 2010-20121 surveys. Ensuring that health services are accessible to all residents and reducing health inequalities is particularly important when it comes to sexual health.

5.2 What sexual and reproductive health services are available in Slough?

Slough BC currently commissions a full range of sexual and reproductive health services for residents, primarily through the Garden Clinic at Upton Hospital and by providing access to long acting reversible contraception in GP practices.

In 2014, more than three quarters of first attendances by Slough residents at the Garden Clinic were female and only a quarter were male, although this reflects both the integrated nature of the service, which provides both sexual health and contraceptive services and differences in health-seeking behaviours between men and women more broadly, there is an opportunity to increase access to sexual health services, including STI testing, for men in Slough.

5.3 What is sexual health like in Slough?

In Slough rates of sexually transmitted infections have remained lower than the England rate over the past three years, the diagnosis rate of gonorrhoea (a marker of high levels of risky sexual activity) has decreased in the last two years and is now significantly lower than the national and comparator group rates, this is against the national trend.

Late HIV diagnosis is the most important predictor of HIV-related illness and short-term death and the proportion of late stage HIV diagnoses in Slough has reduced over the last four years, in line with the national picture.

There are still challenges to improving the sexual health of adults and young people in Slough;

- In 2014 there were 334 people living with HIV in Slough, this equates to a rate of 3.7 per 1000 which is significantly higher than the England rate of 2.2 per 1,000 and the rate of 2.7 per 1,000 in the comparator group of local authorities.

- Rates of new STIs rise with the level of deprivation across England, in Slough rates of new STI were highest in the most deprived fifth of the population

- Men who have sex with men and men and women of black African ethnicity continue to bear a disproportionate burden of HIV

5.4 What is involved in STI screening?

Different sample types are required to screen for different STIs; while a urine sample or self-taken swab is sufficient for chlamydia and gonorrhoea, a small blood sample is required to test for HIV. The samples must then be transferred to a laboratory for testing and the result provided to the individual. Those receiving a positive diagnosis must then be referred to appropriate services for treatment and supported to notify their sexual contacts so that they too can be tested.

  - There is good evidence that home-sampled swabs are a valid method of testing for genital, rectal and pharyngeal chlamydia and gonorrhoea

- There are few studies of the validity of home-sampled urine

- There are few studies of the validity of home sampled blood tests. Dried blood spots have been evaluated for hepatitis and HIV; capillary-tube type tests and home sampled blood drops have now been shown to be an acceptable sample for HIV

- There is extensive evidence for the validity of self-sampled HPV (genital warts) tests

5.4 What is the evidence for effectiveness and acceptability of online sexual health services?

National statistics show that 76 % of UK adults access the internet every day, demonstrating a sizable population that could potentially be reached by an online sexual health intervention

Access via an internet enabled phone or tablet is also prevalent, particularly among young people - in the UK it is estimated that 96 % of 16 to 24 year olds access the internet via mobile device. Globally, the World Health Organisation estimates that 79 % of 18–29 year olds use mobile apps daily.

There is some evidence that online sexual health services increase access, at least for some groups (2, 3) and that this approach may be less expensive than similar services delivered in clinic settings (4). Randomised trials have found uptake for home-based testing to be equal to or higher than clinic-based services (5).

There are an increasing number of commercial providers of online STI testing, which can be confusing for service users to navigate.

Many local authorities and sexual health providers in England now offer free online screening for Chlamydia and gonorrhoea as part of the National Chlamydia Screening Programme for 15 to 24 year olds. Nationally, in 2014 there were xxx online chlamydia screens accounting for xx% of all tests within the programme. Three local authorities in Berkshire have recently commissioned Source BioSciences to provide an online chlamydia screening service for young people as a one-year pilot to evaluate the effectiveness and acceptability of an online-only service. Outcomes for this service will be shared across all Berkshire LAs to inform future service provision

Public Health England commissioned a national online HIV self-sampling service which began in November 2015. The first two month of this service were offered as a free trial for all English local authorities, as of 31st December 6768 of 15,012 HIV tests had been returned, of which 93 were reactive. In Slough 41 tests were ordered in this time with a return rate of 41%.

Provision of a wider range of STI testing is now being commissioned by local authorities and sexual health providers in some areas.

5.4.1 SH:24

This service operating in the London Boroughs of Southwark and Lambeth offers online STI screening but this is only one element of the service.

SH:24 https://sh24.org.uk/ is a not for profit Community Interest Company (CIC) developed as a partnership between Lambeth and Southwark Public Health Directorate and two local NHS Foundation trusts. It is funded by SH:24 is funded by Guy's and St Thomas' Charity during its four year development phase and the evaluation will be undertaken by Kings College London.

SH:24 is being developed in phases using a design–led approach, involving substantial amounts of iterative consultation with stakeholders to inform each phase based on feedback. The service was conceptualised as a full online sexual health service providing a range interventions and is linked to a telephone and clinic based service. Phase 1 is a online STI testing service linked to a telephone and live-chat function and sexual health services

Output from stakeholder interviews suggested that service introduction should be considered as part of a dynamic sexual health economy and not a standalone service. Rather than being a "bolt on" service it is a change to the whole system of sexual health service provision and close working between the different elements of the system is essential to its success (6).

A recent service impact summary for the service (7) suggests that a 10% shift to online provision through this model could release 6% of initial service costs and that a larger shift to 30% could release 17%. The service also reports a high return rate of 72% for STI screening kits.

This service is reported to have increased productivity in the local health system by freeing up capacity in specialist sexual health services for more complex case management

Of those accessing the service in Lambeth and Southwark, 25% are from BAME groups, 30% are under 25 and 15% identify as men who have sex with men. The diagnosis rate for STIs is 11%, compared to between 12 and 14% positivity in clinic settings. Demonstrating that, in the area, the service is being accessed by those groups at risk of poor sexual health outcomes.

In 2016 SH:24 intends to develop its service so that it provides a holistic sex and reproductive health service including; Chlamydia treatment, partner notification, emergency contraception, pregnancy tests, oral contraception and condom distribution as well as rolling out the model in other locations including Essex.

5.4.2 Greenwich Sexual Health

The London Borough of Greenwich has also developed an online home screening kit service, where kits can be ordered through the Borough's "one stop shop" sexual health website
https://www.greenwichsexualhealth.org/

An evaluation of the service (8) found that;

- Home screening kits provided a cheaper way to provide asymptomatic screening for DTI's than clinic-based screening

- A significant minority of service users were willing to use a home screening kit rather than visit a clinic but the majority still wanted to see a clinician – including those who have symptoms, or were worried about something, those who were not familiar with sexual health services and those who were not willing to take their own blood sample

- People accessing the service in Greenwich were not commonly from high risk groups and had low prevalence of STIs - the programme had not been actively promoted at the time of the evaluation

5.5 Are any sexual health services available online in Slough?

Slough, as part of the shared public health agreement has part funded development of a sexual health website for Berkshire residents. Similar to the Greenwich website mentioned above, this will be a shop window for the various sexual health services available across Berkshire. The site is in the final stages of development process that has involved consultation with service users, young people and sexual health providers. There will be a soft launch in April 2016 followed by a marketing and awareness raising campaign.

The site will provide information on STIs and contraception as well as providing the location and time of sexual and reproductive health clinics through a "clinic finder" portal using google maps.

Slough will join the PHE framework for HIV self sampling in April 2016 and access to this for Slough residents will available through the website.

5.6 Considerations for further developing an online sexual health services

Considerable effort should be focused on designing healthcare applications from the patient's perspective to maximise acceptability. This applies to design of the whole system. Online provision should not be a 'bolt on' service but instead should provide a way for people to navigate and access the system in a way that is convenient.

The SH:24 approach has demonstrated that understanding residents motivation to use online services is key to successful take up. Gaining a meaningful level understanding requires significant input.

Close links to specialist sexual and reproductive health services should be maintained to allow service users to move between different types of service provision as appropriate for their needs and in a way that is convenient and simple.

6. Comments of Other Committees

n/a.

7. Conclusion

Online provision of sexual health information and improved access to some elements of sexual health service provision is has the potential to empower people to manage their own sexual health and to improve cost-effectiveness of services by reducing the cost of STI testing and creating capacity in clinic-based services by shifting activity online.

Gaining a good understanding the motivation of young people and adults in Slough with regards to accessing sexual health services would be essential in the development of online service provision

Online sexual health services should not be viewed as an alternative to or "bolt on" addition to clinic based services, but should be developed as an integrated element of a wider service enabling service users to move easily between modes as appropriate for their needs and in a way that is convenient to them

8. Background Papers

1. The National Survey of Sexual Attitudes and Lifestyles http://www.natsal.ac.uk/home.aspx

2. Woodhall SC, et al. Internet testing for Chlamydia trachomatis in England, 2006 to 2010. BMC Public Health. 2012;12:1095.

3. Lorimer K, McDaid L. Young men's views toward the barriers and facilitators of Internet-based Chlamydia trachomatis screening: qualitative study. J Med Internet Res. 2013;15(12):e265

4. Griffiths F, Lindenmeyer A, Powell J, Lowe P, Thorogood M. Why are health care interventions delivered over the internet? A systematic review of the published literature. J Med Internet Res. 2006;8(2):e10

5. Fajardo-Bernal L, et al. Home-based versus clinic-based specimen collection in the management of *Chlamydia trachomatis* and *Neisseria gonorrhoeae* infections. Cochrane Database Syst Rev. 2015;9:CD011317

6. Baraitser et al. How online sexual health services could work; generating theory to support development BMC Health Services Research (2015) 15:540

7. SH:24. Service Impact Summary, January 2016

8. Public Health & Wellbeing department, Royal Borough of Greenwich. Evaluation of home sampling kits for STI testing in Greenwich, May 2015

SLOUGH BOROUGH COUNCIL

REPORT TO: Slough Wellbeing Board **DATE:** 23rd March 2016

CONTACT OFFICER: Sangeeta Saran, Head of Operations, NHS Slough CCG

WARD(S): All

PART I
FOR COMMENT & CONSIDERATION

NHS SLOUGH CCG: 5 YEAR PLAN REFRESH AND UPDATE ON 2 YEAR PLAN

1. Purpose of Report

To inform the Board of the CCGs updated 5 yr plan and to provide an update on our 2 yr operational plan

1.1 The CCG has refreshed its 5 yr strategy and paper below outlines a high level summary. In December 2015 NHS England published – Five year Forward View planning guidance 2016-2020. This sets out the requirement for local areas to set set out plans that are transformational across systems that enable system sustainability. The health and care system will be embarking on planning to respond to the guidance in the coming months.

1.2 The CCG reports annually on our progress and achievements on our operational plans. This report is detailed on page 5

2. Recommendation(s)/Proposed Action

The Wellbeing Board is asked to:

(a) Note the progress to date on the CCG 2yr operational plans.

(b) Note the recommendation for the CCG plans to work on a wider system transformational plans on a wider footprint.

(c) Note and Approve CCG refreshed 5 yr plan and 1yr 16-17 operational plans.

3a. Slough Joint Wellbeing Strategy Priorities –

3a.1 The Slough 5 yr plans and 2 yr operational plan builds on the JSNA and joint wellbeing strategy to put plans in place that enable us to achieve better health outcomes for our population.

Priorities:

- Health
- Regeneration and Environment
- Housing
- Safer Communities

3b. Five Year Plan Outcomes

The CCG refreshed 5yr plan and 2 yr operational plans will support delivery on the Slough Borough Councils five year outcomes listed below

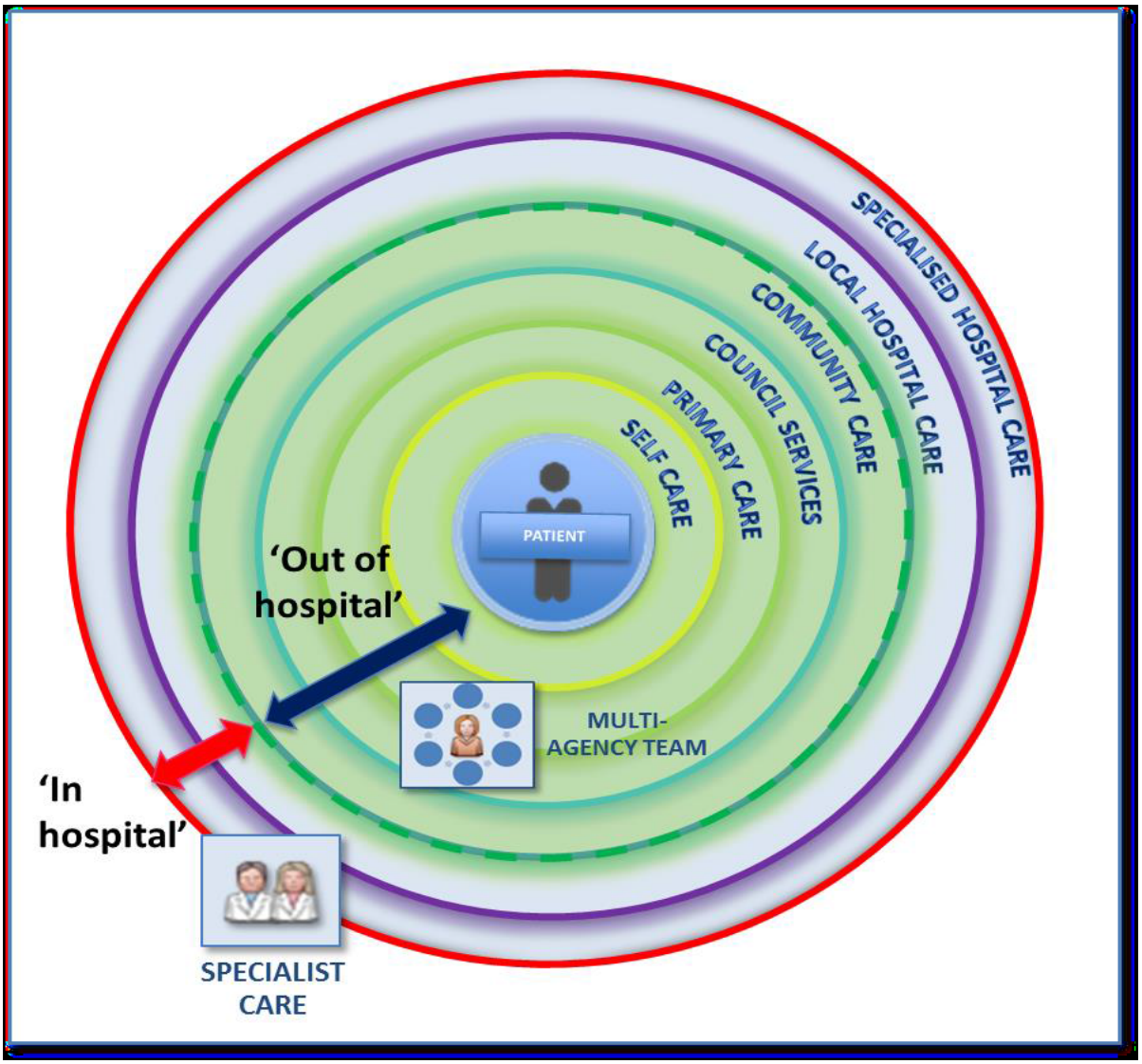
- More people will take responsibility and manage their own health, care and support needs
- Children and young people in Slough will be healthy, resilient and have positive life chances

Our joint ambition is to work closely on all areas that impact our joint strategies and thus we have actively engaged in the Slough one public estate strategy and the Slough digital transformation plans.

4. **A summary of our refreshed strategy is set out below:**

In East Berkshire the three CCGs are committed to working together to deliver high quality, affordable healthcare which delivers excellent patient experience and improved health outcomes.

We believe that individuals should take responsibility for their health and be supported by their family, social networks and communities to do so. We will engage with patients and the wider public in the design and implementation of any changes. Mental health is equally as important as physical health and our commissioning will recognise this. General practice is the foundation on which all other services are built and our aim is to ensure that it is able to deliver this, in tandem with excellent community and hospital based care as demonstrated by our "New Vision of Care" below. Slough Borough Council has been heavily engaged in the development of the 'New Vision of care'



In order to deliver our vision we will need a sustainable workforce that is well trained and open to working differently. We will need to review and develop our estate so that it is fit for purpose to deliver the services of the future. We will ensure that a shared care record is available so that patients only have to tell their story once and clinicians have access to the same information no matter where a patient is seen. Our digital roadmap will set out how we can maximise the use of technology assisted care and improve efficiency through digital technologies.

Change of this nature can only be achieved through a sustained and shared commitment from leaders, clinicians and staff, patients and the public. We will work collaboratively with the other commissioners of our major providers to develop and deliver a system sustainability plan. The ability to commission differently from primary care will be key to the delivery of our vision and we aim to have full delegation of primary care commissioning by April 2017. We will also take on a greater role in the commissioning of specialist services.

The key strategic themes to deliver our vision are:

Self management and prevention

- People will be encouraged to take action to improve their health now and for the future. Understanding how their lifestyles impact on their health and how they can make positive changes.
- Those living with long term and chronic conditions will be supported to understand and have confidence in managing their health needs, and we will improve medicines optimisation for people with multiple conditions.
- We will work better with community pharmacists, carers and the voluntary sector to provide people with support on an ongoing basis, tailoring our approach to different communities.

Primary Care

- Primary care will come together in clusters or federated groups. This will allow pooling of limited resources and expertise which will create efficiencies to sustain primary care.
- Primary care clinicians will develop further areas of specialist expertise and refer patients to each other.
- We will develop a model of primary care for 7 day working from 8am to 8pm which complements the existing high quality services
- New arrangements will be introduced to manage demand, including initial telephone consultations to assess whether an appointment is necessary and non face-to- face appointments.

Person Centred co-ordinated care

- Integrated care will be developed to complement the primary care clusters and federated groups. General practices will contact patients who are most at risk of developing complex care needs and develop a shared care plan.
- The shared care plan will draw on all appropriate services, including other primary care clinicians, social care, community health services, mental health services and acute specialists. They will work in integrated teams to avoid admission and support patients back into the community following acute care.

Elective Care

- Decision support aids will be used to support conversations between clinicians and patients about the best course of action for the individual.
- The traditional outpatient model will change. The aim is that primary care clinicians can increasingly draw upon specialist expertise through networks, enabled by technology, with a much reduced demand on consultant led hospital clinics.

- End to end pathways will be developed. We will take an integrated approach to commissioning these and a standardised approach to implementing them.
- The aim is reduce length of stay in hospital by embedding enhanced recovery across all elective surgical pathways and improving discharge co-ordination.

Urgent Care

- We will develop an urgent care system which removes duplication and maximises the use of resources. Entry points to urgent care will be rationalised, and we will work with NHS 111 to improve their services.
- Access to primary care will be improved through the development of seven day working. Emergency appointments will be available out of hours with a certain number held for children.
- The role of the Ambulance Service will be transformed. There will be a retraining of ambulance staff, enhancing their skills and increasing the number of paramedics who can see people in their own homes.
- People will only go to A and E when they need it. A and E will be designed to ensure that patients have the right level of intervention and support.

4.1 CCG System Sustainability and Transformation plans (STP)

In addition the CCGs are required to work across a wider system 'footprint' to develop a Sustainability and Transformation Plan (STP), which will become an umbrella plan for many of our existing strategies. The STP will have to ensure that all of these strategies are aligned to deliver our collective vision for the transformation of services and the Five Year Forward View. Our system will not have access to any transformation funding from 2017/18 onwards without an agreed STP. STPs are intended to be place/ population based plans, encompassing all partner organisations.

Following discussion with stakeholders, we are working collaboratively as part of the 'Frimley Footprint'. This brings together the populations covered by the three East Berkshire CCGs, Surrey Heath CCG and North East Hants and Farnham. Chiltern CCG will also be involved although not a formal partner. Our footprint brings together a group of high performing and ambitious providers, commissioners and wider systems serving a population of c900,000 people. Together, these organisations have a reputation for delivering excellent care that meet and exceed national targets and benchmarks and innovating to further improve services to patients. Our ambition now is to use our strength and track record to develop an excellent, sustainable health and care system.

We recognise the importance of the layers of plans that sit above and below our STP and the importance of our horizontal links to other STP's. Within our footprint there will be plans that are best taken forward at local, CCG or County level and these will continue the string working relationships we have with our partners. For some services, for example some specialist services, the appropriate planning footprint will be larger than our footprint.

The existing East Berkshire System Leaders Group will play a strong role in the STP and has membership from Slough Borough Council and an Executive Group responsible for pulling the plan together will also have representation from Slough Borough Council. The final plan has to be submitted by the end of June 2016.

5. Slough CCG 2 year operational plans- progress to date:

5.1 Summary

Our 2 year operational plans were refreshed in line with NHS England guidance published in December 2014.
In December 2015 NHS England have published renewed set of planning guidance which will require us to set out transformational plans which address system sustainability over a 5 yr period. We will additionally be required to publish a one year operational plan which must align with our system plans.

This report sets out our journey to date and our plans to further build our system plans

5.2 What is our progress to date on our current 2 year operational plans (Italics states the plan as was submitted to NHS England)

1) *We will continue to ensure that patient is at the centre of all that we do and continue to involve the public and patients in commissioning services.*
   Patient engagement in planning and improving our services has been at the heart of our commissioning plans.
   We have a regular forum of engagement ranging from the community partnership forum to discuss strategic priorities to a well-established patient forum group that has fed into various pieces of improvements e.g. primary care access work streams, engagement in primary specific projects e.g. simple words programme or group consultations work. Actively reporting to Overview scrutiny committees e.g. GP access issues paper, mental health concordant report. We have been working closely with Healthwatch to ensure we improve services in line where Helathwatch have carried out reviews e.g. primary care access.

2) *To deliver all the NHS Constitutional standards sustainably in year and to have in place recovery/improvement plans for those that are currently not achieving the standard.*

   2.1 We have had significant improvement and achievement of our constitutional standards as the year has progressed. To note are A&E waiting times and 18 week RTT targets and cancer waiting time and recently maternity
   2.2. We are actively working to change the pathways on Stroke and thus improve our performance. The model and change of service will be presented to March Slough Health and Overview Scrutiny with an implementation start date in September 2016.

3) *To continue to build on the improvement in outcomes achieved 2014/15 as demonstrated in the 7 outcome measures*.
   3.1 – see areas detailed below in table
4) *To improve integrated working and emergency care through the delivery of our Better Care Fund plans.*
   a. 4.1 The committee to note the previous report that have detailed performance on Better Care fund plans and significant delivery to date of our plans and impact these have had of our metrics.

5) *We will continue to progress our major programmes of service improvement – see table 1*
6) *We will work with Frimley Health to improve the quality of local services following the acquisition and system wide transformation through the Collaborative Care for Older Citizen.*

6.1 This programme has now been reinvigorated since the summer and is now renamed New Vision of Care as a recognition that frailty is not always associated with older age but more aligned to complexity of the health and social care issues an individual and family endures.
6.2 the programme is a key enabler in the CCG transformational plans as detailed in our 5 yr plans refreshed

7) *We will work with Public Health colleagues to develop prevention programmes at an industrial scale to prevent ill health and empower individuals to manage their own health.*

7.1 We have been actively promoting and scaling up programmes of work eg diabetes prevention, physical activity and smoking cessation. **The CCG is the highest in the country** in achieving number of diabetics having all eight care processes in diabetes measured
7.2 We have engaged in a local initiative to case find within our population people/ families at risk of Familial Hypercholesterolemia and where found a service that supports these families intensively to prevent premature death. The CCG is first in East Berkshire to offer this initiative.
7.3 We have been successfully awarded monies to promote / screen population for latent TB and we have actively engaged with Frimley health and the TB control board to ensure the service is targeted to our hard to reach populations.
7.4 We have a funded programme of improving cancer screening and early identification specifically in the BME communities supported by Macmillan UK. This programme has delivered a number of outreach promotion activities in our communities as well as meeting with GP practices to support the promotion of and uptake of national screening programmes.

8) *We will drive quality and incentivise service improvements through robust and enforceable contractual levers.*

8.1 We have seen significant improvement in Frimley health quality markers and recently the CQC revisited the trust. The trust was rated overall good with outstanding rating in Accident and emergency department and critical care.

9) *We will work together with member practices to deliver sustainable improvement to primary care and support the development of co-commissioning*.
9.1 The CCG is commissioning primary care jointly with NHS England and will be working towards full delegated responsibility from April 2017 onwards.

Table 1 – Report on progress on workstreams as identified

Delivery Priorities	**Outcomes**
Cardio Vascular Disease	- Deliver the optimum pathways for Chest Pain, Heart Failure, Arrhythmia, rehabilitation with our partners- *Plans have been scoped with a view to implement in 2016* - Increase the number of people getting an early diagnosis of hypertension in line with the commissioning for value pack indicators- *We will review our progress as QOF data is published* - Work with Public health and primary care around prevention of disease in partnership with our patients –*Working with public health to promote NHS health checks and target diabetes prevention programmes.*

	- commission the optimum Stroke pathway - *Plans underway and will be implemented in Sept 2016.*
Mental health services & Learning Disabilities and see (Maternity , Children & Young people)	- Deliver the Mental Health concordat- Is incorporate din overall plans - Increase dementia diagnosis to national recommendations as a minimum- Slough currently as 62% against a target of 67%. Working actively with GP practices and support from Alzheimers Association to promote early identification and referral for assessment as well as support for patients and carers - From April 2015 we will meet 15% referral rate for IAPT as a minimum and continue to target those with a long term condition by reaching out to our population groups which are hard to reach. We are currently achieving this target - Be assured of parity of esteem for people with mental illness- Is incorporated in all our plans and commissioned services - An east Berkshire LD steering group with representation from all partner agencies has been initiated and meets monthly. The terms of reference include development and improvement of LD specific services, development of a strategy to improve all health and social services interface with LD clients, ensure multiagency governance and ensure full implementation of the Transforming Care agenda. Work underway and is being led jointly with the Unitary authority
Diabetes	- Reduce the number of hospital admissions where diabetes is a secondary condition – *Slow progress on reduction but we have seen significant improvement in diabetes outcomes measures* - Improve the knowledge of and support to diabetics to enable them to self-care more effectively- *Ongoing* - Expression of interest to pilot the national diabetes prevention programme.- *We have submitted our case for piloting the NDPP service and will be starting the service from April 2016.*
Cancer	- Improve early diagnosis by improving the uptake of screening especially in our BME populations- *Successful in securing Macmillan funding and have in place a programme manager leading this work piece with impressive engagement achieved* - Improve clinical pathways for early assessment and treatment- *Piloting a CRUK programme to improve pathways and have appointed a clinical lead who is reviewing breast cancer pathways*
Better Care Fund	- Commission enhanced paediatric asthma service- *Asthma nurses in post and we have seen a reduction in non elective admissions in children* - Reduce the number of emergency admissions through the development of single point of access-

	on going and is reported via BCF programme update. - Identify vulnerable adults and children and manage their care through integrated teams- This has been reviewed in the BCF delivery groups and JCC . *Implemented a complex case management programme that is delivering significant impact* - Increase the involvement of voluntary services to provide care to our identified at risk populations.- *Ongoing and picked up in BCF programme report* - Reduce the number of falls by adopting falls prevention programme- *Successful programme and has delivered a reduction in falls over the previous 3 months*
Referral management	- Adopt referral guidelines and education to ensure we manage as many patients appropriately in the community – - *We have commissioned a system called DXS that will improve access to best practice pathways for GPs and will significantly improve availability of these pathways at the time of consultations with additional patient information immediately available at the time of the patient consultation* -
Self-care and prevention programme	- Increase in people feeling supported to manage their own condition - Increase in recorded prevalence of hypertension - Increase in numbers of women taking up breast screening and cervical smear tests - Prevention is a part of our major programmes of work around cardio vascular disease, diabetes, frail older people and mental health - Self-care and management for people with long term conditions and their Carers will be supported through Integrated Care Teams - Continue to support various programmes started under PMCF on self-care e.g. peer support groups and wellbeing programme Prevention strategies are being worked with jointly with patients , local authority and public health. We have actively worked with Slough Borough council to promote self care via digital platforms e.g participating in the Smart City initiative and Adult social care reform programmes
Urgent & Emergency Care	As indicated in our 5 year plan we require system plan to develop and implement new urgent care working arrangements across the system. During 2014/15 this will be developed through the follow areas of work:- - Confirmation of strategy and agreement of year 1 implementation plan, which will include proposal to change A&E access, urgent care ambulatory care pathways, discharge arrangements and 7 day working. - Collaborate with Frimley Health on the clinical vision to underpin the major rebuild of Wexham Park

	Emergency Department - Re-procurement of 111 - Re-procurement of walk In/Urgent Care Centre - Re-procurement of OOH *All of the above are underway and have made significant progress in year. Reported via various committees including System Resilience Group and System Leaders groups.*
Primary Care	- We will continue our successful pilot of Prime Ministers Challenge Fund as extended access- *Successfully implemented this pilot and have been nationally commended on the success.* - We have expressed an interest to develop a multispecialty practice group as a test pilot for new models of care – *we were not successful but we will continue to work up new models of working* - We have applied to jointly commission primary care with NHS England with a view to apply for delegated responsibility in year- *we are jointly commissioning with NHS England*
Pathway redesign • Parkinson's • Community IV & DVT • Urology • Spinal • End of Life Care	- Pathways are being redesigned and developed collaboratively with our secondary care, community & primary care. We are also collaborating with Frimley Health on the clinical vision to underpin the building of a state of the art cold elective centre on the Heatherwood site. - These have been established as service improvement plans in our contracts for 15/16. These will support the following outcomes: o better prevention, o earlier diagnosis o better treatment o Improve access. *This work is underway- Ref Slough Operating plans 2016-17 appendix 1*
Maternity , Children & Young people	- CCG plans to develop women's and children and young people's strategy with their partners. - Take part in NHS England review for maternity services and develop action plan on the recommendation to provide appropriate choice for mothers without compromising on safety. - Collaborate with Frimley Health on the capital refresh of Wexham Park Maternity and Gynaecology facilities to improve patient flow and experience. - The CCG will work with Local Authorities, Public Health, midwives, schools and primary care to identify and treat emerging mental health issues earlier, before difficulties escalate. This includes Early Intervention in Psychosis. - Additional capacity will be provided to tier 3 CAMHs to meet the growth in demand and complexity of cases.

	- The CCG will continue to work with NHSE and BHFT to improve access to local Tier 4 CAMHs provision. *A national maternity strategy has been published and we will be reviewing our services in line with the strategy. Regular updates are reported to the Governing Body on our performance measures on maternity services and all measure have seen a substantial improvement.* *Our Transforming Children's Services plan was signed off last November and we continue to work with our partners and providers to improve delivery of CAMHS services to our population*
Collaborative Care for the Older Citizen	Through this project, the four CCGs and Frimley Health and Berkshire Healthcare Foundation Trusts and Local Authorities will work in partnership to develop a new and transformed model of Care for older people. The new model will cover the population of people aged over 65 who are registered with one of the Four CCGs. *As detailed in 5 yr strategy- the programme has been refreshed to New Vision of Care -*

Financial Performance
The CCG aims to report a balanced budget in 2015/16 but there are significant pressures on the budget with reserves now all committed and will leave the CG with significant gaps into the next financial year.

CCG Assurance;
The CCG has been assured overall with support. The significant improvements seen on performance and quality within Frimley have improved our overall rating.
We are moving into next year with an improved position especially as we have been successful in appointing a substantive Accountable officer.

Appendices

Appendix 1 - Draft Slough CCG operating Plan 2016-17

Operating Plan 2016-17

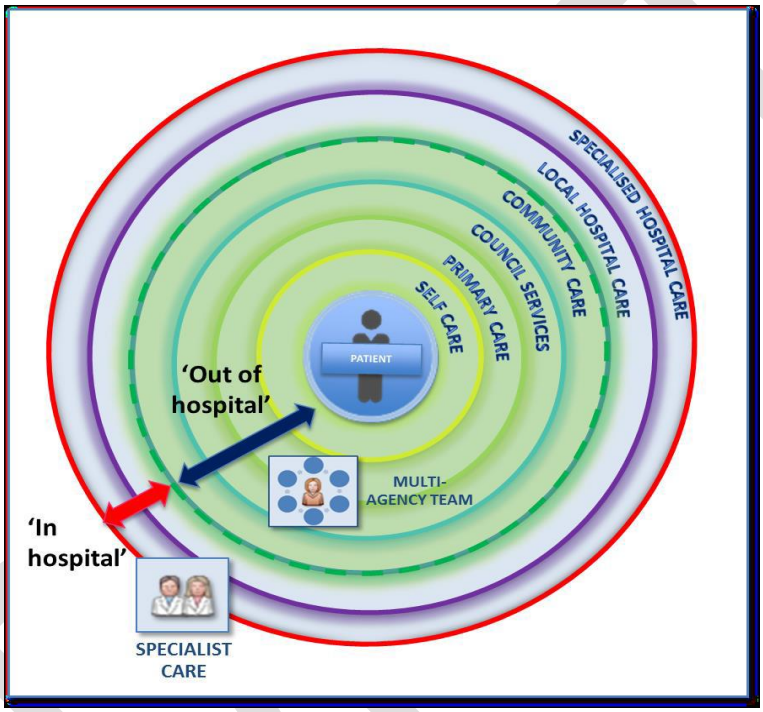
CONTENTS

2. Vision & Strategic Objectives

CCGs Joint Vision

2.1 In East Berkshire the three CCGs are committed to working together to deliver high quality, affordable healthcare which delivers excellent patient experience and improved health outcomes.

2.2 We believe that individuals should take responsibility for their health and be supported by their family, social networks and communities to do so. We will engage with patients and the wider public in the design and implementation of any changes. Mental health is equally as important as physical health and our commissioning will recognise this. General practice is the foundation on which all other services are built and our aim is to ensure that it is able to deliver this, in tandem with excellent community and hospital based care as demonstrated by our "New Vision of Care" below.



2.3 In order to deliver our vision we will need a sustainable workforce that is well trained and open to working differently. We will need to review and develop our estate so that it is fit for purpose to deliver the services of the future. We will ensure that a shared care record is available so that patients only have to tell their story once and clinicians have access to the same information no matter where a patient is seen. Our digital roadmap will set out how we can maximise the use of technology assisted care and improve efficiency through digital technologies.

2.4 Change of this nature can only be achieved through a sustained and shared commitment from leaders, clinicians and staff, patients and the public. We will work collaboratively with the other commissioners of our major providers to develop and deliver a system wide sustainability and transformational plan. The ability to commission differently from primary care will be key to the delivery of our vision and we aim to have full delegation of primary care commissioning by April 2017. We will also take on a greater role in the commissioning of specialist services.

2.5 The key strategic themes to deliver our vision are set under the following programmes of work, these will continue to be developed and updated in line with our Sustainable Transformation Plan.

2.6 Self-management and prevention

- People will be encouraged to take action to improve their health now and for the future.
- People will understand how their lifestyles impact on their health and how they can make positive changes.
- Those living with long term and chronic conditions will be supported to understand their condition have confidence in managing it. They will be provided with information on how to seek help when they need it.
- We will work with the third sector and other networks to provide people with support on an ongoing basis.
- We will tailor our approach to different communities.

2.7 Primary Care

- Primary care will come together in clusters or federated groups. This will allow pooling of limited resources and expertise which will create efficiencies to sustain primary care.
- Primary care clinicians will develop further areas of specialist expertise and refer patients to each other.
- We will develop a model of primary care for 7 day working from 8am to 8pm which complements the existing high quality services
- New arrangements will be introduced to manage demand, including initial telephone consultations to assess whether an appointment is necessary and non-face-to- face appointments.

2.8 Person Centred co-ordinated care

- The 'New Vision of Care' for frail people will drive commissioning for our most vulnerable patients.
- Integrated care will be developed to complement the primary care clusters and federated groups.
- General practices will contact patients who are most at risk of developing complex care needs and develop a shared care plan.
- The shared care plan will draw on all appropriate services, including other primary care clinicians, social care, community health services, mental health services and acute specialists. They will work in integrated teams.
- Integrated teams will provide support to avoid admission and support patients back into the community following acute care. These integrated teams will support short term intermediate care and re-ablement.
- The integrated teams will work closely with voluntary groups and carers to help people manage their health more effectively. The role of community pharmacists will also be developed to support self care.
- We will take steps to improve medicines optimisation for people with multiple conditions.

2.9 Urgent Care

- We will develop an urgent care system which removes duplication and maximises the use of resources.
- Access to primary care will be improved through the development of seven day working. Emergency appointments will be available out of hours with a certain number held for children.
- The role of the Ambulance Service will be transformed. There will be a retraining of ambulance staff, enhancing their skills and increasing the number of paramedics who can see people in their own homes.

- Entry points to urgent care will be rationalised. We will work with NHS 111 to improve their services.
- People will only go to A and E when they need it. A and E will be designed to ensure that patients have the right level of intervention and support.

3.0 Elective Care

- Decision support aids will be used to support conversations between clinicians and patients about the best course of action for the individual.
- The traditional outpatient model will change. The aim is that primary care clinicians can increasingly draw upon specialist expertise through networks, enabled by technology, and with a much reduced demand on consultant led hospital clinics. Primary care clinicians will require access to diagnostics to achieve this.
- Specialists will provide remote support when required for GPs, carers and patients based in practices.
- End to end pathways will be developed. We will take an integrated approach to commissioning these and a standardised approach to implementing them through system wide use of DXS.
- Post-operative care will be provided by senior decision makers and specialist nurses in the community, enabled by technology.
- There will be improved access to enabling services such as therapy and pain management.
- The aim is reduce length of stay in hospital by means of highly co-ordinated discharge.
- The principles of enhanced recovery will be embedded across all elective surgical pathways.

3.0 CCG Demographics / Population health needs

3.1 There are three Clinical Commissioning Groups (CCGs) in the East Berkshire area:

- **Bracknell and Ascot** has a registered population of 136,863. 81% of the CCG's population reside in Bracknell Forest Council and the remainder in Ascot within the Royal Borough of Windsor and Maidenhead.
- **Slough** has a registered population of 143,343. This CCG shares the same boundaries as Slough Borough Council.
- **Windsor, Ascot and Maidenhead (WAM)** have a registered population of 150,364. This CCG covers the majority of the Royal Borough of Windsor and Maidenhead, together with one ward in North Surrey.

3.2 The three CCGs work together as the East Berkshire Federation and also work closely with their unitary authorities: **Bracknell Forest Council, Slough Borough Council** and the **Royal Borough of Windsor and Maidenhead (RBWM).**

3.3 The three unitary authorities are different in terms of their population and demographics, their health needs and present challenges. Life expectancy in Bracknell Forest and the Royal Borough of Windsor & Maidenhead is higher than the England average. In contrast, life expectancy in Slough is lower than the England average.

3.4 These differences give rise to different priorities set out in full in the Joint Health and Wellbeing Strategies and are summarised below:

- **Bracknell Forest Council**
  - Falls prevention
  - Smoking
  - Immunisations
  - Mental health in the community
  - Self-Care
- **Slough Borough Council**
  - **Diabetes:** Increase early diagnosis of all types of diabetes
  - **Tuberculosis:** Increase access to TB screening for earlier diagnosis
  - **Obesity:** Increase the level of physical activity undertaken by residents of all ages and encourage healthier eating
  - **Children:** Improve emotional and physical health of children of all ages from 0 to 19 years
  - **HIV:** Improve the sexual health of adults and young people
  - **CVD:** Improve access to CVD screening programmes and develop care pathways that support prevention of CVDs
  - **Drug and alcohol misuse:** Reduce drug and alcohol misuse and their impact on domestic abuse and violent crime
  - **Self-care/mental health:** Increasing access to self-care programmes and to effective services for people with long-term conditions and mental health problems
- **Royal Borough of Windsor and Maidenhead**
  - **Supporting a Healthy Population:** Stopping smoking, health checks, vaccinations, exercise, health and wellbeing campaigns
  - **Prevention and Early Intervention:** telecare/telehealth services, long-term conditions, dementia, children, elderly falls, respiratory tract infections amongst children, early support, addressing domestic abuse
  - **Enable Residents to Maximise their Capabilities and Life Chances:** long-term conditions, commissioning home-based services, housing options, employment/volunteering opportunities, patient experience, supporting carers, drug/alcohol treatment

4.0 Five Year Forward View Key Priorities for 16/17 Summary

In response to NHS England delivery requirements for the **'Forward View' our response to the nine 'must do'** for our system are outlined in the table below:-

	Delivering Priorities	Provide an summary of high level plans to deliver this priority	Outcomes
1	Development of a high quality and agreed **STP**	The CCGs in East Berkshire are proposing to develop our footprint at three interlinked levels: • In line with our New Vision of Care to work with the three Unitary Authorities, Berkshire Healthcare Trust and Frimley Health to develop integrated social care, primary care and community care for populations of approximately 50,000 people. • To continue with the successful arrangements for mental health, learning disabilities and specialised community services on a Berkshire footprint with the West Berkshire CCGs and Berkshire Healthcare Trust. • To work collaboratively with Chiltern CCG, North East Hants and Farnham and Surrey Heath CCGs to commission high quality acute care from Frimley health for those people who cannot be supported safely in the community. These footprints will deliver the benefits of working at scale whilst responding to local needs and delivering a patient centred approach. Once the footprint has been agreed by NHS England the CCG will work with stakeholders to put in place formal governance arrangements.	Achieve the triple aim as set out in the **Forward View**
2	Return the system to **aggregate financial balance**	See section -7 – Sustainable Finances	
3	Develop and implement a local plan to address the **sustainability and quality of general practice**, including workforce and workload issues.	**Infrastructure: -** Practices are working at scale within each CCG to deliver extended opening hours by centralising and sharing access points across practices and by working smarter through use of technology On line and email consultations are planned to use interactive digital Applications. The Primary Care Transformation fund will be used to support premises to meet the needs of modern general practice. **Focus on care and quality: -** Development of a local Quality dashboard with a portal linking externally available sources of information to identify and support vulnerable practices. Introduce a local support team to lead training and development for CQC standards and beyond including local specialists to provide support and mentorship. The 3 CCGS will review how the Quality and Outcomes Framework for General Practice could be re-engineered to provide most relevant local patient quality outcomes. **Workforce analysis & development**: - Each CCG will have clear data to show GP workforce in primary care and highlight areas of risk by June 2016 as a starting point for our development plan. Individual CCGs have plans in place	20% of the population will have enhanced access to primary care at evenings and weekends leading to improved access to services All practices to be the best they can and deliver high quality services and be rated Good or above by the CQC. 6WTE Clinical pharmacists will be recruited by July 2016 in Slough.

	Delivering Priorities	Provide an summary of high level plans to deliver this priority	Outcomes
		to deliver the following programmes:- ➢ Windsor Ascot & maidenhead CCG is establishing a training hub to develop new primary care and community roles with support from HETV. It will link with voluntary sector and local authority. This will retrain and retain a workforce. ➢ Slough CCG is implementing Clinical Pharmacist role in Slough practices to include: • Long-term condition clinics • Post-discharge medication review and support • Polypharmacy medication review • Domiciliary medication reviews • Minor ailments clinics • Resolving prescription problems • Reducing waste by monitoring repeat ordering processes • Ensuring monitoring of medications is correct and identify people on combinations increasing risk of admission • Implementation of national & local clinical guidance and Drug Safety Alerts ➢ Bracknell and Ascot CCG is extending the role of Health makers in 2016 to optimise self-management and support to others. The aim is to recruit 420 health makers by March 2017 and 800 by March 2018.	
4	Urgent and Emergency care Transformation	**Undertake robust marketing study to fully understand patient behaviours** and why they choose to attend A&E rather than go via NHS 111 or alternative services. **Review Slough Walk in Centre** and commission effective primary care provision on site. **Extend Out of Hours Contract** and commence integration with NHS 111 services including warm transfer of care plan patients and directly bookable appointments into OOH primary care centres **Review and Transform the NHS 111 Directory** of Services to reduce number of ED dispositions and make better use of alternative services in the system **Improve discharge flows from hospital**, a key project is to develop and agree and approve a single common transfer of care protocol that clearly defines the processes that will transfer a patient to their home or other care provider. **Commence investigating Discharge to Assess**" model where patients are discharged once they are medically fit and have their support needs assessed on arrival at home by members of the community intermediate care and social care teams. **Mobilisation of PTS.** This service represents a key part of the patient flow within the system and will need to work in conjunction with all stakeholder organisations including the emergency transport service provision. **Use of ambulatory care pathways** and delivery of these in community to avoid unnecessary admissions hence to reduce A&E episodes.	Achieve 95% A & E Achieve 75% Category A calls within eight minutes Reduce the number of DTOCs

	Delivering Priorities	Provide an summary of high level plans to deliver this priority	Outcomes
		Increased use of 'hear & treat' and 'see & treat'. This project will need to undertake a full review of current activity and understand the interdependencies with other incentives to appropriately contract levels of see/Treat and Hear/Treat with the focus being on the ambulance trust providing a high level mobile urgent care service and not purely a transport service. Review and continue to develop the real-time data systems used to monitor daily resilience and system health	
5	Improvement against and maintenance of the NHS Constitution standards of 92% non-emergency pathways	The three CCG is committed to achieve the 92 % Incomplete RTT standard and has consistently achieved it from April – November 2015/16. Our main Provider Frimley Health is achieving the 92% standard but with pressure in Dermatology and T&O. However our alternative Provider RBFT has not been achieving the RTT standards for some time in Ophthalmology **Planned action** • Frimley North Dermatology backlog reduction is underway with additional resource and weekend clinics being held in to reduce waiting times to within 18 weeks by mid-February 2016. Longer term plans to review the Dermatology pathway are in development by all 3 CCGs • Frimley North and South T&O backlog exists in orthopaedics and is being addressed by utilising capacity in the local independent sector plus the use of locums taking additional lists at Heatherwood Hospital site. The Trust is also developing a longer term plan to focus on hips, knees to be undertaken by Extended Scope Practitioners (ESP's) thus enabling them to take more patients. This will be further developed in 2016/17. • Ophthalmology backlog at RBFT has a remedial action plan in place which includes actions on data quality where patients waiting >18 weeks were not visible. This is being monitored on a monthly basis and will be achieved by 31 March 2016.	Achieve the 92% of Non-emergency pathways for RTT
6	Improve Cancer survival rate via early diagnosis and treatment	The three CCGs support East Berkshire wide strategic cancer steering group which has the following aims: • Improve quality of 2ww referrals (Slough CCG with support from Macmillan Charity) • Use of benchmarking to review the patients presenting at a late stage of cancer development through the emergency admission • Implementation of NICE guidance • Reviewing cancer pathway across the two sites of Frimley Health NHS Foundation Trust. • Improvement to early cancer diagnosis and achieve the Cancer NHS constitutional standards. All the cancer targets are being achieved by the three CCGs with exception of WAM CCG which is not achieving the 31 day cancer target in Q2. There is an improvement plan in place with RBFT to achieve the appropriate performance. The CCGs plans to improve uptake by early diagnosis for	Deliver the **62 day cancer waiting standard**,; continue to deliver the constitutional two week and 31 day cancer standards and make progress in improving **one-year survival rates** by delivering a year-on-year improvement in the proportion of cancers diagnosed at

	Delivering Priorities	Provide an summary of high level plans to deliver this priority	Outcomes
		breast and GI and screening uptake. The CCG has prioritised screening of colorectal cancer by increasing uptake of bowel screening especially for the BME populations, where uptake is low and outcomes worse than national averages. The three CCGs has education plans in place for ensuring implementation of NICE guidelines including adhering to clinical guidelines and utilising audit tools and dashboards to enable a sharing of expertise within primary and secondary care.	stage one and stage two; and reducing the proportion of cancers diagnosed following an emergency admission.
7	Improve Mental Health service	The Mental Health programme will support the continued delivery of parity of esteem and delivery of the national priorities for mental health as outlined in Delivering the Forward View: NHS Planning Guidance 2016/17. These will include: 1. Enhanced perinatal mental health services 2. Review of antipsychotic prescribing in primary care for Learning Disabilities and/ or autism 3. Dementia – maintain enhanced younger people with dementia service 4. Crisis Care Concordat delivery – including maintained 24/7 MH Liaison, Street Triage, review of Place of Safety, and scoping the commissioning of crisis beds 5. Continuation of the wellbeing and recovery community programme for the elderly, those with LTC and socially isolated 6. Review of MH & LD placements 7. Achievement and sustainability of national requirements in the following areas:- **IAPT** - This access target is already achieved; this will be maintained thorough 2016/17 **Early Intervention in Psychosis -** A NICE concordant service will be in place to achieve the access standard in 2016/17. **Dementia Diagnosis** – Bracknell & Ascot CCG have been achieving since summer 2015 and Windsor Ascot and Maidenhead CCG have recently achieved in December 2015. This achievement will be maintained throughout 16/17. Slough CCG is currently achieving 61.3% and has plans in place to achieve the target by the end of quarter 2.	Achieve and maintain the **two new mental health access standards**: more than 50 percent of people experiencing a first episode of psychosis will commence treatment with a NICE approved care package within two weeks of referral; 75 percent of people with common mental health conditions referred to the Improved Access to Psychological Therapies (IAPT) programme will be treated within six weeks of referral, with 95 percent treated within 18 weeks. Continue to meet a **dementia diagnosis** rate of at least two-thirds of the estimated number of people with dementia.
8	Deliver actions set out in local plans to transform care for people with **learning disabilities**, including implementing enhanced	A three year plan across Berkshire is in place to improve services for people with learning disabilities and/or autism, who display behaviour that challenges, including those with a mental health condition. This will drive system-wide change and enable more people to live in the community, with the right support, and close to home. The Transforming Care programme will focus on addressing long-standing issues to ensure sustainable change that will see:	Delivery of improved choice in LD

	Delivering Priorities	Provide an summary of high level plans to deliver this priority	Outcomes
	community provision, reducing inpatient capacity, and rolling out care and treatment reviews in line with published policy.	1. more choice for people and their families, and more say in their care; 2. providing more care in the community, with personalised support provided by multi-disciplinary health and care teams ; 3. more innovative services to give people a range of care options, with personal budgets, so that care meets individuals' needs; 4. providing early more intensive support for those who need it, so that people can stay in the community, close to home; 5. but for those that do need in-patient care, ensuring it is only for as long as they need it. This will take the form of: • a reduction in the number of inpatients to between 10-15 inpatients/million • implementation of an intensive intervention service • implementation of the positive behaviour support model • community teams for people with a learning disability/ autism that have the right skills and capacity • wider and more local range of providers to support individuals which will support reduced out of area placements • increased use of personal health budgets • redesigned assessment and treatment unit	
9	Develop and implement an affordable plan to make **improvements in quality** particularly for organisations in special measures. In addition, providers are required to participate in the annual publication of **avoidable mortality**	We agree with our Providers a range of Quality Indicators both nationally mandated and locally developed to track quality performance and patient safety based on concerns, national initiatives or poor performance. Regular monitoring of such indicators occurs at Provider Clinical Quality Review Meetings (CQRM's) and CCG Federated Quality Committee.	

5. Transformation Programme and QIPP Delivery

5.1 **Development of a high quality and agreed Sustainability Transformation Plan**

The CCGs in East Berkshire are proposing to develop our footprint at three interlinked levels:

- In line with our New Vision of Care to work with the three Unitary Authorities, Berkshire Healthcare Trust and Frimley Health to develop integrated social care, primary care and community care for populations of approximately 50,000 people.
- To continue with the successful arrangements for mental health, learning disabilities and specialised community services on a Berkshire footprint with the West Berkshire CCGs and Berkshire Healthcare Trust.
- To work collaboratively with Chiltern CCG, North East Hants and Farnham and Surrey Heath CCGs to commission high quality acute care from Frimley health for those people who cannot be supported safely in the community.

5.1.1 These footprints will deliver the benefits of working at scale whilst responding to local needs and delivering a patient centred approach. Once the footprint has been agreed by NHS England the CCG will work with stakeholders to put in place formal governance arrangements.

5.2 **Right Care**:

The CCG has adopted the NHS Right Care approach to enable effective prioritisation of our plans to deliver population wide health benefits. Where do we target our efforts best to deliver effective outcomes by creating a culture of clinical change led by effective systems and processes underpinning the change in a sustained manner.

5.2.1 Using the Right care methodology and commissioning for value packs the CCG has identified the following areas for improvement and which will be addressed during 16/17:

- **Cardiology**
- **Respiratory**
- **Gastro medicine**
- **Integrated care**

5.2.2 A task and finish group has been set up to enable the CCGs is East Berkshire to embed the NHS right care methodology including its business processes into the way we deliver QIPP.. The three CCGs in East Berkshire are in the Wave 1 cohort of CCGs that will be working with the National NHS Right care team to lead on embedding the process and thus support population benefit. Slough CCG has been showcasing its successful implementation of Diabetes and Complex case management which is being rolled out to all CCGs in East Berkshire.

5.3 New Vision of Care

During 2015/16 The East Berkshire CCGs together with Chiltern CCG have been working with Frimley Health FT, Berkshire Healthcare FT, LA, voluntary sector and the public to develop a new and transformed model of care to commission health and social care services for people with complex needs.

Through this project the partners are developing a new and transformational vision of care to help avoid unnecessary admissions to hospitals and care homes and the loss of independence. This will be for all adults but the vast majority of intensive users will be people with more complex conditions.

The pathways of care have now been worked through and the key project areas for delivery during 2016/17 will be:-

- Workforce development
- Communication & engagement
- Collaborative leadership
- Aligning incentives
- Share your care
- System governance

5.4 Continuation of 2015/16 Transformation Programme and QIPP Delivery

5.4.1 The CCG's 2015/16 plan outlined eight transformation programme of work which will continue to remain in place during 2016/17 and will be responsible for the delivery of the identified QIPP programme. We used a structured process to develop the schemes, engaging with clinicians, groups and localities-

a. We used right care and the commissioning for value packs to identify areas for review. A task and finish group has been set up to enable the CCGs to embed the right care methodology including its business processes into the way we deliver QIPP.

b. We used a hackathon to develop a longlist of possible opportunities for unscheduled and planned care

c. We refined the 'longlist' into a 'shortlist' and the analytics and finance team sized the scheme to confirm financial impact by provider and POD.

d. Supporting projects have been identified in each project area and these are now in the scoping stage with savings being assessed as transformational or transactional.

e. All schemes are profiled into contracts through the negotiation round together with appropriate quality and efficiency measures. Negotiations are particularly challenging this year given the requirements on Trust to reduce deficits and increase surpluses. As far as possible in all cases the CCGs have looked to reduce demand in areas which will allow the Providers to reduce costs at the same time.

5.4.2 These programmes are listed below and supported by detailed project plans

- **Starting Well, developing Well, living Well, ageing**
- **Primary care**
- **Integrated care including Better Care fund**
- **Urgent care**
- **Elective care**
- **Mental Health and Learning Disabilities**
- **Maternity & Children & young People**:
- **Medicine Optimisation**

6.0 Improving Quality

6.1 The CCG has a Quality Strategy which covers the time period from 2014-2017 which sets out how the CCG will work collaboratively to endeavour to ensure high quality, safe care is provided and that patients and their carers experience is a good one from the services they receive. The Quality Strategy in 2016 is to be refreshed to reflect the changes and priorities within the CCG. The model below illustrates the three components of quality and when quality is discussed throughout the document each of the 3 areas are considered.

6.2 **Sign up to Safety**

The CCG is committed in 2016/7 to publish its five Sign up to Safety pledges from a Commissioners perspective. By making a commitment to bringing them to life, and by helping others to understand their role in this, we are working together to create the right conditions for safer care.

6.2.1 Putting safety first. Committing to reduce avoidable harm in the NHS by half.

6.2.2 Continually learn by reviewing incident reporting and investigation processes to make sure that providers are truly learning from them and using these lessons to make their organisation more resilient to risks. Listen, learn and act on the feedback from patients and staff and by constantly measuring and monitoring how safe the Provider services are

6.2.3 Being honest. Being open and transparent with people about our progress to tackle patient safety issues and working with them.

6.2.4 Collaborate. Stepping up and actively collaborating with other organisations and teams; sharing work, ideas and learning to create a truly national approach to safety. Work together with others, join forces and create partnerships that ensure a sustained approach to sharing and learning across the system

6.2.5 Being supportive. Be kind to our staff; help them bring joy and pride to their work. Be thoughtful when things go wrong; help staff cope and create a positive just culture that asks why things go wrong in order to put them right. Give staff the time, resources and support to

work safely and to work on improvements. Thank our staff, reward and recognise their efforts and celebrate your progress towards safer care.

6.2.6 Frimley Health and BHFT have already 'signed up to safety'. We are working with our lower activity providers to assist them in 'signing up to safety'.

6.3 Developments and improvements in quality for Primary Care

6.3.1 The CCG has been working with NHSE on the quality of Primary Care through Co-commissioning. The first Quality Improvement Meeting for Primary care met in February 2016. This meeting will focus on Quality issues and ways for improvement using local intelligence and relationships. There will be representation from Primary Care, Healthwatch, NHSE and the CCG. The Quality Team are in the process of developing a data base which will be populated with intelligence from Primary Care this includes Patient experience (FFT, complaints and NHS Choices), incidents, safeguarding and CQC compliance.

6.3.2 The CCG aims to measurably reduce examples of poor patient experience, both within and outside of the hospital settings, utilising tools such as the Friends and Family Test, complaints safeguarding alerts and other patient and carer feedback. To work with Providers to ensure that they have a robust complaints system in place using the NHSE Assurance of good complaints handling toolkits. A Commissioner themed complaints observational visit will be used for Frimley Health and BHFT using the toolkit as a framework. The CCG will continue to monitor implementation of Providers Duty of Candour with moderate and serious harm incidents.

6.4 Antimicrobial Prescribing and resistance rates

6.4.1 The IPCN will be working closely with the medicine optimisation and public health team on the antimicrobial prescribing and resistance rates. There is a local Antimicrobial plan to improve antibiotic prescribing within primary and secondary care. This plan for 2016/17 is to have a reduction in the number of antibiotics prescribed. Frimley Health have an antimicrobial stewardship action plan, which includes ward rounds, evidence based prescribing, audit programme and education and training. The IPCN will work with all Providers and the antimicrobial prescribing and resistance rates are included in all 2016/17 Quality Schedules.

6.4.2 Within Primary Care individual practice reduction is to be agreed by the CCG. Indicators are monitored quarterly, and a local Antimicrobial Stewardship Group has been set up to start in 2016. The ambition for prescribing is to ensure best practice, through education and local incentive schemes.

6.4.3 All NHS Standard Quality schedules have an ambition for effective antibiotic use this will be monitored through CQRM and individual improvement plans as necessary.

6.5 Post Infection reviews

6.5.1 There is support and attendance at Provider Root Cause Analysis & Post Infection Review meetings including Primary Care to investigate local Healthcare acquired infections. Local Root Cause Analysis & Post Infection Review meetings are organised for *Clostridium difficile* & MRSA which are allocated to primary care. The review ensures working together with colleagues to identify any area for learning about *C. diff* & MRSA cases and taking forward recommendations across the health economy e.g. awareness and compliance with antibiotic prescribing guidelines.

6.6 Sepsis

6.6.1 The local Sepsis plans will be broadened to include the NICE guidelines that are to be published in March 2016. Primary care will be supported in ensuring compliance with these guidelines, raising awareness of Sepsis, encouraging routine and seasonal immunisation programmes, and highlighting the importance of hand hygiene in preventing infections**.** A national CQUIN focusing on sepsis screening and antibiotic administration has been in place for acute Trusts in 2015/16; results from Frimley Health have shown significant improvement throughout the year on the screening metrics, with further improvement targeted by year-end. Baseline antibiotic administration scores are good, and an improvement trajectory to the end of the year has been set; latest figures against the baseline are due at the end of January 2016 and these were achieved. These improvements have followed the introduction of a standardised screening and treatment protocol, incorporating the 'Sepsis Six' red flag clinical action framework. This has been supported by a staff awareness campaign. These measures will continue to be monitored into 2016/17 as part of the Quality Schedule requirements. The ambulance service has had a local CQUIN on Sepsis. The Urgent Care centre will be having a local CQUIN on Sepsis for 2016/17 on sepsis screening.

6.7 Avoidable deaths

6.7.1 The Frimley Health will continue to give commissioners an analysis of Mortality data (SHMI) and CRAB surgical complications / medical practice triggers data via the monthly Quality and Performance Reports. The February 2016 CQC inspection report highlighted this as an area of good practice at Frimley Health. These will be supplemented by quarterly Mortality and Morbidity reports submitted in line with the Quality Schedule, and scrutinised by the Clinical Quality Review Groups. Additionally, there will be a requirement in 2016/17 for the Provider to report on numbers of avoidable deaths, giving a quarterly number which will be compared against a 2015/16 baseline.

6.7.2 Latest data shows that SHMI scores remain satisfactory with a marked improvement in elective SHMI

	14/15	Nov-14	Dec	Jan-15	Feb	Mar	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov-15	YTD	Target	Threshold
Mortality (one month's data)																	
Number of deaths	2470	208	228	272	222	230	201	204	179	185	171	209	189	212	1550		
Number of discharges	199183	16546	16839	15927	15923	18307	16008	16264	17109	17732	15771	17440	17703	16983	135010		
% deaths	1.2%	1.3%	1.4%	1.7%	1.4%	1.3%	1.3%	1.3%	1.0%	1.0%	1.1%	1.2%	1.1%	1.2%	1.1%		
SHMI (Summary hospital-level mortality indicator) (12 months' rolling data)																	
Overall observed number of deaths		3129	3164	3242	3292	3352	3396	3420	3427	3419	3433	in arrears	in arrears	in arrears		TBC	
Overall expected number of deaths		3341	3406	3491	3522	3603	3638	3666	3687	3708	3737	in arrears	in arrears	in arrears		TBC	
Overall SHMI rate		94	93	93	93	93	93	93	93	92	92	in arrears	in arrears	in arrears		<=100	>125
Non-elective SHMI rate		93	93	93	93	93	93	93	93	92	92	in arrears	in arrears	in arrears		<=100	>125
Elective SHMI rate		114	107	109	109	103	100	94	90	90	86	in arrears	in arrears	in arrears		<=100	>125

KEY: Higher than expected | Within expected range | Lower than expected

6.7.3 Other relevant areas of focus are the National Hip Fracture Database, which periodically publishes national audit results; the Provider performance on these has improved in 2015/16 and commissioners will look to see that this is sustained. In Stroke care, there is a planned move to a new model that will see the Frimley Park site, which scored a grade 'A' in the recent national SSNAP results, continue to operate as a Highly Acute Stroke Unit (HASU) while Wexham Park, currently an Acute Stroke Unit, converts to Stroke Rehabilitation. This is aimed at focusing timely and excellent care in HASUs with better patient outcomes in terms of both mortality and rehabilitation.

6.7.4 Commissioners also hold monthly Serious Incident Panels at which all serious incident investigation reports are scrutinised and signed-off. This involves the agreement and monitoring of action plans for each case, along with thematic reviews and overarching action plans where required. Recent examples include the development of a thematic review of patient falls to feed into the organisational falls action plan, and an upcoming thematic review of Never Events. Examples of key actions taken in relation to Serious Incidents include:

- Alarms added to exit doors on wards to minimise risk of dementia patients leaving unsupervised.
- Improved links between Radiology and cancer multi-disciplinary teams to ensure that there is effective follow-up post-imaging where indicated.

6.7.5 For BHFT all unexpected deaths are reported as Serious Incidents, for people that have come in contact with their services as per National guidance. As per National guidance for reporting of serious incidents the provider discusses the serious incident with the Commissioner. These discussions are minuted at the serious incident panel meeting. If the coroner confirms natural causes, the incident is then downgraded. BHFT will be reviewing the 'Independent review of deaths of people with a Learning Disability or Mental Health problems in contact with Southern Health NHS Foundation Trust April 2011 to March 2015' report to assess whether there is any learning for the organisation. This will also be discussed with other providers to ensure lessons are learnt.

6.8 Maternity Assessment of performance

6.8.1 For Frimley Health we receive monthly submissions of maternity clinical quality dashboards covering both maternity units. For 2016/17 the content of these dashboards is to be revised to refresh the performance thresholds and for standardisation across sites. These indicators will be monitored against agreed performance thresholds, with improvement trajectories and action plans set out where required. These will be benchmarked against other providers.

6.9 Routine identification of carers and signposting to support

6.9.1 There has been a CQUIN in place Heatherwood and Wexham Park Hospital during 2015/16 focusing on the improvement of support to carers of patients with Parkinson's disease and Multiple Sclerosis. Work to date has included setting up a carers' steering group which has overseen the carrying out of discovery / survey work to map out areas for improvement in the carers' journeys. From this, carers' pack and website are in development, along with the appointment of link nurses on each ward and a staff awareness campaign. The aim is to build on this work in 2016/17 with a local CQUIN being considered which would broaden the work to patient / carer groups in other settings for example outpatients.

6.10 Quality in Action

6.10.1 **Quality Schedule Monitoring** – We agree with our Providers a range of Quality Indicators both nationally mandated and locally developed to track quality performance and patient safety based on concerns, national initiatives or poor performance. Regular monitoring of such indicators occurs at Provider Clinical Quality Review Meetings (CQRM's) and CCG Federated Quality Committee. Clinical Quality penalty notices can be raised where performance is deemed unsatisfactory

6.10.2 **Patient Safety Incidents** - The CCG aims to encourage Providers to increase reporting of patient safety incidents. This will be tracked and monitored via the CQRM's. The CCG chairs monthly SI Panels with Providers to review serious incidents resulting in harm and Never

events, review and approve action plans, share learning and agree to changes in clinical practice.

6.10.3 The CCG is working collaboratively with the NHS England to improve reporting of patient safety incidents in Primary Care.

6.10.4 **Clinical Concerns** - The CCG actively encourages GP's reporting of clinical concerns regarding Providers. These concerns are collated on a database and themes identified. The concerns are then raised with Providers and where appropriate actions identified.

6.10.5 **Patient Experience** – CCG monitors patient experience from our Providers by review at CQRM of a quarterly patient experience report that includes, complaints with themes by Specialty and actions arising, FFT outcomes, compliments, PALS, NHS Choices summary, you said we did. Robust scrutiny by CCG is given to Providers to ensure learning and improvement in experience of patients. A collated summary report of Provider patient experience including CCG PALS and complaints is presented at CCG Federated Quality Committee in order to review Provider performance across east Berkshire. Each Provider presents a patient story quarterly to the CQRM and what lessons were learnt.

6.10.6 **Friends & Family Test** – CCG monitors FFT on a monthly basis via Quality Schedule submission and review of nationally published data, this is reported quarterly to the CCG Quality Committee.

6.11 Safeguarding of Vulnerable People

6.11.1 The Clinical Commissioning Groups (CCGs) recognises and works to the NHS Commissioning Board revised *Safeguarding Vulnerable People in the NHS – Accountability and Assurance Framework* July 2015**.** This framework details CCG statutory responsibilities for safeguarding vulnerable people which includes ensuring that the organisations from which they commission services provide a safe system that safeguards children and adults at risk of abuse or neglect. The framework was primarily revised to recognise new responsibilities of all statutory organisations under the Care Act 2014. Additionally, primary care co-commissioning arrangements between CCGs and NHS England will have implications for safeguarding responsibilities; progress against the framework is identified within the action plan detailed below:-

- The framework includes specific responsibilities for **looked after children** and for supporting the **Child Death Overview process**. CCGs have a statutory duty to be members of **Local Safeguarding Children Boards (LSCBs) and, from April 2015 (Care Act 2014), local Safeguarding Adults Boards (SABs),** working in partnership with local authorities to fulfil their safeguarding responsibilities.

- CCGs should ensure that robust processes are in place to learn lessons from cases where children or adults die or are seriously harmed and abuse or neglect is suspected. This will include contributing fully to Serious Case Reviews (SCRs) which are commissioned by LSCBs/SABs and also, where appropriate, conducting individual management reviews.

- The CCGs' designated clinical experts (children and adults) are embedded in the clinical decision making of the organisation, with the authority to work within local health economies to influence local thinking and practice. They are able to give clinical advice, for example in complex cases or where there is dispute between practitioners.

6.12 Identification of violence and abuse and improved support to victims.

6.12.1 The CCGs are responding to improved identification of violence and improved support to victims. To by introducing new quality schedules for our Frimley Park Hospital and for Berkshire Healthcare Foundation Trust. Quality schedules will include submission of a Domestic violence strategy for FPH and BHFT including training, support for staff who are victims of violence and how concerns are raised. Midwives will be requested to submit level of interventions following domestic abuse inquiry to all pregnant women. Routine information will continue to understand identification of violence which includes allegations of abuse against professionals and number of assaults perpetrated against staff members.

7.0 Sustainable Finances

7.1 The table below shows the 'programme' funding allocation for our three CCGs for 2016/17 of £490m *and the growth compared to 2015/16. For 2016/17 NHS England has made some fundamental* changes to how the 'target' allocations are calculated for CCGs (the amount a CCG should theoretically receive based on a 'fair share' of the national funding available) and this means the actual funding for each of our CCGs is now much closer to this theoretical target. Slough CCG is funded marginally above the target, with Bracknell and Ascot CCG 1.5% below target and Windsor Ascot & Maidenhead CCG 3.3% below target.

	2016-17 Final allocation after place based pace-of-change £k	2016-17 Final growth £k	2016-17 Final growth %	2016-17 Final per capita allocation £
NHS Bracknell and Ascot CCG	153,421	6,601	4.50%	1,085
NHS Slough CCG	171,799	5,083	3.05%	1,117
NHS Windsor, Ascot and Maidenhead CCG	165,111	9,160	5.87%	1,077

7.2 In total the three CCGs have received 'growth' of £20.8m, but this includes:

- An underlying inflation assumption of 1.7% (the GDP Deflator)
- Population growth
- Three funding streams which we previously received via non-recurrent allocations in 2015/16 for GP IT, additional funding for CAMHS, and for additional national tariff costs.

7.3 Therefore the 'real growth' number, after taking account of these items is only about £4.3m and the additional requirements outlined in the NHS Mandate need to be funded from within this growth number. In addition to our 'programme' funding we receive an allocation for CCG running costs and are allowed a 'carry-forward' of the surplus from 2015/16. Therefore in total the available resources for 2016/17 are £507.6m, as shown in the table below. The table also outlines our forecast expenditure for 2016/17. In preparing our plans we have taken account of key national planning requirements, including:

- Delivery of a 1% surplus in 2016/17
- Holding contingencies of at least 0.5%
- Holding a further 1% for non-recurrent expenditure (in line with the planning guidance, there are currently no commitments against this)
- Increases in national tariff prices of on average 1.7% for acute services and 1.1% for other services
- Growth in acute activity of 2.4% (3% in elective activity and 1.5% in non-elective activity), before taking account of QIPP savings
- Increasing expenditure on mental health services by 3.6%

7.4 In order to meet these planning assumptions significant savings will be required in 2016/17, amounting to about £18m which is equivalent to 3.7% of our recurring funding. The second table below shows the key areas where we are looking to achieve these savings.

Summary of Allocations, Expenditure, Contingency and Surplus for 2016/17	NHS Bracknell and Ascot CCG £000s	NHS Slough CCG £000s	NHS Windsor, Ascot and Maidenhead CCG £000s	Total £000s
Programme Allocation	153,421	171,799	165,111	490,331
Programme Allocation -Adjustments	4	9	18	31
Running Cost Allocation	2,996	3,168	3,188	9,352
Return of Surplus	3,304	1,954	2,634	7,892
Total Allocation & Return of Surplus	**159,725**	**176,930**	**170,951**	**507,606**
Acute	83,707	96,595	90,710	271,012
Mental Health	14,409	17,055	15,993	47,457
Community	10,513	11,866	11,418	33,797
Continuing Healthcare	19,153	15,047	17,703	51,903
Primary Care	21,585	21,565	22,171	65,321
Other Programmes	3,009	5,646	5,110	13,765
Sub Total	**152,376**	**167,774**	**163,105**	**483,255**
Running Costs	2,996	3,168	3,188	9,352
Contingency (Minimum 0.5%)	1,221	2,500	1,296	5,017
Non Recurrent Reserve (Minimum 1%)	1,534	1,718	1,651	4,903
Surplus (Minimum 1%)	1,598	1,770	1,711	5,079
Total	**159,725**	**176,930**	**170,951**	**507,606**

Summary of QIPP for 2016/17	NHS Bracknell and Ascot CCG £000s	NHS Slough CCG £000s	NHS Windsor, Ascot and Maidenhead CCG £000s	Total £000s
Urgent and Emergency Care Programme	2,587	4,977	4,314	11,878
Elective care	1,035	2,076	1,533	4,644
Medicine Management	450	619	494	1,563
Other	78	61	136	275
Total	**4,150**	**7,733**	**6,477**	**18,360**
QIPP as % of Resource	2.7%	4.4%	3.8%	3.7%

7.5 Alignment of our plans with our providers

The CCGs are working collaboratively to agree contracts with our main providers, Frimley Health NHS Foundation Trust, Royal Berkshire NHS Foundation Trust, South Central Ambulance NHS Foundation Trust and Berkshire Healthcare NHS Foundation Trust.

7.5.1 We are seeking to agree the following key planning assumptions with our providers:

- A common start-point of the Month 9 2015-16 forecast outturn;
- Annual underlying growth of 3% in elective activity and 1.5% in non-elective activity, before taking account of pathway redesigns which move activity into new settings, or the application of business rules for example for procedures of limited clinical value;
- A gradual repatriation of activity to Frimley Health Foundation Trust from other acute providers, partly from patient choice (due to of the improved quality of care at Wexham Park hospital), and partly from the proactive repatriation of more specialist activity from London and other tertiary providers.

7.7 Contracting

7.7.1 The three CCGs in East Berkshire intend to act reasonably and responsibly as commissioners of healthcare. To this end the following principles will apply. We will:

- aim to commission sufficient activity to meet the demand and constitutional standards required for our populations.
- apply standard NHS Contracting principles of engagement as well as guidance and regulations.
- not seek to unfairly shift risk across other parts of our healthcare system
- use all tools and leverage available to ensure receipt of provider services to the prescribed standards and quality
- use all relevant contractual clauses and schedules in support of developing and implementing service change.

7.7.2 We will use the NHS Standard contract to drive quality, innovation, productivity and efficiency to ensure the delivery of the highest quality services at best value.

7.7.3 We will benchmark productivity measures with the aim of achieving or further moving towards upper decile performance in line with affordability. We expect to work with our providers and with primary care to reduce unnecessary activity within the principles of providing the lowest level of intervention required to manage the patient's condition effectively.

7.7.4 Through jointly agreed Service Development & Improvement Plans we are intending to reflect work programmes throughout the year with our Acute, Community and Mental Health service providers to improve patient pathways, inter-organisational delivery, provider performance and to develop services. We expect all organizations to strive to achieve the agreed milestones and report to the Contract Management Meetings if any have not been delivered. Day to day monitoring of these plans will be undertaken at monthly intervals unless there is failure to progress, in which case, in the absence of reasonable impediments, contractual levers will be used to maintain pressure for delivery.

8.0 Enabling Strategies

Engagement and Co-production-

8.1.1 The CCGs believes strongly that engagement is a continuous process of discussion and listening. Wherever possible this will be done in conjunction with our local authorities and provider stakeholders.

8.1.2 Our Communications and Engagement Strategy was completely revised at the end of 2015 and views are currently being sought from patients, the public and other stakeholders. The strategy is now shared across the three CCGs and sets out the principles for communications and engagement and three key objectives:

- To proactively engage with stakeholders and enable people in East Berkshire to contribute to shaping future health services commissioned by the CCGs.
- To develop a culture that promotes open communication and engagement with patients and the public.
- To ensure member practices and staff are informed, engaged and involved in the work of their CCG and participate in commissioning activities for the benefit of patients.

8.1.3 Two key Forums are in place to facilitate and plan communications and engagement:

- **Each CCG has a Forum/Network** bringing together representatives from their practice Patient Participation/Reference Groups. Each meets bi-monthly and their agendas include a section for bringing an update from the CCG about key projects and initiatives which might be of interest to their groups and opportunities to get involved. Hosting and chairing arrangements vary but the lay member for Patient and Public Involvement is a member and Healthwatch also attend. The groups offer support to each other and share good practice as well as develop work plans for the year.

- **The Community Partnership Forum** brings together representatives from the communities across east Berkshire to allow for wider discussion about issues that are shared. Membership includes representatives from local councils, voluntary sector, Healthwatch, PPGs, Patient groups and the public. The Clinical Chairs and other members of the CCGs attend and the topics are agreed with the wider membership. All meetings are open to the public with information published on the CCG websites, including papers and presentations. This Forum is chaired by voluntary sector representative.

8.1.4 The CCGs recognise that their ambition in relation to engagement will only be realised by exploiting technology. This will allow a much greater reach, more projects to engage effectively and will increase efficiency. This is being achieved through a number of initiatives:

- **Twitter:** The CCGs are actively engaging via their Twitter accounts and incorporate twitter into all project communications and engagement plans.
- **Health Connect:** This on-line engagement tool was launched in February 2015 and has more than 650 members to date. Patients, public and community organisations are encouraged to register. The tool is currently used to broadcast messages, send invitations to events, such as workshops and public meetings and to run surveys to enhance the engagement in various projects. The format of the site is consistent with the other Thames Valley CCGs so that collaborative engagement can also be facilitated. For example, NHS111 is being re-procured on a Thames Valley-wide basis and the public engagement needs to be coordinated across all 10 CCGs. Having the same online systems for running surveys allowed the format to be cloned onto the engagement sites for each CCG. Results were analysed on a CCG basis as well as drawing themes across CCGs for the project.
- **CCG Website**: The website is a key tool for engaging and communicating with the public. Its use is monitored and reviewed regularly. Plans are in place for a refresh of

sites with Slough's new site planned to go live in the spring with full engagement of patients to ensure it holds information and is structured to support effective engagement.

8.1.5 **Engaging diverse communities:** The diverse communities across East Berkshire are engaged in the work of the CCG in a variety of ways. The communities are very different and the CCGs employ different methods depending on the community to be reached. For Bracknell and Ascot CCG, this includes the Nepali community around Sanhurst, for Slough CCG, this includes recognising the changing demographics with new migrant communities as well as the existing diverse communities, for Windsor, Ascot and Maidenhead CCG this includes recognising the growing number of older people and the relatively large number of people living in care homes. Methods for engaging these diverse communities varies and includes making sure information are accessible and available in different languages. A local translation service responds to requests in a timely way. The CCG attends community events and meetings including one-off events such as an information day for the Somali Community in Slough, the Retirement Fair in Ascot, Self-Care Week events in Bracknell Forest and Older People Forums in all areas.

8.2 System leadership

8.2.1 The CCGS recognise the importance of system leadership in the development and delivery of our Sustainability and Transformation Plan and Operating Plan. We are clear about the governance arrangements required to lead the Frimley system and also that all partners in this also need to work across other systems. We are comfortable with this complexity as we have been working across different footprints for a number of years.

8.2.2 We have set up a Frimley System Leaders Group, comprising CCGs, providers and local authorities. This will be the 'umbrella' group which will work closely with our other system leadership arrangements, to ensure coherence of plans and leadership within the Frimley footprint. In East Berkshire, we will build on our successful System Leaders Group which has championed a number of system programmes including Share Your Care and New Vision of Care. Several of our partners have been working with the Kings Fund on developing our system leadership and we are looking for them to support us in developing our new arrangements.

8.2.2 The Frimley footprint has a number of work streams underway to identify the three gaps in the Five Year Forward View (Health and Wellbeing, Care and Quality and Finance and Sustainability) which will inform our focus as a system. We also have set up an Executive Group which will drive the development and then operationalisation of our plans. As the Operational Plan is in effect year 1 of our STP we will ensure that those areas that require system leadership will be incorporated into these arrangements.

8.3 The digital roadmap/ interoperability

8.3.1 Digital technologies are fundamentally changing the way clinicians are working, information is shared and care is provided. They are also enabling patients to access information about, and participate in their care, in new and innovative ways. Our plans through to 2020 are being summarised in a document known as the Digital Roadmap. The 'footprint' for our Digital Roadmap covers the three CCGs in East Berkshire, the three Local Authorities and our main providers. The Roadmap will be completed by June 2016 and is overseen by our Digital Roadmap Board.

8.3.2 Central to our strategy is our 'Share Your Care' project which involves a £5m investment over 7 years to allow:

- Interoperability and information exchange between health and social care organisations with the flow of real time data between organisations to improve service provision, care and data analysis;
- Having a person held health and social care record with accurate real time data from GPs, providers, and citizens, enabling people to hold and manage their care data and give consent to providers/carers to view their record.

8.3.3 In February 2016 we selected Graphnet as our strategic partner for this project. In addition to being a fundamental prerequisite for delivering our 'New Vision of Care' for frailty it assists in delivering the national policy objectives that:

- by 2018 all clinicians in primary, urgent and emergency care operate without paper records;
- from March 2018 all patients able to record their own comments and preferences on their care record;
- by 2020 all care records will be digital, real time and interoperable.

8.3.4 Other key technology themes in our plans through to 2020 include:

- Increasing the use of clinical decision making tools which provide clinicians with computer-generated knowledge to aid with diagnostic and treatment decisions. During 2016 the DSX Clinical Pathway and Triage Solution will be implemented in the three CCGs;
- The remote monitoring of patients and improving self-care through use of apps, wearables and other devices, for example for diabetes and heart conditions;
- Enabling our GPs to expand the range of services they offer for example through point of care testing where GPs undertake tests on site which historically would have required a hospital laboratory;
- Supporting professional-to-professional telehealth in the form or real time phone, video or web consultations;
- Delivery of care and care advice electronically, for example psychological interventions through online modules such as computerised cognitive behavioural therapy;
- Using the data generated through shared electronic health records and monitoring devices to move to a model of more proactive care to identify those at risk and enabling early intervention;
- Using technology to support efficiencies in the clinical and managerial workforce through mobile working and better workforce planning.

8.4 Workforce development

8.4.1 The development of our workforce is a key enabler to our longer term plans and will require some attention in year. In order to deliver the transformed care we are aspiring to by 2021, we will need to re-design roles, address recruitment issues and develop a culture amongst our collective workforce that delivers our ambitions. We have a number of opportunities to do this at scale across the Frimley system and will be working closely with the local offices of Health Education England to develop our collective approach.

8.4.2 We will also be working across the Thames Valley Urgent and Emergency network to develop workforce plans and implement changes to roles within the 111 service.

8.4.3 During 2016/17 WAM CCG will be piloting a community education provider network which will provide an opportunity to develop a new approach to workforce development in primary care.

8.4.4 The New Vision of Care programme as part of the implementation of the new model of care has set up a system wide workforce work stream. The aim of this work stream is to identify the workforce changes and developments that will be required to successfully implement the new model and to capture this as a work stream action plan that has been developed and owned by the health, social and voluntary sector.

8.6 Estates Plan

8.6.1 The CCGs are developing an Estates Strategy which draws together plans across the primary, community and acute sectors to ensure we have the right premises available for new models of NHS care, at an appropriate cost. Key elements of the Strategy include:

8.6.2 Working with Frimley Health Foundation Trust on their ambitious plans to reconfigure the emergency care and assessment facilities on the Wexham Park hospital site, and a complete rationalisation of the outdated Heatherwood Hospital facilities. This will entail a complete rebuild to provide a state of the art elective care centre with 6 theatres and 62 beds.

8.6.3 A review of the services using community hospital facilities at Upton Hospital, King Edward VII Hospital and St Marks Hospital, with an immediate priority to reducing the amount of empty and derelict space which is an unnecessary financial burden on the local health economy.

8.6.4 Ensuring we have sufficient and appropriately located primary care (GP) facilities to meet the growing population in East Berkshire and the increasing focus on providing non urgent care in settings away from hospital and closer to people's homes. During 2015/16 some 17 schemes were given full or outline approval for funding through the Primary Care Transformation Fund, and a further X bids will be submitted in April 2016. Key proposed practices developments / extensions include:

- Langley Health Centre (Slough) – major extensions;
- Farnham Road Practice (Slough) – fundamental review of practice location and capacity;
- Binfield Practice (Bracknell) – fundamental review of practice location and capacity;
- Ascot Practices - opportunity to consolidate onto two sites as part of the wider Heatherwood Hospital redevelopment;
- Reprovision of the Skimped Hill site which is part of the Bracknell town centre redevelopment zone.

8.6.5 Working with our local authorities to get a common view of 'One Public Estate' to support integrated care across health and social care, and maximising the opportunities from planning and Community Infrastructure Levy arrangements.

8.8.6 Underpinning our plans by thorough patient, public and partner participation via three Local Estates Forum.

9.0 Risk & Governance of Plan

9.1 CCG Assurance Framework

9.1.1 The CCGs are currently assessed as 'medium risk' and based on Q2 report we have been assessed as good on finance, planning and delegated functions and have limited assurance on well led organisation and performance. Following progressed made in Q3 and the confirmation of appointment of a permanent AO together with the work being carried out on our OD strategy we are planning to receive a good assessment on all areas by Q4.

9.1.2 With the development and implementation of the new CCG assessment framework we would anticipated that this good performance assessment will continue in relation to the four key facets outlined in the new arrangements. Our ambition during 2016/17 is for the CCGs to achieve an outstanding rating in at least one facet area.

9.2 Risk to delivery of the Operational Plan

9.2.1 The CCG has a risk management strategy and framework which is followed to identify and manage risks. All high and extreme risks are reported on a quarterly basis in public to the CCG Governing Body is using the Assurance Framework. The top risks are:-

- Negotiation of contracts with providers to ensure delivery of our financial, quality and activity plans
- Delivery of the transformation of services and at scale and pace during 2016/17 in order to deliver the requirements for our local system
- Resilience and sustainability of our local system during periods of high service demand
- Ability to recruit and retain workforce across the local system.

9.3 Governance & Local Assurance Process

9.3.1 As part of our organisational development programme we have been reviewing governance processes and will have two key subcommittees of the Governing Bodies that will play a role in the delivery and assurance of the Operational plan. These are Strategy and Planning which will ensure strategic alignment and the sign off of business cases across the three CCGs and Finance and QIPP Committee which will review QIPP delivery.

9.3.2 Our organisational structure is being aligned to the delivery of the major programmes of work in the Operating Plan. Clinical engagement at practice level will remain through member meetings and our clinical leadership is being aligned to programme delivery.

9.3.3 Programme Management Office

9.3.1 The CCGs has a Programme Management Office (PMO) to monitor the delivery of all projects across the three CCGs and identify areas of risks and non-delivery of benefits.

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SLOUGH BOROUGH COUNCIL

REPORT TO: Slough Wellbeing Board **DATE:** 23 March 2016

CONTACT OFFICER: Lise Llewellyn, Strategic Director, Public Health Services across Berkshire

(For all Enquiries) Angela Snowling, Consultant in Public Health, Wellbeing Directorate (01753 87 5142)

WARD(S): All

PART I
FOR DECISION

PUBLIC HEALTH ANNUAL REPORT 2015/16

1. Purpose of Report

1.1 To inform Slough Wellbeing Board members of activity on public health in Slough during 2015/16 and help stimulate a discussion and debate around the future priorities and work of the Board (including Slough's Children Services Trust) and the wider partnership.

2. Recommendation(s)/Proposed Action

2.1 That the Board notes and agrees to publish the draft document at Appendix A in principle subject to any comments or amendments that are raised at the meeting.

3. The Slough Wellbeing Strategy (SJWS), the Joint Strategic Needs Assessment (JSNA) and the Council's Five Year Plan

3.1 The Annual Report 2015/16 relates to all aspects of the Slough Joint Wellbeing Strategy's (SJWS) *current* priorities and its cross-cutting themes[1] in so far as they relate to children and young people.

3.2 The Annual Report is written using information from the latest available needs assessment and evidence supplemented from other information sources such as education and other community services.

3.3 The relevant Council priorities/outcomes[2] are "*Enabling and preventing:*

Outcome 5 *- More people will take responsibility and manage their own health, care and support needs*

Outcome 6 *- Children and young people in Slough will be healthy, resilient and have positive life chances"*

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[1] The SJWS is due to be refreshed in 2016.
[2] Slough Borough Council's 5 Year Plan 2016 - 2021

4. **Other Implications**

a) Financial - Work on Public Health has implications for all health care providers and commissioners. However this report has no direct financial implications
b) Risk Management – – n/a
c) Human Rights Act and Other Legal Implications - The Director of Public Health (DPH) has a statutory responsibility to produce an annual report for Public Health. The Health and Social Care Act 2012 states: *"The Director of Public Health for a local authority must prepare an annual report on the health of the people in the area of the local authority. The local authority must publish the report".* The DHP's final report will be published electronically on the Council website.
d) Equalities Impact Assessment (EIA) – n/a

5. **Supporting Information**

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

5.2 The draft Report at Appendix A therefore pulls together a snapshot of some of the key challenges and inequalities that exist within one group of the population - our children and young people - and describes the impact of these inequalities in later life and on current service provision. The evidence shows that children should be a key focus for attention if we are to address inequalities. If Commissioners and partners are serious in addressing health inequalities in our communities then the early year's period presents a key intervention point.

5.3 Slough has a young population with a growing number of children. One question would be does the Board work demonstrate this young profile.

5.4 The Report also highlights some of the issues that challenge our children as well as the inequalities that work within this group. Services can be too focussed on clinical conditions and not recognise the huge impact that other issues contribute to outcomes. Education and health are intertwined. Whilst Slough performs well with regard to overall educational attainment in secondary schools and supports children who are eligible for free school meals better than its neighbours, there is a still gap that is significant. In contrast, our children have higher and worsening levels of obesity which will have significant long term health impacts and could put at risk the educational success to date since in general children who are obese do less well educationally.

5.5 The Report shows the key issues that should be addressed to support good health in childhood that should be incorporated into plans to develop health visiting services as part of early year's services working with Slough's Children Service's Trust. The key issues of smoking cessation, breast feeding and childhood obesity are important for both morbidity and mortality.

5.6 Finally, the Report highlights that whilst we should focus on improving children's health (because it has key long term benefits), if we were to focus on improving our support in some of our more deprived wards, then we could alter the pattern of health services use positively over the short term and so improve effectiveness of spend.

6. Comments of Other Committees / Priority Delivery Groups (PDGs)

Whilst the Report is the independent report if the DPH and as such does not require public consultation, colleagues from Public Health and Slough's Children's Services Trust have added valuable expertise and helped shape its content.

7. Conclusion

- The role of the DPH is to be an independent advocate for the health of the residents in this authority.
- The Annual Report at Appendix A provides an independent review of the health needs and challenges facing one area of our population - not the population as a whole (this information is reflected separately in the JSNA).
- It highlights some of the key challenges and inequalities at work within this group and is intended to help stimulate a debate about what local organisations, including the Board (and the wider partnership), could do in response to these important health issues.
- The Board are asked to consider how this report will influence the work to improve health inequalities

8. Appendices Attached

A - DPH's Draft Annual Report 2015/16

B - DPH Annual Report 2014/15 – Summary of achievements

9. Background Papers

None

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Appendix A:
Draft
Public Health
Annual Report
Slough Borough Council

Dr Lise Llewellyn

Strategic Director of Public Health

Public Health Services across Berkshire

Why children?

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

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

Additionally within each LA we can see that life expectancy varies according to the affluence of the ward – 4.5 years for men and 3.0 years for women within Slough.

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

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

"Give every child the best start in life"

and

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

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

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

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

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

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

Infant Mortality

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

Death in childhood is measured in a number of ways.

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

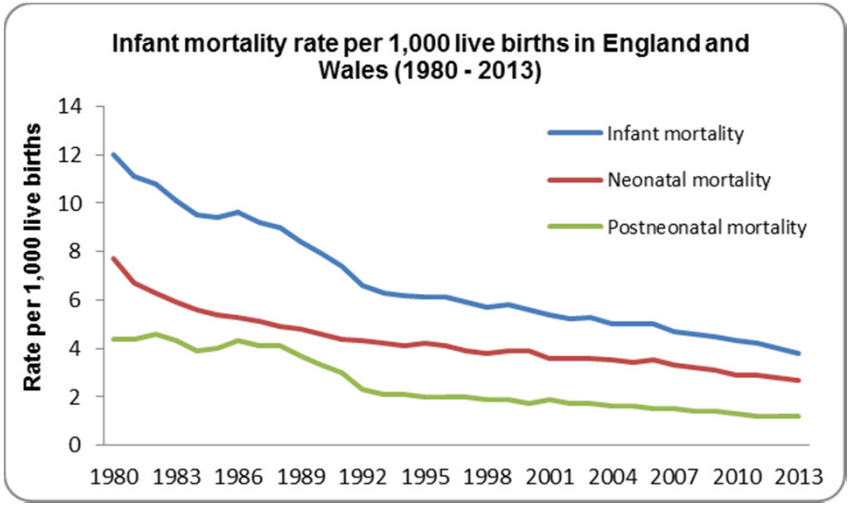
Neonatal mortality - *deaths before age of 28 days per 1,000 live births*

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

Child mortality - *deaths before age of 5 years*

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

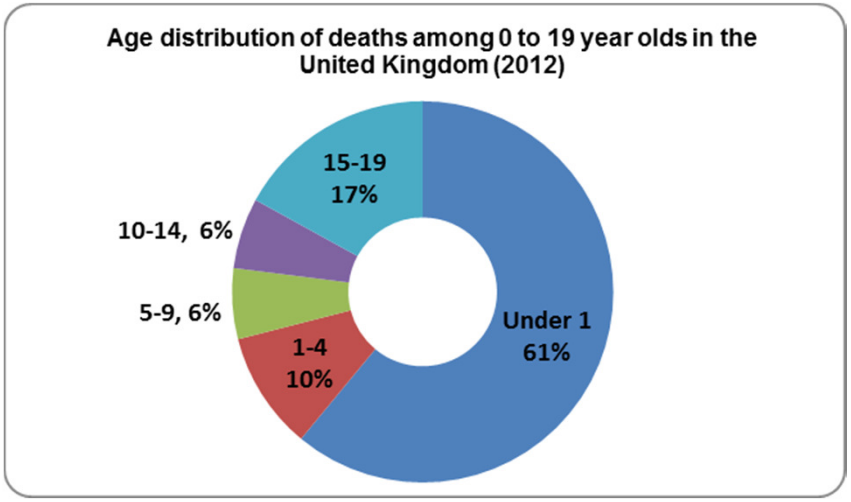
In 1980, there were 12.0 deaths per 1,000 live births and in 2013 there were 3.8 deaths per 1,000 live births. This was the lowest level recorded in England and Wales .[3]

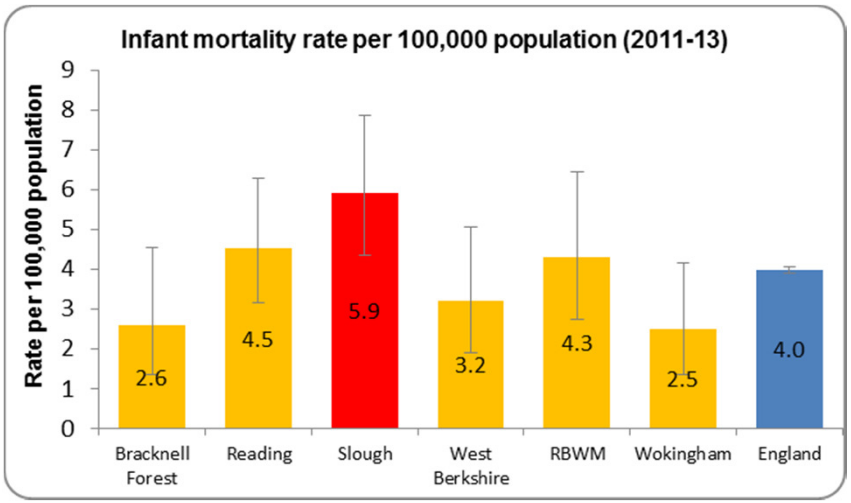


In contrast, 20 years ago mortality in the UK for under 19 years compared favourably with the rest of Europe. However, now we have one of the highest rates. If we compare ourselves against Sweden then **every day 5 extra children under the age of 14 die in the UK.** [4, 5]

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

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





Causes of childhood deaths

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

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

- any matters of concern affecting the safety and welfare of children in the area of the authority
- any wider public health or safety concerns arising from a particular death or from a pattern of deaths in that area; and
- putting in place procedures for ensuring that there is a coordinated response by the authority, their Board partners and other relevant persons to an unexpected death

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

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

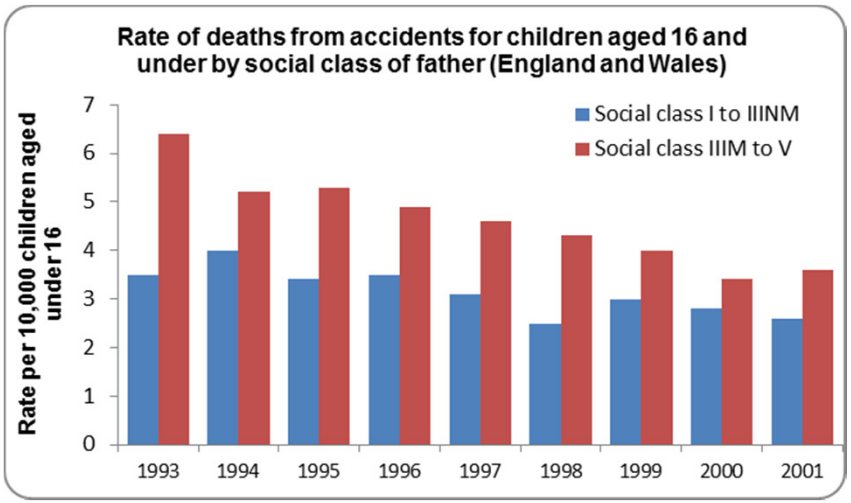
In 2011-13, 75 children were killed or seriously injured in road traffic accidents in Berkshire. The rate in England was 19 per 100,000 children (aged under 16). Slough's rates were similar to England's rate.

Childhood mortality

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

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

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



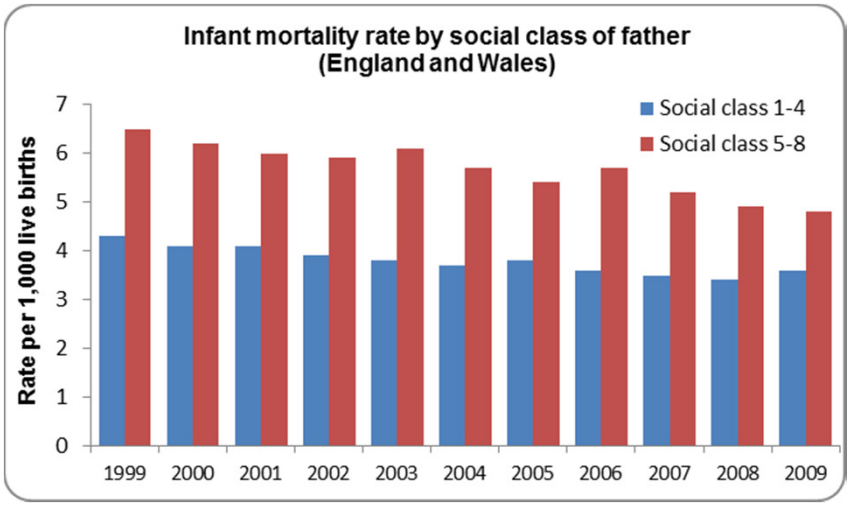
Deaths from accidents and injuries are reducing, but at rates comparable to European countries that already have lower childhood mortality. This does not, therefore, explain our worsening relative position in childhood death rates within Europe.

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

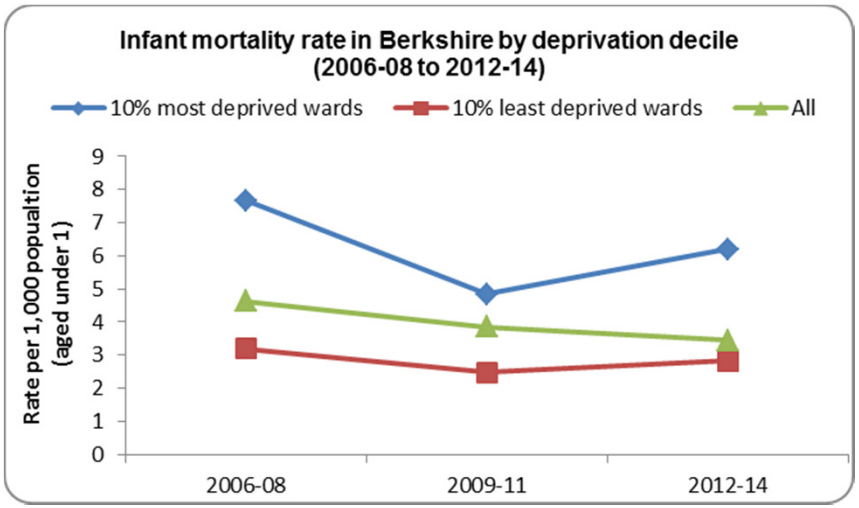
Wider influences

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

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

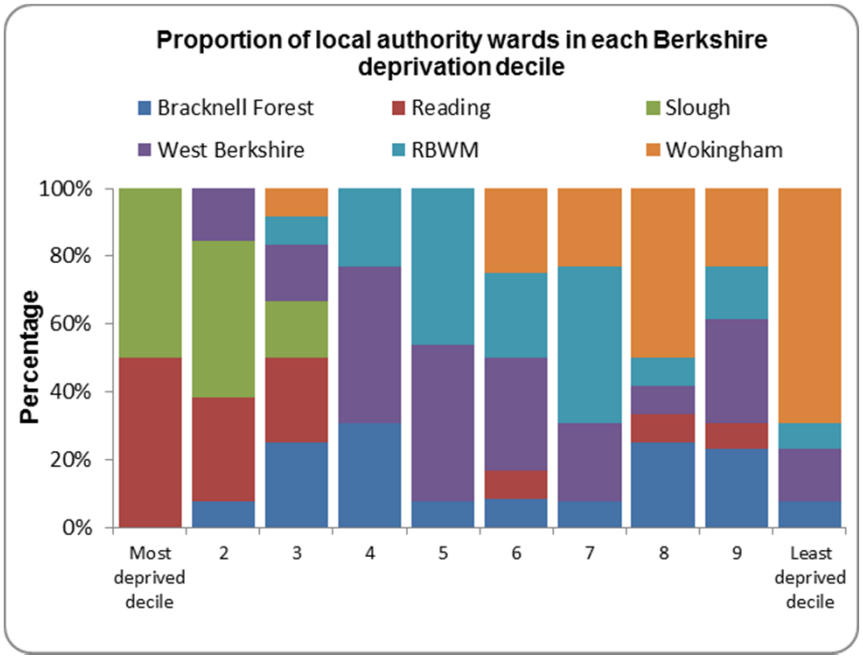


When the improvement in infant mortality is reviewed by ward, it is possible to see that wards that were relatively less deprived experienced a greater reduction in infant mortality rates compared to the national rates in England and Wales [1, 8]. Likewise when one looks at infant mortality across Berkshire, the differences in infant mortality according to deprivation can be seen.



Slough is the most deprived local authority in Berkshire. Compared to other areas across England, it has average levels of deprivation and we would therefore expect to see similar infant mortality rates to the England average. However, this is not the case. Slough's infant mortality rate is significantly worse at 5.9 deaths per 1,000 live births in 2011-13, compared to 4.0 per 1,000 live births in England.

Over the past 5 years, the death rate has been higher than England's and is likely to be linked to deprivation, as well as the high levels of new immigration and BME profile of the Borough. Both of these are recognised as risk factors for higher infant mortality. Reviews of all deaths identify and mitigate and risk factors and programmes of wok are in hand to address factors



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

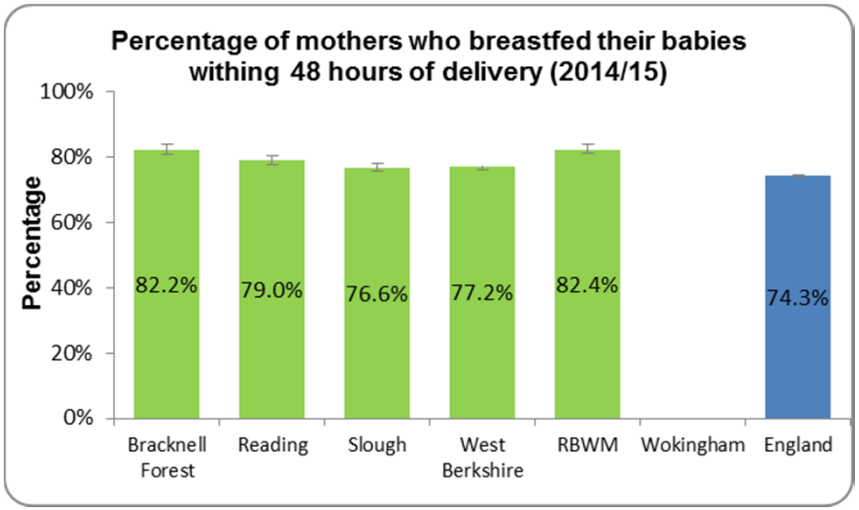
Rates of low birth weight are higher in less advantaged socio-economic groups[11] and are particularly linked to a number of negative health behaviours such as poor prenatal care, substance abuse, poor nutrition during pregnancy and smoking which are more common in these groups. [7]

Breastfeeding

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

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

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



Other inequalities

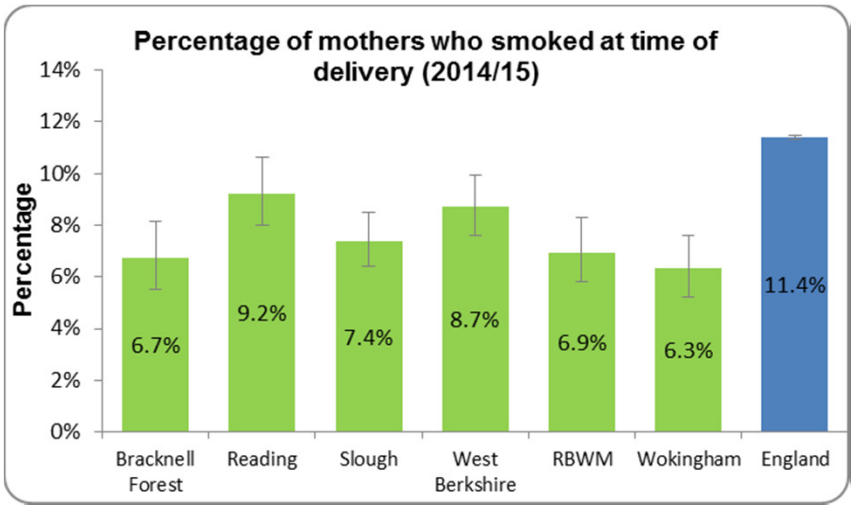
Smoking

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

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

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

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



Obesity

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

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

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

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

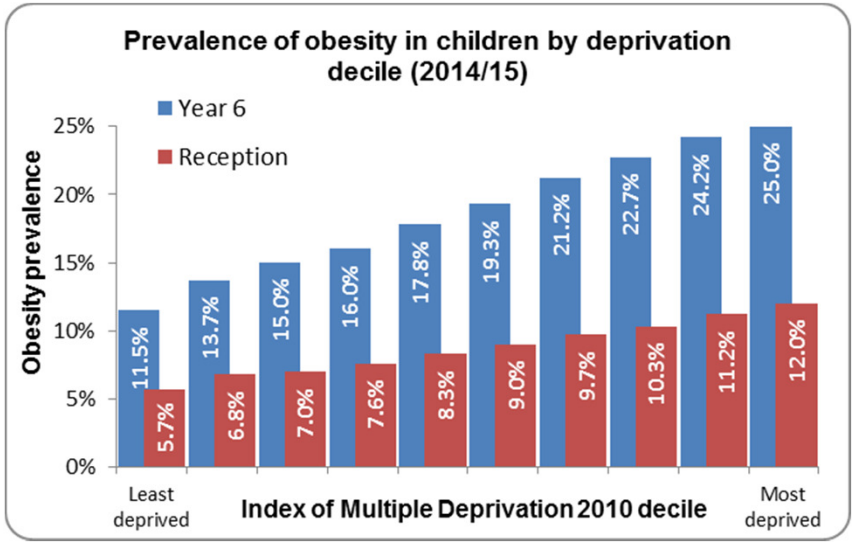
UK studies within the last five years have shown an increase in the prevalence of obesity amongst pregnant women presenting to hospital for booking. [17]

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

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

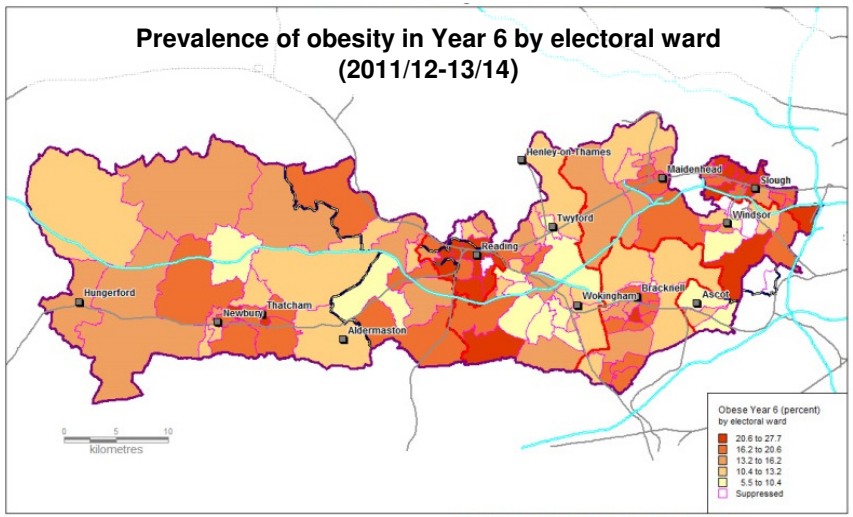
We have tried to describe in this report a 'social gradient' in health – that is a pattern in outcomes that show how outcomes get worse as the level of deprivation increases, such as infant mortality.

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

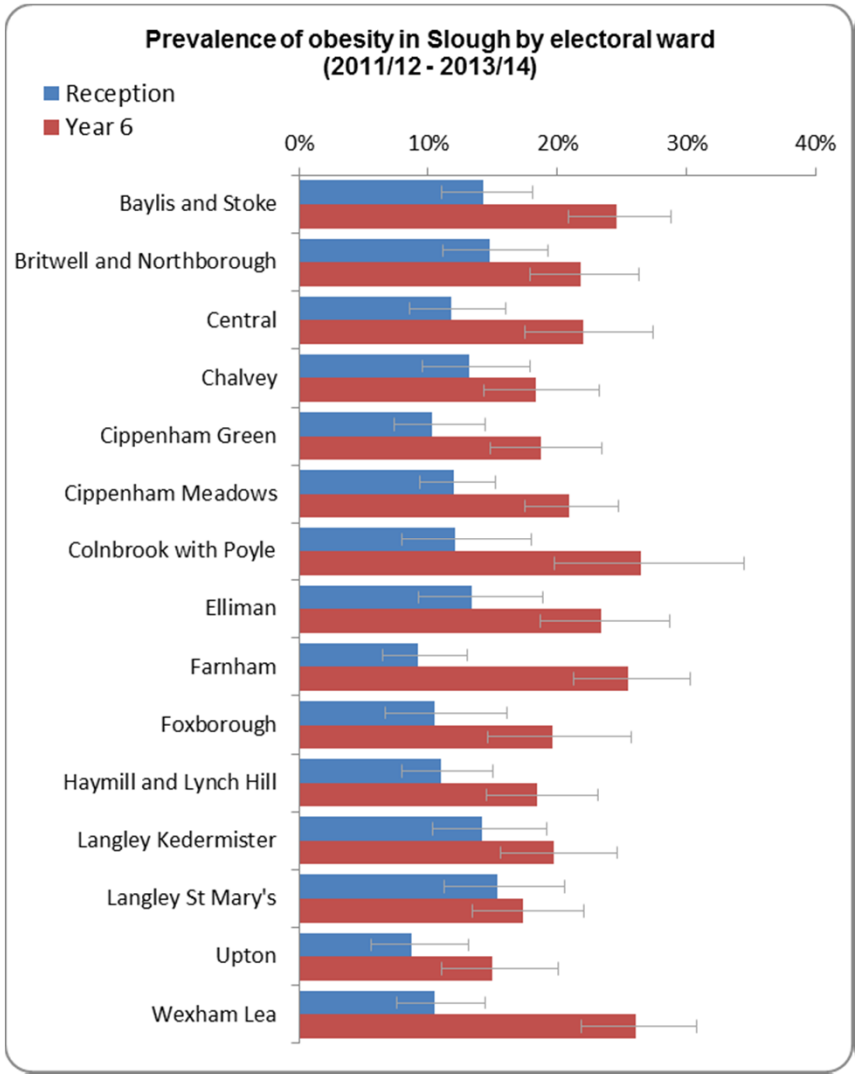


The well described national picture that children in deprived areas are more obese is also mirrored in Berkshire. The more affluent local authority areas have lower levels of obesity in Berkshire, as shown in the table and map below. [18]

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



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



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

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

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

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

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

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

Education and health

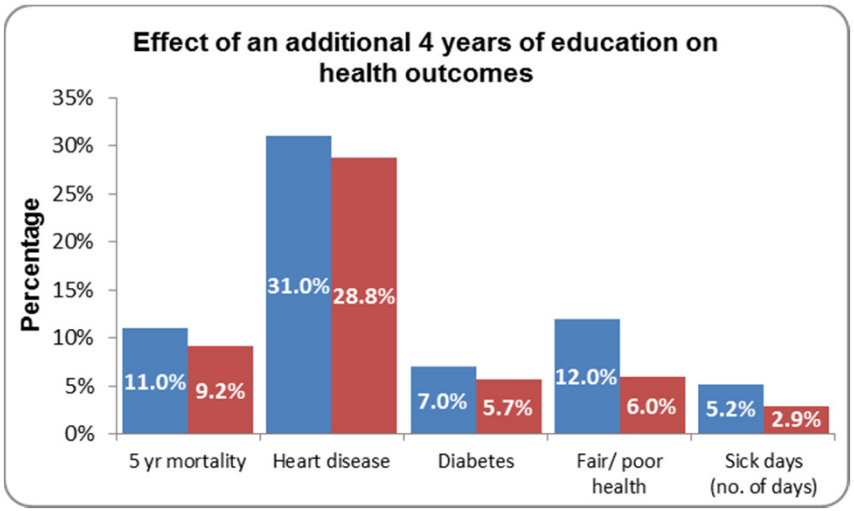
The relationship between health and education is complex. It is widely evidenced that in general those with higher educational attainment earn higher salaries. This may be the basis of the government policy which encourages more children to go to university as a route to promote economic growth.

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

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

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

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



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

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

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

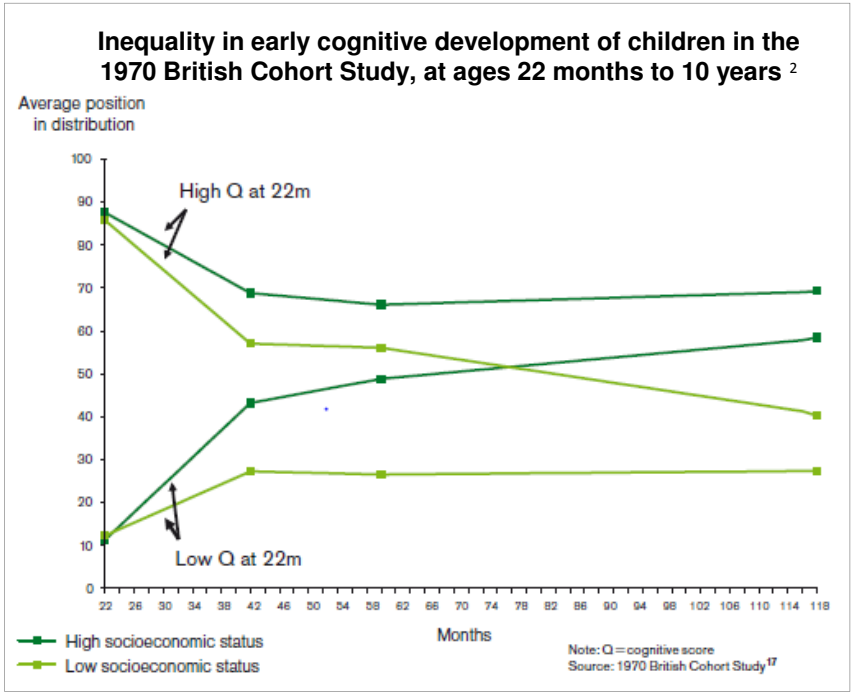
What influences education?

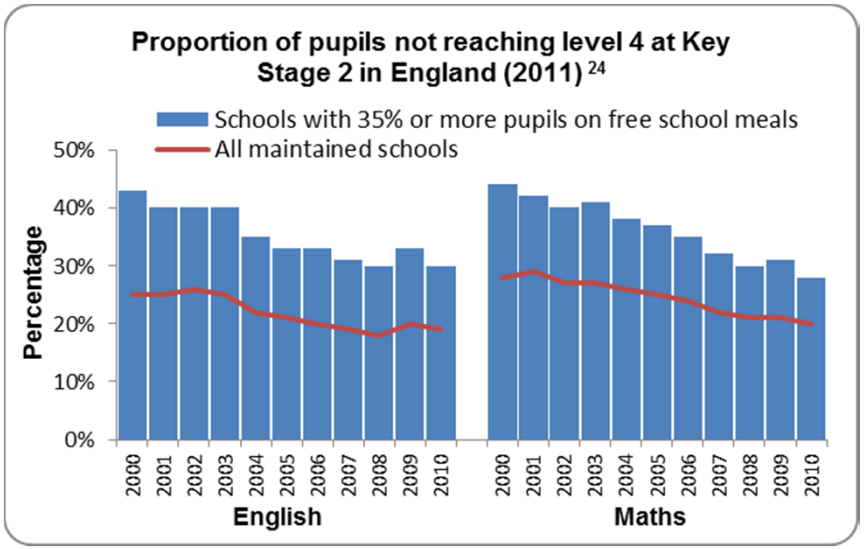
So if education has such a powerful impact on health, do all our children have the same educational success or the same chances of this success?

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

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

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

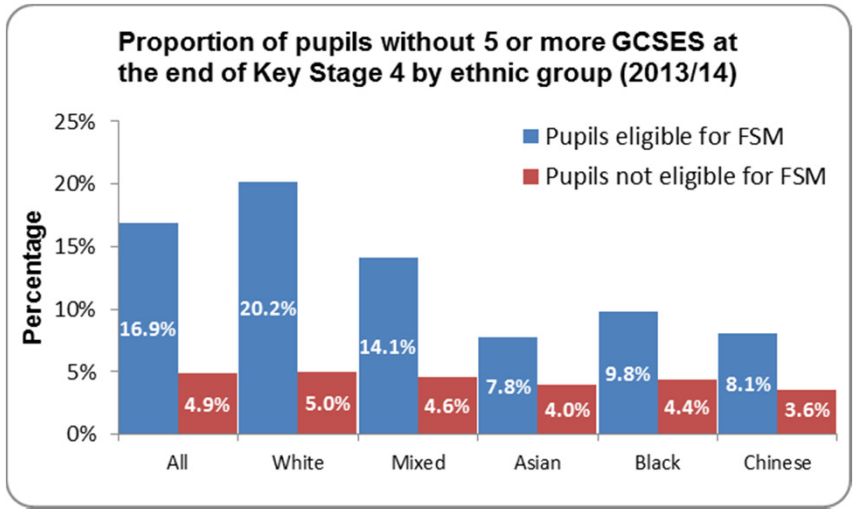




In the UK, children eligible for free school meals (FSM) are used as a proxy measure for families with lower incomes. To be eligible for FSM, the family must receive one of a series of income support mechanisms.

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

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



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

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

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

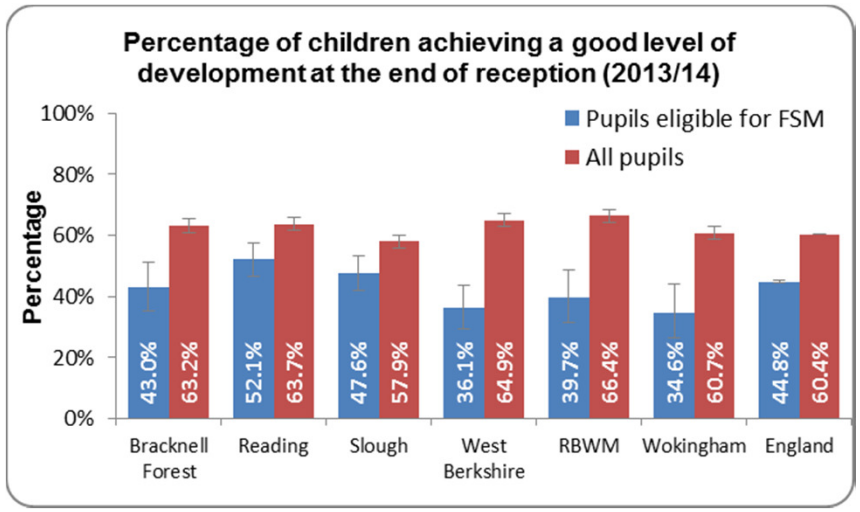
This 'narrowing the gap' issue is replicated in each of the local authorities in Berkshire. Bracknell Forest has the largest gap and, together with West Berkshire, is under the South East average attainment. In Slough we see the greatest success with exams in children eligible for FSM , where success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

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

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

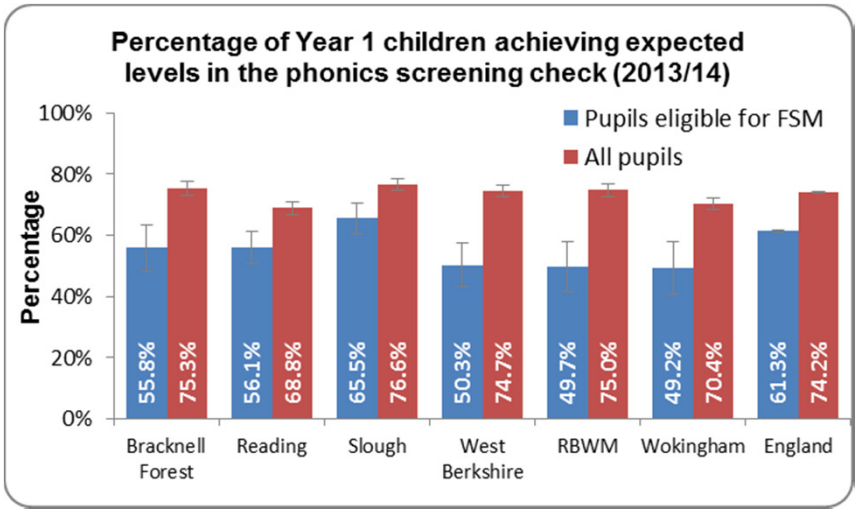
The difference in school attainment for children who receive Free School Meals is also evident in primary school. The Public Health Outcomes Framework includes 2 measurements of school readiness for children who are in Reception and Year 1 (ages 4 to 6). Evidence shows that gaps in attainment emerge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

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



In 2013/14, 47.6% of children eligible for free school meals in Slough achieved a good level of development at the end of reception. This was an achievement gap of 10.3% points, compared with all children. This is lower than England's gap, however the percentage of all children in Slough who achieved a good level of development was significantly worse than England's.

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



65.5% of Slough's pupils eligible for Free School Meals achieved the expected levels in phonics screening. This was higher than the England average and also the highest level in Berkshire. The achievement gap between pupils eligible for Free School Meals and all children in Slough was also lower than England's at 11.1%.

Looked after children

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

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

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

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

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

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

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

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

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

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

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

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

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

Mental health disorders are more common in looked after children

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

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

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

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

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

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

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

The SDQ is an important measure of emotional distress in this vulnerable group. In 2014, 68% of looked after children had an SDQ score submitted in England, but the submission rate across Berkshire did vary significantly from 29% in West Berkshire to 93% in Bracknell Forest. Slough submitted SDQ scores for 95% of looked after children in 2014.

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

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

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

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

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

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

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

Use of hospital services

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

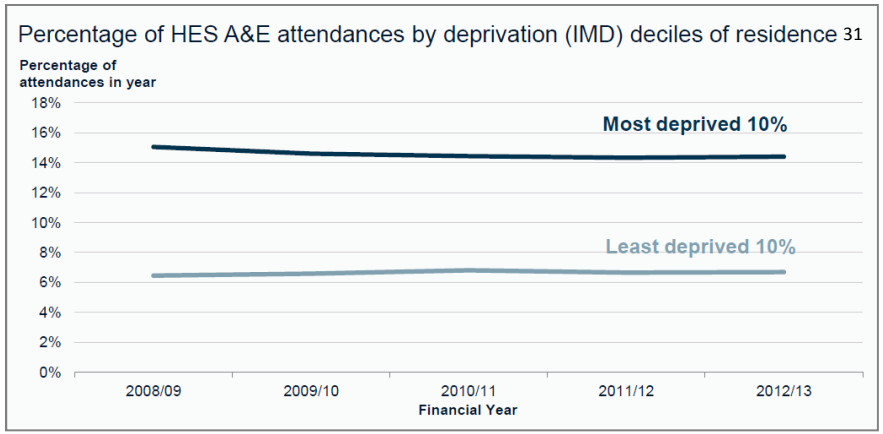
The consensus of the evidence available on the relationship of health service use in relation to deprivation is that GP use is broadly equitable by social economic group. However, evidence highlights a number of systematic differences between the use of secondary care by residents in deprived areas and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

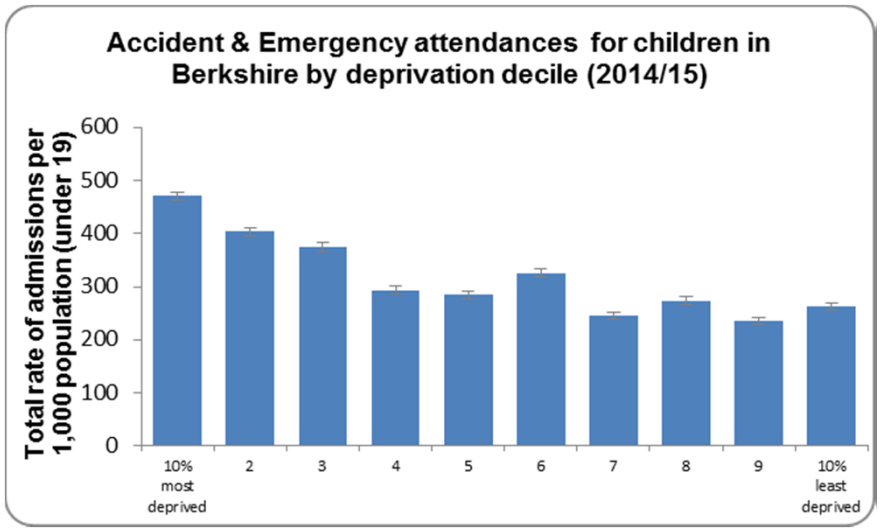
Compared with people in more affluent area, those living in deprived areas:

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

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

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





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

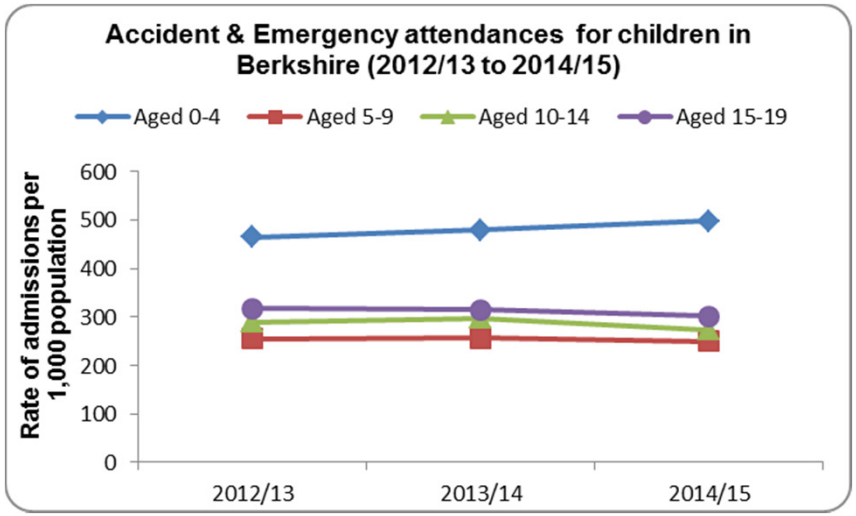
The higher use of A & E in more deprived communities can be partly explained by higher rates of illness and accidents, with the rate of accidents more prevalent in lower SEC groups. This also shows differing behaviours in response to illness and injury.

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

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

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

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



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

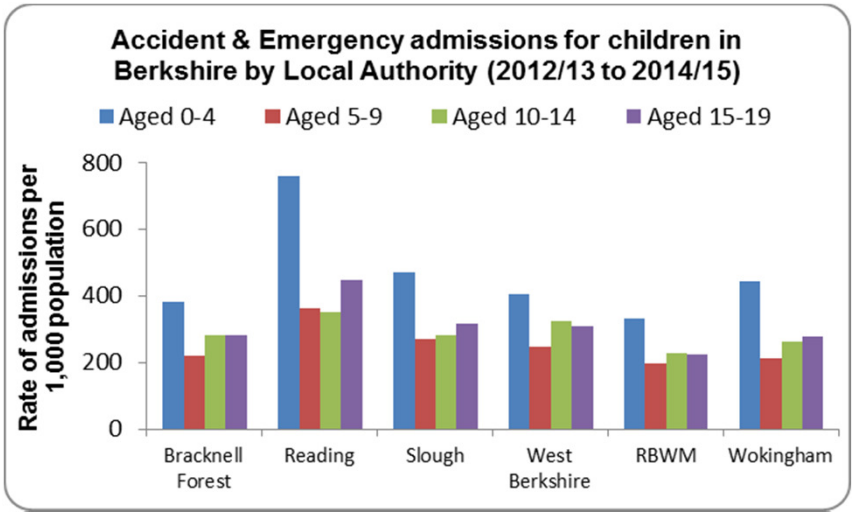
0-4 year olds use A & E the most across the UK, accounting for 3% of all attendances. People aged 80 account for less than 1% of all attendances.

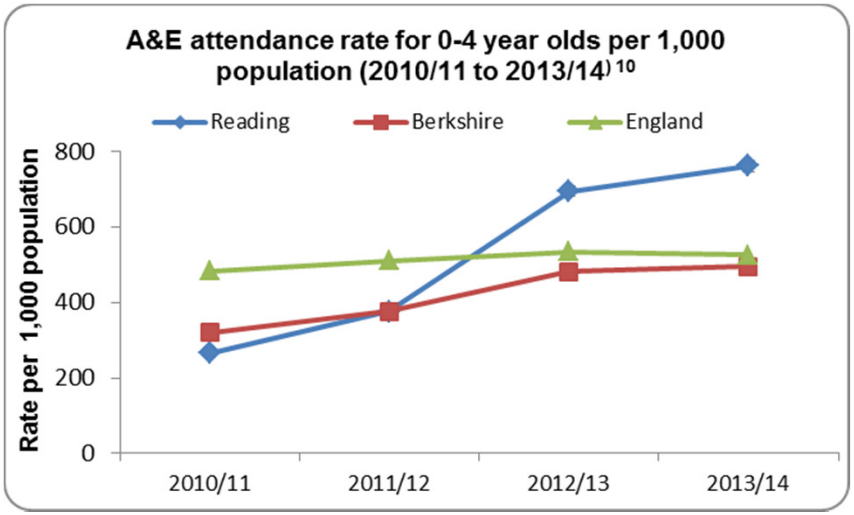
Similarly, the 0-4 age group has the highest number of emergency admissions, with approximately 225,000 nationally. This is a similar rate of attendances as 80 year olds . 31

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

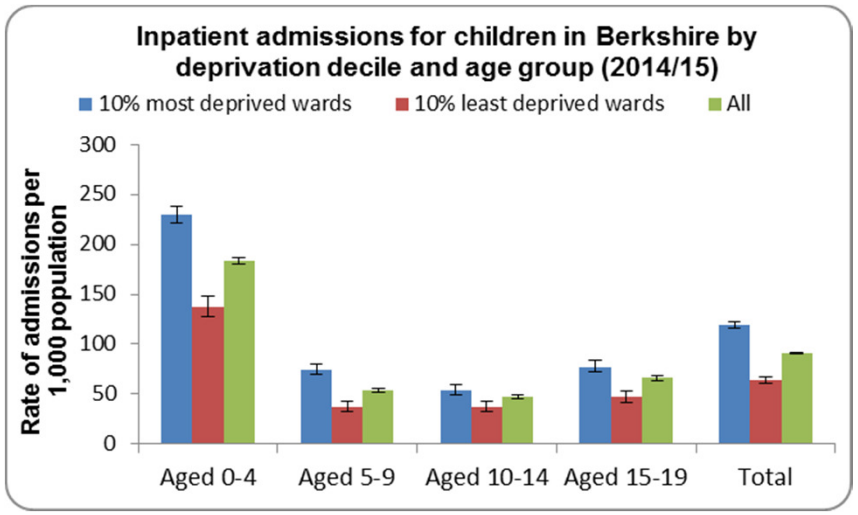
In each local authority, the highest rate of admissions were in the 0-4 year old age band. Other Berkshire local authorities had significantly better rates compared to England.

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





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



Conclusions

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

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

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

The mandated services for health visiting are :

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

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

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

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

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

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

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

Graham Allen Early Intervention: The Next Steps [33]

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Appendix B - DPH Annual Report 2014/15 – Summary of achievements

- Last year's Annual Report raised and described the issue of Mental Health within our population and described (in both childhood and adulthood) the widespread impact and inequality that this major health issue was causing locally.
- The publication of the Report was coupled with a new sense of priority around mental health services in the national NHS guidance and positively this year (2015/16) has seen significant investments in this major area of health burden and inequality.
- Moreover, it has been a major area of work in the health and well being board arena and joint work between the NHS and local government.
- Developments that have occurred include street triage services for residents in crisis, improved capacity and access to services and improvement in mental health prevention and promotion services.
- Whilst we are just seeing the impact on service experience for our residents this is the start of a long journey to achieve parity of esteem and understandably yet to be translated into improved outcomes for residents.
- We will review the indices around mental health as part of the JSNA annually and continue to review the trends on outcomes over the coming years.

To read this report **click here.**

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SLOUGH BOROUGH COUNCIL

REPORT TO: Slough Wellbeing Board **DATE:** 23 March 2016

CONTACT OFFICER: Amanda Renn, Corporate Policy Officer, Policy Team, Slough Borough Council

(For all Enquiries) (01753) 875560

WARD(S): All

PART I
FOR DISCUSSION

SLOUGH WELLBEING BOARD'S ANNUAL REPORT 2015/16

1. Purpose of Report

1.1 To present a final draft of the Slough Wellbeing Board's Annual Report 2015/16 (and retrospective) to the Board. The Annual Report provides information about how and why the Board was set up and explains what it has been doing since it became a statutory Committee of the Council.

2. Recommendation(s)/Proposed Action

2.1 The Board is requested to resolve:

(a) That the Slough Wellbeing Board Annual Report 2015/16 be endorsed;

(b) That the Annual Report be recommended for endorsement by the Council at its meeting on 19th April 2016.

3. The Slough Wellbeing Strategy (SJWS), the Joint Strategic Needs Assessment (JSNA) and the Council's Five Year Plan

3.1 The Annual Report 2015/16 (and retrospective) relates to all aspects of the Slough Joint Wellbeing Strategy's (SJWS) *current* priorities and its cross-cutting themes[1].

3.2 The relevant Council priority/outcome[2] is "Enabling and preventing: More people will take responsibility and manage their own health, care and support needs".

4. Other Implications

a) Financial - None
b) Risk Management – None
c) Human Rights Act and Other Legal Implications - None

[1] The SJWS is due to be refreshed in 2016.
[2] Slough Borough Council's 5 Year Plan 2016 - 2021

d) Equalities Impact Assessment (EIA) – None

5. Supporting Information

5.1 There is an expectation on the part of Heath and Wellbeing Boards to promote openness and transparency in the way that they carry out their work and how they engage with partners and the people who use health and care services and the general public. It is in this spirit of openness that the Board has produced its first Annual Wellbeing Report.

5.2 The draft Report at Appendix A sets out the origins of the Board, drawing upon national documents including the Health and Social Care Act 2012. It also draws on local work to develop the Board through its shadow form and more recently it's formal statutory status and describes:

- The purpose of the Board
- The governance of the Board
- The vision and values of the Board
- The work undertaken by the Board during 2015/16 (including a short retrospective of its activities during 2013 – 2015).

5.3 The key achievements during 2015/16 include:

- Oversight of the development of a number of strategies and action plans;
- Implementation of several national policy agendas: Better Care Fund, Children and Families Act, Care Act and the Transforming Care agenda;
- Partnership working to deliver a number of key initiatives.

6. Comments of Other Committees / Priority Delivery Groups (PDGs)

6.1 The Board's thematic PDGs were invited to comment on the latest draft where necessary[3]. The Council's Health Scrutiny Panel will consider the Annual Report at its meeting on 4 April. Any comments made at this meeting will be fed into our plans for the future and will be incorporated into the way that information is presented in next year's annual report.

6.2 Subject to the agreement of the Board, the Annual Report will be presented to Council for endorsement at its meeting on 19th April 2016 along with any other annual reports e.g. scrutiny.

7. Conclusion

7.1 Publishing an Annual Report provides the Board with an opportunity to:

- Promote its work (and that of the wider partnership);

[3] No comments were received.

- Provide a narrative, setting out the practical progress that has been made in achieving its statutory functions and the aims of the Wellbeing Strategy against each of its strategic priorities; and
- Set out some of the emerging priorities that will influence the Board's future work programme.

8. **Appendices Attached**

A - Slough Wellbeing Board's Annual Report 2015/16

9. **Background Papers**

21 January 2016 – Report to Wellbeing Board including a 1st draft of the Slough Wellbeing Board's Annual Report for 2015/16

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APPENDIX A

Appendix A

Slough Wellbeing Board

Annual Report

2015 – 2016

Slough Wellbeing Board
Annual Report 2015 – 2016

Contents

1. The purpose of this Report

The intention of this report is to provide a description of the work of the Slough Wellbeing Board. This report provides information about how and why the Board was set up and to explain what it has been doing since it became a Committee of the Council in April 2013.

The principles of the Board include an undertaking to promote openness and transparency in the way that the Board carries out its work and engages with people who use health and care services and the general public.

It is in this spirit of openness that we are producing an Annual Wellbeing Report.

2. Foreword

Welcome to the first annual report of Slough's Wellbeing Board.

It gives me very real pleasure to be able to showcase the Board's achievements so far and which are helping to make Slough a more attractive, healthier and safer place to live and where first class services are provided to those who need it.

Since the Boards inception in 2013, we have made enormous strides in establishing our self as the body to oversee the substantial changes and challenges to the system that plans and provides health, social care and wellbeing services to the people of Slough.

In the run-up to the launch of the new NHS structure in April 2012, one of the few aspects which everyone agreed on was that Health and Wellbeing Boards were potentially a good idea. They were to be the place where, under the umbrella of the council, clinical services could combine with all the other services which shape people's health and wellbeing – notably social care, housing and public health, to tackle not only illness and poor health but also the root causes of ill health and health inequality.

In a system characterised by fragmentation and confused accountability, Health and Wellbeing Boards were seen as being one of the few places where the services that matter to local people could be joined up. This has led to big expectations on the shoulders of Wellbeing Boards that they can solve problems, such as the integration of health and social care services, which governments have struggled with for decades. And while it's fair to say that enormous progress has been made locally the Board is still grappling with some of these issues, including how we make sure that health and social care is organised in the best way possible both to prevent ill-health in Slough and to treat it effectively when it happens.

There are some big challenges in this not least the financial challenges that we all face and the need to reconsider how we all use services, especially our local hospitals and community services. However I think that this, the first Annual Report of the Board, gives the assurance that in Slough we have a Board with members drawn from the Council, the local Clinical Commissioning Group, the Police and Fire services, the voluntary and business sectors and Healthwatch who are committed to

working together to overcome these challenges to improve not only the health but wellbeing of the people of Slough.

We have made a good start - but we still have a lot of work to do and this Annual Report sets out the work that we have done and the work that we are planning to undertake in 2016/17 to ensure that we take much more of a strategic view of the issues facing Slough - by not only drawing on the expertise of our members but also more broadly and from others specifically outside of the health and social care sector.

Our next Wellbeing Strategy, planned for publication later this year, will set out the outcomes that we and our wider network of partners can achieve together to improve both the health and wellbeing of local people.

Councillor Rob Anderson
Chair of Slough's Wellbeing Board

3. Executive Summary

Slough's Wellbeing Board's Annual Report of 2015/16 contains a summary of the business, achievements and progress made towards the Board's main responsibilities during its first three years of statutory operation.

This Report is intended for Board members, stakeholder organisations and members of the public for assurance purposes and contains evidence that the Board is achieving what it set out to do and is meeting its statutory responsibilities.

The Board's key achievements during 2015/16 include:

- Oversight of the development of a number of strategies and action plans;
- Implementation of several national policy agendas: Better Care Fund, Children and Families Act, Care Act and the Transforming Care agenda;
- Partnership working to deliver a number of key local initiatives.

4. Introduction

The origins of Health and Wellbeing Boards

As early as 2010 the government set out its intention to strengthen the role of local government in local health services. It announced that Health and Wellbeing Boards would be established across the country to encourage local authorities to work with NHS partners in organising and providing joined up health and local government services. The proposals to establish local Health and Wellbeing Boards were confirmed as part of the Health and Social Care Act 2012.

Who are we?

The 2012 Act required local authorities to create Health and Wellbeing Boards as a forum where leaders from across the health and social care system work together to improve the health and wellbeing of local residents and reduce health inequalities.

This was part of wider plans to modernise the NHS. These Boards are intended to help communities understand and have a greater say in how health and social care services meet their needs.

Slough's Wellbeing Board was established as a shadow Wellbeing Board in April 2012. A comprehensive programme to support its transformation (from a local strategic partnership – Slough Focus -[1] into a Committee of the Council) and help to shape its future ways of working, competencies and structures was pursued throughout 2012/13. This process culminated in Board being effectively established as a Committee of the Council in April 2013.

The Boards statutory function is to:

- Ensure strong democratic legitimacy and involvement across the health and social care systems;
- Provide system leadership across health and social care;
- Strengthen relationships between health and social care providers;
- Encourage the development of more integrated commissioning of services.

It also has a responsibility to:

- Understand and use health and wellbeing needs, inequalities, risks and assets locally to determine priorities for local action,
- Promote integration and partnership working in addressing these priorities and delivering services, and
- Act as the high level strategic partnership for the borough.

The Board has a small core statutory membership as set out in the legislation, but additional members have been appointed by the Council and/or by the Board itself. The following organisations/sectors were represented on the Board in 2015/16:

- Slough Borough Council
- Slough's Clinical Commissioning Group
- Public Health, Berkshire
- Healthwatch Slough
- NHS England
- Thames Valley Police
- Royal Berkshire Fire and Rescue Service
- Slough's business sector
- Slough's Council for Voluntary Service

The Board is unique as a Committee of the Council in that officers and external representatives can be appointed to it, as full voting members. A list of current members of the Board is attached at Appendix 1.

The Board is also subject to the same openness and transparency rules as other Committees of the Council. It meets every eight weeks and its meetings are open to the public.

[1] *Slough has a proven track record of working closely with partners from the various sectors both at the strategic and operational levels. Between 2001 – 2012, Slough Forward, the borough's Local former Strategic Partnership brought together organisations from across Slough and developed some of the borough's earliest combined strategies, including its Sustainable Community Strategy.*

The collective work and decisions of the Board are subject to scrutiny through the Council's Health Scrutiny Panel and all of its agendas and minutes of meetings are available at www.slough.gov.uk.

All the decisions taken by Board are recorded and available at www.slough.gov.uk/moderngov/ieListMeetings.aspx?CId=592&Year=0.

The Board does not work alone to improve Slough's health and wellbeing. In order to ensure that the town's former local strategic partnerships [2] focus on the wider determinants of health (which are key to improving the wellbeing of residents), was not lost during its transition, a number of the priorities which formed a part of towns former Sustainable Community Strategy were incorporated into the Board's 2013 - 2016 Joint Wellbeing Strategy and its governance structure. The sub groups that currently report into the Board include:

- Health and Adult Social Care Priority Delivery Group
- Children and Young People's Partnership Board
- Safer Slough Partnership
- Climate Change Priority Delivery Group

The Board also maintains close links with the towns Adult Safeguarding Board and its Local Children's Safeguarding Board.

What do we do?

The Board's vision is to make Slough a place where ***"People are proud to live, where diversity is celebrated and where residents can enjoy fulfilling, prosperous and healthy lives".***

The legislation that established the Board gave it a number of specific statutory functions. These are:

- To prepare a Joint Strategic Needs Assessment [3] of the health needs of the people of Slough.
- To develop the Slough vision and Strategy for health and wellbeing that connects health, social care and the wider determinants that affect the health and wellbeing of local people, such as housing, the environment and education services.
- To provide leadership and drive delivery to promote the change that's needed across the town to provide better services and better outcomes for communities, families and individuals.
- To encourage integrated working between organisations that plan and deliver health and social care services for local people.
- To encourage close working relations between all partners that plan and provide services that can improve the health and wellbeing of local people.

[2] *Slough Focus*

[3] *Joint Strategic Needs Assessments analyse the health needs of populations to inform and guide commissioning of health, wellbeing and social care services within local authority areas. The main goal of a needs assessment is to accurately assess the health needs of a local population in order to improve the physical and mental health and well-being of individuals and communities. The NHS and upper-tier local authorities have had a statutory duty to produce an annual needs assessment since 2007.*

This means:

- Making a real difference to the health, wellbeing and the life chances of Slough's people by dealing with the really stubborn challenges and closing the inequalities gap.
- Making the Board work more effectively - which involved members signing up to the Board's Strategy and what we all need to do to make it happen. This requires us to make the best use of the collective money and resources available to the people of Slough.
- Leading on Slough's Better Care Fund Plan.
- Ensuring that strategic issues arising from Slough's Adults Safeguarding Board and Local Safeguarding Children's Board inform the work of the Board.
- Receiving the annual report of these safeguarding boards and ensuring that partners respond to issues pertinent to the Wellbeing Board.
- Publishing and maintaining a Pharmaceutical Needs Assessment[4] for Slough.
- Involving Healthwatch Slough and the local community in the shaping of health and wellbeing services.
- Encouraging new thinking (and working) and behaviour to challenge traditional thinking and ways of doing things where will improve outcomes for local people.
- Contributing to the debate at a local strategic level about the issues that residents say affect them the most. This means collaborating with others to address the issues that cannot be solved by any single organisation and taking actions that not only narrow Slough's health inequalities but also address a range of wider, more cross cutting social and economic issues that impact on resident's wellbeing, such as:

    - Slough's local economy and job market
    - Supporting children and families
    - Developing a vibrant housing sector
    - Fostering safer communities
    - Building a better environment/place

The Board's current work programme is designed around encouraging integrated working across all of the borough's health and social care systems and influencing other key partnerships and agencies to tackle the wider determinants of health through their plans and actions.

To support this, the Board's current Joint Strategic Needs Assessment and Joint Wellbeing Strategy contain a series of recommendations to increase collaboration, encourage local action and improve service delivery so that services are responsive

[4] The Health and Social Care Act 2012 Act transferred responsibility for preparation of pharmaceutical needs assessment to Health and Wellbeing Boards. The pharmaceutical needs assessment presents a picture of community pharmacies and other providers of pharmaceutical services, reviewing services currently provided and how these could be utilised further. Community pharmacies can support the health and wellbeing of the population of Slough in partnership with other community services and GP practises. The pharmaceutical needs assessment is also a tool for NHS England and local commissioners to support the decision making process for pharmacy applications and ensure that the services they provide address local needs. In addition to NHS contracts, Slough's pharmacy services support the Wellbeing Board in achieving the health priorities and outcomes outlined in its joint Wellbeing Strategy. Their contributions include signposting, screening, awareness raising, management of medicines and support with monitoring and self-care. In the future, community pharmacists could become involved in more targeted care, working closely with other health and social care providers.

to resident's needs and patients and care users receive the right package of health and social care at the right time and delivered seamlessly.

5. Getting started – a retrospective of early collaboration and the Board's first two years of activity

The following provides a brief summary of the Board's early work:

Key activities in 2013/14

The Board's first year of formal activity focused on building relationships between partners, understanding the complex architecture of both a reconfigured NHS and the local authority, increasing understanding of the multiplicity of services commissioned and provided and their interdependencies and taking the first steps towards creating integrated service. Early work also included carrying out, in conjunction with Board members, the development of a Joint Needs Assessment and Pharmaceutical Needs Assessment for the town for 2013/14, Slough Clinical Commissioning Groups Commissioning Plan for 2014 – 2017 and the implementation of the Board's Joint Wellbeing Strategy for 2013 – 2016.

The Wellbeing Strategy is owned by all the organisations that make up the Board. It builds upon the information in the Joint Needs Assessment which describes the needs of local people. Using this information the Wellbeing Strategy identified the following priorities areas that the Board could support to improve the health and wellbeing of local people.

- Heath
- Economy and skills
- Housing
- Regeneration and the environment
- Safer Slough

The Board's current Wellbeing Strategy for 2013 – 2016 can be viewed on the Council's website at www.slough.gov.uk/council/strategies-plans-and-policies/slough-joint-wellbeing-strategy.aspx .

A copy of the town's latest Joint Needs Assessment (which is updated annually) can be viewed on the Council's website at www.slough.gov.uk/council/joint-strategic-needs-assessment/.

A list of all the issues discussed by the Board in 2013/14 can be found at Appendix 2.

A short summary of the progress made against delivering each of the Board's 2013 – 2016 priority areas is provided at Appendix 4.

Key activities in 2014/15

The second year of activity continued to build upon the work that the Board had carried out in year one. The Board focused on monitoring delivery of the shared

priorities and increasing its knowledge and influence of existing and developing strategies. It also started to consider what integration might look like in practise in Slough. Self evaluation ensured that the Board's architecture and governance arrangements were robust and fit for purpose. Key pieces of work included:

- ***Refreshing the Joint Needs Assessment*** to help the Council, the NHS and local partners understand the range of services that needed to be commissioned in order to improve the health and wellbeing of local people. The needs assessment also makes recommendations based on the latest evidence about the way that these services are run or the sorts of services that need to be put in place in future.
- ***Prime Minister's Challenge Fund*** – The Prime Minister's Challenge Fund was announced in October 2013 as a way to improve access and innovation in the delivery of GP services. 16 local GPs and their practices worked with local patients on a plan called *Steps to the Future* for improving primary care services across Slough. They listened to what patients said about how things could be improved and put together a bid for funding which included a range of initiatives (such as different practices working together to provide longer opening hours in the evening and weekends, different ways for patients to talk to their GP, improving links with the community and support for patients with long term conditions). This bid was successful and the 16 participating practises were awarded £2.95 million in additional funds to operate a seven day service. These services have now been running for well over a year now and provide routine appointments from 9am to 5pm on Saturdays and Sundays, and on weekdays from 8am to 8pm. The scheme has also proved popular with patients, the public and with GPs, and has helped reduce unplanned emergency admissions to Accident and Emergency.
- ***Better Care Fund***- the Better Care Fund was announced by Government in June 2013. The purpose of the Fund is to speed up the local integration of health and social care so that people can have personalised care closer to home. This should, in turn, reduce the number of unplanned admissions to hospitals. The Fund pools a number of separate budgets previously held by Slough's Clinical Commissioning Group and the council for a range of health and social care provisions including reablement, carers' breaks and disabled facilities grants. When the Fund was announced, each health and wellbeing board was asked to produce a local plan by April 2014 (for rollout from April 2015) to demonstrate how health and social care partners would deliver personalised care. The Council and Slough's Clinical Commissioning Group have worked together to develop a plan for the borough, which focuses on delivering increasingly high quality, value for money services and tangible outcomes for patients and service users. Implementation is being overseen by a dedicated Delivery Group and F Joint Commissioning Board with issues escalated to Slough Wellbeing Board, the Clinical Commissioning Groups' Governing Body and full Council, as appropriate.
  The Fund provides £8.762 million of funding, through a pooled budget agreement for local spending on health and social care with progress regularly reported to the Wellbeing Board. Initiatives during 2014/15 included the provision of an independent information and advice service and practical support and activities to promote self management, peer support, prevention and the use of personal budgets.

As part of this transformation programme, the Clinical Commissioning Group and the Council also embarked on a programme to ensure patients, their families and carers, including health and social care practitioners are empowered and enabled to make the right choice and access the most appropriate service to meet their needs.

- ***Preparing for the implementation of the Care Act –*** Throughout 2014/15 the Board also prepared for the introduction of the Act in April 2015. Partner's policies and procedures were revised to ensure that they were compliant with the new legislation. Training and other learning opportunities were used to help embed a person centred approach and put service users at the heart of our decision making. A number of major projects were also completed to provide support for carers, allow for the introduction of deferred payment agreements for care home costs and improve access to information, advice and independent advocacy services.
- ***The Council's Five Year Plan*** – The Council's Five Year Plan 2015-2019 was developed using the town's Joint Needs Assessment (and the Slough Story) as its evidence base. This Plan sets out the focus of the Council's work around eight outcomes. These outcomes also collectively support and compliment the Board's Wellbeing Strategy's priorities. The Plan therefore effectively represents the contribution of the Council to the delivery of the Wellbeing Board's priorities for Slough.

A list of all the issues discussed by the Board in 2014/15 can be found at Appendix 3.

6. Key activities and achievements in 2015/16

The Board's third year of activity continued to build upon the work carried out in year one and two. Key pieces of work have included:

Statutory functions undertaken by the Board

- **Expanded the management and content of the Town's Joint Needs Assessment** to include information from the Clinical Commissioning Group, voluntary and community sector and service related information from the Council. The latest version of the Needs Assessment also includes new information on early detection and prevention of cancer, alcohol and liver disease, long term conditions, tuberculosis, dementia, material on early years, offender health, and fuel poverty. This Assessment is now published as a web based resource on the Council's website, which means it can be kept up to date and new information added to it as and when it becomes available. This website also contains links to the evidence used to develop the Assessment so that people can explore a topic in more depth if they wish to do so.
- **Championed and encouraged the increased sharing and use of health and wellbeing data** (in the Needs Assessment) in local Council service planning.
- Continued to identify and oversee opportunities to **integrate and commission** services across the town's health, social care and wellbeing sectors.
- Continued to approve, oversee and sign off Slough's **Better Care Fund**.
- Agreed an updated **pharmaceutical needs assessment** for the town.

- Started to **refresh its Wellbeing Strategy** - Following an extensive review of the Board and its increasing strategic functions (at a development workshop held in January 2016) it became clear that the Wellbeing Strategy would also benefit from an update.
  A refreshed Strategy will be published during the summer of 2016.

Influenced policy and strategy

The Board maintained oversight of a large number of detailed strategies, work programmes and partnership activity to supports the core aims of its Wellbeing Strategy, including:

- Endorsing a five year Get Active Leisure Strategy for Slough;
- Signing up to the Local Government Declaration on Tobacco Control;
- Signing up to the Mental Health Crisis Care Concordat;
- Endorsing Mental Health4Life: Building Resilient Communities- Sloughs' Children and Adults Mental Health Strategy for 2015 – 2019;
- Endorsing a Promoting and supporting the wellbeing of residents with the voluntary sector 2015 – 2020 Partnership Strategy;
- Endorsing Slough Clinical Commissioning Groups report on GP planning;
- Endorsing Slough's Child Poverty Strategy for 2015 - 2018;
- Endorsing Slough's Children and Young People's Partnership Plan for 2015 - 2016;
- Endorsing Slough Borough Council's Five Year Plan - Refresh of outcomes for 2016 – 2010.

The Board also considered, commented on and championed:

- Healthwatch Slough's research in access to extended hours primary care appointments;
- Healthwatch Slough's research into the experiences of deaf and hard of hearing people's experiences when accessing health services across the borough;
- The Director of Public Health's Annual report for 2015/16;
- Healthwatch Slough's Annual Report 2014/15.

Encouraged the appropriate and effective use of services

The Board continues to promote integrated working through shared priorities, plans, action and continuing to develop relationship between partners and stakeholders. Examples of this include:

- Improving access to information, advice and independent advocacy for service users as part of the implementation of the Care Act 2012 Care Act;
- Transforming health and social care services through the development of an updated Better Care Fund Plan 2015/16;
- Investing in initiatives to support an anticipated increase in demand throughout the winter of 2015/16 at Heatherwood and Wexham Park, by

improving hospital Operational Resilience and Capacity Planning, discharges and avoiding unnecessary hospital admissions during the winter of 2015/16;
- Endorsing and trialling the introduction of a Mental Health Triage Programme across Slough;
- Endorsing the introduction of web based sexual health services for young people across Berkshire.

Fostered a more strategic approach to joint working from across the wider partnership network in Slough

The Board received reports from the following sub groups, partners and partnerships:

- The Safer Slough Partnership's Strategic Assessment 2014/15;
- Slough's Local Annual Safeguarding Children Board's Report 2014/15;
- Slough Safeguarding Adult Board's Annual Report 2014/15;
- The Climate Change Priority Delivery Group's annual report into its climate change and carbon management plan activities;
- Slough Youth Parliament's manifesto commitment regarding young people's mental health.

Strengthened its governance and accountability structures

The Board took time during the year to refresh the governance structures within which it operates in order to ensure that it was fully aware of the extent and limitations of its statutory powers and duties. This work stream involved:

- Reviewing the Board's effectiveness early in 2015 with the assistance of the Local Governance Association and Kings Fund;
- Developing and agreeing an Overarching Information Sharing Protocol to manage the lawful exchange of information and data between Board members;
- Developing templates and guidance for the Board's sub groups to use when developing their own Information Sharing Agreements;
- Agreeing a Protocol with the Local Safeguarding Children's Board and the Adults Safeguarding Board to agree how these bodies would work together to safeguard and promote the welfare of children and adults;
- Developing and publishing dedicated web pages about the Board and its work;
- Refreshing its Terms of Reference and other governance structures in light of feedback provided by participants at the Wellbeing Board's development workshop in January 2016.

In addition, Democratic Services and policy leads reviewed the Boards planning and reporting arrangements and introduced a number of improvements, including:

- Refreshing the Board's template for reports to include a summary, address key questions and inform the Board if noting, discussion or decision was required;

- Creating a meeting schedule to provide a consistent process for report submission;
- Developing and publishing a forward plan/forward work programme to effectively plan the business of the Board;
- Publish a quarterly Newsletter to help inform the wider partnership about the work of the Board and subgroups. Copies of these newsletters can be found at www.slough.gov.uk/council/strategies-plans-and-policies/slough-wellbeing-board.aspx.

Facilitated Member and Board development

The Board agreed at an early stage that its success would depend on a high level of understanding, trust and collaboration. The Board's success requires a combination of being agile enough to respond to challenges but also to have clarity and robust arrangements for conducting its business. Members committed to making time for individual and shared development so that the Board had strong foundations for the future. This included participating in:

- Member development sessions/ opportunities
- The Local Government Associations South East Area Chair and vice chair network
- Local Government Associations leadership workshops
- Outcomes and visioning workshops

7. Future plans and activities

The ability of the Board to manage the structural and financial challenges posed by current financial settlements, public sector reform and the public expectations with regard to the delivery of local services will be tested in the coming years.

The Board began a comprehensive review of its Wellbeing Strategy and the governance structures needed to deliver it, at a development workshop held in January 2016. There was broad agreement amongst Board members at this event that the Strategy and the five priorities areas that sit beneath it should be refreshed and updated to align with this evolving context and associated programmes of work.

A refreshed Wellbeing Strategy, setting out the Boards future priorities for reducing health inequalities and improving residents health and wellbeing outcomes will be published during the summer of 2016.

Appendix 1: Members of Slough Wellbeing Board 2015/16

- Councillor Robert Anderson, Leader of Slough Borough Council (Chair)
- Lise Llewellyn, Director of Public Health, Berkshire (Vice Chair)
- Councillor Sabia Hussain, Commissioner for Health and Wellbeing, Slough Borough Council
- Ruth Bagley, Chief Executive, Slough Borough Council
- Jane Wood, Strategic Director of Wellbeing, Slough Borough Council
- Simon Bowden, Thames Valley Police
- Ramesh Kukar, Chief Executive, Slough Council for Voluntary Service
- Dr Jim O'Donnell, Slough's Clinical Commissioning Group
- Les O'Gorman, Business representative
- Naveed Ahmed, Business representative
- Rachel Pearce, NHS England representative
- Dave Phillips, Head of Prevention and Protection, Royal Berkshire Fire and Rescue Service
- Colin Pill, Healthwatch Slough

Appendix 2: Issues discussed by the Slough Wellbeing Board in 2013/14

- Annual review of the Slough Wellbeing Board's activity and effectiveness
- Autism Self Evaluation by Public Health England
- Berkshire Public Health spending
- Better Care Fund and Local Delivery Plan
- Department of Health funding transfer to social care services
- Disabled Children's Charter
- Governance arrangements for the Slough Wellbeing Board
- Introduction to Healthwatch Slough
- Living together : A Community Cohesion Strategy for Slough 2013 – 2018
- Measles, Mumps and Rubella (MMR) Vaccination Programme
- Pharmaceutical Needs Assessment
- Place Shaping Programme
- Primary Care Trust Funding transfer to social care services
- Protocol between Slough Wellbeing Board and Slough's Children and Young People's Partnership Board
- Protocol between the Slough Wellbeing Board and Scrutiny
- Public Health Strategy
- Refresh of Slough's Children and Young People's Partnership Plan 2013 - 2015-
- Safer Slough Partnership's Strategic Assessment for 2013/14
- Slough Borough Council's Housing Services update
- Slough Clinical Commissioning Group's (CCG) Commissioning Plan 2014 – 2017
- Slough's Adult Safeguarding Board's Annual Report 2012/13
- Slough's Joint Strategic Needs Assessment for Slough 2013/14
- Slough's Local Safeguarding Children's Board's Annual Report 2012/13 and Business Plan
- Strategic Asset Planning report – options for improving primary care access
- Climate Change Priority Delivery Group's update on their climate change and carbon management activities
- Update on the activities of Healthwatch Slough
- Upgrade to Slough Trading Estate's Multi-fuel site

Appendix 3: Issues discussed by the Slough Wellbeing Board in 2014/15

- Annual review of the Slough Wellbeing Board's activity and effectiveness
- Better Care Fund Pooled Budget Agreement for 2015/16
- Child Adolescent Mental Health Strategy for Slough
- Climate Change Priority Delivery Group's annual update on climate change and carbon management activities
- Disbanding of the Skills, Enterprise and Employment and Community Cohesion Priority Delivery Groups
- Healthwatch Slough's annual report for 2013/14 and work programme for 2014/15
- Heatherwood and Wexham Park Hospitals' Operational Resilience and Capacity Planning for 2014/5
- Information and data sharing arrangements

- Introduction of the Care Act – Transforming care and support
- Joining the Dots – Slough's Joint Autism Strategy 2014 – 2017
- Local response to the Winterbourne View concordat
- Mental Health Crisis Concordat
- NHS England funding transfer to social are 2014/15
- Pharmaceutical Needs Assessment – final document
- Place shaping project – Impact 1 year on and forward planning
- Primary care co-commissioning arrangements
- Prime Ministers Challenge Fund Pilot to improve primary care access
- Recruitment of two business sector representatives to the Slough Wellbeing Board
- Revised Terms of Reference of Slough's Children and Young People's Partnership Board
- Self care, personal responsibility and engagement task and finish group final report
- Review of Slough Wellbeing Board's governance arrangements
- Re-commissioning of the borough's sexual health services
- Slough Borough Council's Housing Services update
- Slough Borough Council's Five Year Plan 2015 - 2020
- Slough Clinical Commission Groups (CCGs) Five Year Plan (final draft)
- Safer Slough Partnership's Strategic Assessment for 2014/15
- Slough Wellbeing Board's development plan
- Slough Wellbeing Boards' communications and engagement
- Slough Adult Safeguarding Board's Annual Report 2014/15
- Slough's Local Safeguarding Children's Board's Annual Report 2014/15
- Transfer of commissioning responsibility for health visitors and family nurses to Slough Borough Council
- Update on CAMHS pathway mapping and app development

Appendix 4: Progress made towards achieving Slough Wellbeing Board's the key priorities

The Board's 2013 – 2016 Joint Wellbeing Strategy includes five overarching priorities to help make Slough a better place to live, work and visit by 2028. This appendix gives a position statement on each of these priorities:

- **Health - Slough will be healthier with reduced inequalities, improved wellbeing and opportunities for our residents to live positive, active and independent lives.**
  Despite some recent and noticeable improvements in health and life expectancy the gap between in health outcomes between those at the top and bottom ends of the borough's town's social scale remains large and in some wards continues to widen. The borough's health and social care providers have a key part to play in contributing to the delivery of the Wellbeing Board's continuing health inequality outcomes.

- **Economy and Skills - Slough will be an accessible location, competitive on the world stage with a sustainable and varied business sector and strong knowledge economy, supported by a local workforce who has the skills to meet local businesses' changing needs**.
  Slough's economic conditions remain both fast changing and optimistic. The global financial crisis and recession which followed placed pressure on some of our businesses and on our local economy. Fortunately we have left this period in reasonably good economic shape and now have a thriving £9 billion economy and ambitious plans for the future. We continue to be one of the top three most productive towns in the UK outside London and are home to the highest concentration of European head quarters in the UK. Companies continue to locate to Slough because of our location, accessibility to valuable markets and highly competitive and dynamic business environment. We cannot be complacent though: our Economic Development Plan for Growth highlights the need for us to improve and build on what's been achieved so far and use our strengths to maintain our resilience in the face ongoing financial and economic

pressures. In particular, we must ensure that Slough continues to be the premier location of choice for businesses of all sizes to locate, start, grow and stay. Our Smart City ambitions will further develop the ICT sector by promoting engagement and partnership opportunities in exploring solutions for more effective council service delivery. There is also a continuing need to ensure that local people have access to the towns many employment opportunities. Our Economic Development Plan for Growth has helped improve the job prospects of hundreds of local people in the two years since it was launched. Local action continues to be directed to raise these and other skills amongst our most disadvantaged groups to enhance opportunities for work. Education remains one of the key routes out of poverty and disadvantage to a good job and adequate income. Unfortunately employment prospects remain bleak for those without at least a good grounding in the basic skills.

- **Housing – Slough will possess a strong, attractive and balanced housing market which recognises the importance of housing in supporting economic growth**.
  Demand for housing of all tenures in Slough remains high with increasing competition from the London boroughs. Slough's close proximity to the capital makes it an attractive alternative to the high house prices and increasingly high rents in London. In response to this increased demand, the council has embraced the opportunity to build new homes and had set an ambitious target of delivering 555 new homes each year. In recognition of the role that the private rented sector has to play, much work has been done to engage with private landlords, offering incentives to encourage them to accept nominations from the council to house homeless families, whilst the council's Regulation Team have embraced the powers that are available to drive up the quality of private rented accommodation. The Money to Move scheme is also being used to incentivise people who are under-occupying their home, to move them into more suitably sized accommodation and make better use of the council's housing stock. All of the council's stock now meets the Decent Homes Standard and there is a robust programme of improvement works in place to further enhance the quality of these homes. Emerging government policy will undoubtedly prove challenging to the service over the coming years. These impacts are currently being analysed and where possible will be mitigated to ensure that a range of affordable housing is available to those residents who wish to live in the borough. This information will also feed into the boroughs forthcoming Local Development Plan and Housing Strategy on which the public will be consulted in 2016.

- **Regeneration and the environment - Slough will be distinctive from our competitors, harnessing the diversity and creativity of our people and our customers and physical fabric to create an attractive local environment for our residents and businesses**.
  The borough's long term regeneration programme has (and will continue) to bring about significant investment and improvements to the living environment of a number of our communities. This applies to housing as well as the quality of public and green spaces in and around the places where people live, work and play. The Heart of Slough regeneration project is already having a positive impact on the High Street and will allow more people to live and work in the centre of town. A number of other projects are also underway to develop our retail sector and create a vibrant town centre for residents. National infrastructure projects such as Crossrail, Western Rail Link to Heathrow and Heathrow expansion will also further enhance our connectivity and increase our global attraction for international and national businesses. Our Local Transport Plan has also brought about significant improvements to our road infrastructure and public transport systems .The ability to find work and key services in critical in addressing local health inequalities and other forms of social advantage. Accessibility planning has helped eliminate a number of the obstacles faced by disadvantaged groups and our communities in accessing work, schools, healthcare and shops. The borough's health and social care providers continue to have a vital role in supporting and contributing to the town's planning processes.

- **Safer communities – Slough will have levels of crime and disorder that are not significantly higher than any other town in the Thames Valley.** *Despite Slough being considerably safer than three years ago, crime is still a difficult issue for some of our communities. We have seen significant reductions in vehicle crime, criminal damage, and burglary. Incidents of violence against the person, robbery of personal property, domestic burglary, domestic abuse and substance misuse – all of which tend to be concentrated in areas of high social deprivation (and are reflected in high levels of nuisance and anti social behaviour) continue to be a priorities for the borough's Safer Slough Partnership (SSP).*

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SLOUGH BOROUGH COUNCIL

REPORT TO: Slough Wellbeing Board **DATE:** 23 March 2016

CONTACT OFFICER: Sarah Forsyth (Children's Services Partnership and Policy Officer)
(For all Enquiries) (01753) 875657

WARD(S): All

PART I
FOR INFORMATION

CHILDREN AND YOUNG PEOPLE'S PARTNERSHIP BOARD – UPDATE

1. Purpose of Report

To update the Slough Wellbeing Board on the work of the Children and Young People's Partnership Board.

2. Recommendation(s)/Proposed Action

The Board is requested to note the report.

3. The Slough Joint Wellbeing Strategy, the JSNA and the Five Year Plan

3a. Slough Joint Wellbeing Strategy Priorities

The Children and Young People's Plan sits underneath the Slough Wellbeing Strategy and sets out how the Children and Young People's Partnership will deliver the children and young people's agenda within it.

The priorities in the Children and Young People's Plan supports Slough's Joint Wellbeing Strategy's (SJWS) priorities in the following ways:

- Health – the priorities in the CYPP aim to improve children and young people's emotional and physical health and encourage healthy eating.
- Economy and Skills – working on the child poverty and educational attainment priorities directly links to the SJW's aim to increase prosperity, improve the take up of free school meals and improve the educational attainment of the most deprived pupils.
- Safer Communities – the Plan will support the Slough Local Safeguarding Children's Board (SLCB) in safeguarding and supporting vulnerable children through the children's services improvement programme and early help agenda.

A children and young people's needs assessment was completed using the Joint Strategic Needs Assessment (JSNA) and other data sources to help identify the key priorities that the Children and Young People's Partnership should include in their Plan.

3b. **Five Year Plan Outcomes**

The Children and Young People's Plan sits in line with Slough Borough Council's Five Year Plan in delivering against Outcome 5: Children and Young People in Slough will be healthy, resilient and have positive life chances.

There are a series of key actions underneath Outcome 5, which the Plan will help to:

- Enable children and young people to lead emotionally and physically healthy lives
- Enable children to live safe, independent and responsible lives
- Enable children and young people to enjoy life and learning, to feel confident about their futures and aspire to achieve their individual potential

4. **Other Implications**

(a) Financial -

There are no financial implications of proposed action.

(b) Risk Management

There are no significant risks related to the recommendation in this report.

(c) Human Rights Act and Other Legal Implications

There are no Human Rights Act or other legal implications related to this report.

5. **Supporting Information**

5.1 The new Children and Young People's Plan was agreed in July 2015 made up of seven priorities:

1) To provide outstanding services to the most vulnerable children and young people in the borough.
2) To support children and young people's emotional and mental wellbeing.
3) To support children and young people's physical wellbeing.
4) To reduce the level and impact of poverty on the life chances of children and young people in the borough.
5) To deliver the expanded 'Families First' programme, achieving significant and sustained progress for our most troubled families.
6) To strengthen our universal offer, making it accessible to vulnerable groups.
7) To ensure children and young people are engaged and helped to access opportunities that will enable them to reach their full potential.

5.2 The Children and Young People's Partnership Board have established three permanent Sub Groups who have been allocated specific priorities to deliver:

- Health Sub Group – priorities 2 and 3
- Early Help Sub Group – priorities 4 (which includes the Child Poverty Strategy), 5 and 6
- Achieving Sub Group – priority 7

There was also a Children's Services Improvement Sub Group which has been disbanded for the time being, whilst the new Slough Children's Services Trust reviews its improvement programme and agrees on the most appropriate partnership arrangements to take this agenda forward.

5.3 Each of the permanent Sub Groups have developed action plans to deliver their allocated priorities and some key activities have begun:

- The development of a draft CAMHS Strategy for public consultation;
- The completion of a Transformation of Service pilot in two secondary schools to assess the effectiveness of early help interventions on the mental wellbeing of young people identified with anxiety, low mood and self harm issues. The interventions were seen as effective, reducing symptoms and need for referral to specialist CAMHS;
- Increasing uptake of free toothbrushes although not yet at planned levels, with negotiations planned with local dental practices regarding preventative visits;
- The commissioning of a new lifestyle weight management service;
- The allocation of money to Slough through the Clinical Commissioning Group (CCG) from NHS England, to deliver the Anti-Stigma Campaign around mental health assessments for children who have been sexually exploited;
- The Families First Programme has moved into phase two with the proposed outcomes approved and work commencing with families;
- An Early Help Strategy is in development;
- Actions to deliver the Child Poverty Strategy include a matching exercise of family level data from Families First and Early Help services and a Quarter 3 audit will review identification of poverty and impact on the early help offer and outcomes;
- Training has been provided on Universal Credit; and
- The 2015 education validated results are coming through, with improvements being seen in key stage 1 and key stage 2, however white disadvantaged boys are still a concern.

6. Conclusion

The Children and Young People's Partnership Board has begun the process of delivering the priorities identified in the Children and Young People's Plan (May 2015-December 2016), and will continue to focus on its key aims over the next 12 months.

In addition, in light of the findings from the recent Ofsted inspection, and review of the Slough Wellbeing Board partnership arrangements, the Children and Young People's Partnership arrangements will also be reviewed.

7. Background Papers

1 - Children and Young People's Plan May 2015-December 2016

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SLOUGH WELLBEING BOARD – 23rd MARCH 2016

ACTION PROGRESS REPORT and FUTURE WORK PROGRAMME

Progress key

√√ **C**	-	Action completed
√ **P**	-	Action commenced but not yet complete
A	-	Awaiting action

Meeting date	Action agreed	Progress / comment	Lead member/officer
12/11/14	Slough Wellbeing Board (SWB) Development Plan 2014/15 That the Slough Wellbeing Board Development Plan 2014/15 be agreed. • A review of the Slough Joint Wellbeing Strategy in 2015 which would include a review of the vision, priorities and workplan for the Board. • Update the Board's terms of reference including a 'Welcome to SWB' guide and implementation of a SWB newsletter. • A review of the membership of the Board, including acute sector representation.	√ **P** √ **P** √ **P**	Amanda Renn
13/05/15	Get Active Slough – A 5-Year Leisure Strategy for Slough That the Board note the report and support its objectives as described. That partners give due consideration to how they could provide proactive support, and where possible budget, to assist in delivering the proposed outcomes.	√ **P**	All
15/07/15	Children & Young People's Plan 2015-16 That the Children & Young People's Plan 2015-2016 be agreed. That a progress report be received by the Wellbeing Board in early 2016.	√√ **C**	Krutika Pau
15.07/15	Child Poverty Strategy That Slough's Child Poverty Strategy 2015-2018, as at Appendix A to the report, be agreed. That the Board be updated on the progress of delivery alongside the Children & Young People's Plan reporting process.	√√ **C**	Sarah Forsyth
23/09/15	Local Government Declaration on Tobacco Control That partners and Council departments further consider how the principles of the Declaration could be developed and promoted more widely, including	√ **P**	Angela Snowling

	by working together to raise awareness of growing public health risks of shisha smoking and chewing tobacco. That the experience and good practice of partners be shared as the Council implemented its commitment to become a smoke free council by 1st April 2016.	√ **P**	
11/11/15	Heatherwood & Wexham Park Operational Resilience and Capacity Planning for Winter 2015/16 That the CCG and NHS England be encouraged to utilise best practice and local knowledge in the communications plan for winter to ensure effective and targeted engagement with Slough's communities. That discussion with partners on winter communications and planning for future years begin as soon as possible to properly plan and co-ordinate public health messages. That the communications plan be shared with SWB partners and a report on the lessons learned be considered by the Board at a future meeting.	**A**	Sangeeta Saran
11/11/15	Slough Local Safeguarding Children's Board (SLSCB) Draft Annual Report 2014/15 That partners encourage their staff to participate in courses and events as part of the SLSCB Training Programme.	√ **P**	All
11/11/15	Healthwatch Slough: Annual Review of Activities That the Board give further consideration to how best practice on community consultation and engagement can be defined and shared.	√ **P**	SWB
21/01/16	Cumberland Initiative That further consideration be given to identifying the practical opportunities for the Cumberland Initiative and Slough Wellbeing Board to work together to improve the planning, design and efficiency of health and wellbeing services. That Lise Llewellyn lead the exploration of practical opportunities to work with the Cumberland Initiative and that the Board be informed of progress in due course.	√ **P**	All Lise Llewellyn
21/01/16	Overarching Information Sharing Protocol – 6 Month Update That the four partners that had yet to formally sign the protocol agreed by the Board in July 2015 do so as an urgent priority.	√ **P**	Amanda Renn

DATES FOR 2016/17 AND FUTURE WORK PROGRAMME

- Board Members are invited to note the dates of Slough Wellbeing Board meetings for 2016/17 and early 2017/18.
- The Future Work Programme will be further developed and shaped by the refreshed Slough Wellbeing Strategy and any changes to the partnership arrangements and terms of reference. Members are invited to propose issues to be added to the work programme.

Meeting date	Report deadline	Agenda Publication
11th May 2016	29th April	3rd May
20th July 2016	8th July	12th July
28th September 2016	16th September	20th September
16th November 2016	4th November	8th November
26th January 2017	16th January	18th January
29th March 2017	17th March	21st March
10th May 2017	27th April	2nd May
19th July 2017	7th July	11th July
27th September 2017	15th September	19th September
15th November 2017	3rd November	7th November

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SLOUGH WELLBEING BOARD - ATTENDANCE RECORD 2015/16

MEMBER	13/05	15/07	23/09	11/11	21/01	23/03
Naveed Ahmed	P	Ap	P	Ap	P	
Cllr Rob Anderson	P	Ap	P	P	P	
Ruth Bagley	P	P	P	P	P	
Simon Bowden	Sub (Cl Wong)	Sub (Cl Wong)	P	Sub (Cl Wong)	P	
Cllr Sabia Hussain	P	Ap	P	P	P	
Ramesh Kukar	Ap	P	Sub (Jesal Dhokia)	P	P	
Lise Lllewellyn	P	P	P	P	P	
Jim O'Donnell	Sub (Carrol Crowe)	Sub (Dr Iyer)	Ab	Sub (Sangeeta Saran)	Sub (Sangeeta Saran)	
Les O'Gorman	Ap	P	Ap	P	P	
Dave Phillips	P	P	P	P	P	
Colin Pill	P	P	P	P	Ap	
NHS England representative	Ap	Ab	Ab	Ab	Ap	
Jane Wood	Sub (Alan Sinclair)	Sub (Alan Sinclair)	Ap	Sub (Alan Sinclair)	Ap	

P = Present
Ap = Apologies given

Sub = Substitute sent
Ab = Absent, no apologies given

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