Date of issue: Tuesday, 21 March 2017

MEETING:	**SLOUGH WELLBEING BOARD** Councillor Sabia Hussain (Chair), Health & Social Care Commissioner Naveed Ahmed (Vice-Chair), Business Representative Roger Parkin, Interim Chief Executive Ramesh Kukar, Slough CVS Lise Llewellyn, Strategic Director of Public Health Jo Moxon, Interim Director of Children's Services Dr Jim O'Donnell, Slough Clinical Commissioning Group Les O'Gorman, Business Representative Lloyd Palmer, Royal Berkshire Fire and Rescue Service Colin Pill, Healthwatch Representative Rachel Pearce, NHS Commissioning Board Representative Alan Sinclair, Director of Adult Social Care Superintendent Gavin Wong, Thames Valley Police
DATE AND TIME:	WEDNESDAY, 29TH MARCH, 2017 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.

ROGER PARKIN
Interim Chief Executive

AGENDA

PART I

AGENDA ITEM	REPORT TITLE	PAGE	WARD
	Apologies for absence.		
CONSTITUTIONAL MATTERS			
1.	Declarations 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.	Minutes of the last meeting held on 26th January 2017	1 - 6	-
THEMED DISCUSSION			
3.	Protecting vulnerable children	7 - 22	All
ITEMS FOR ACTION / DISCUSSION			
4.	Strategic Director of Public Health Annual Report 2017/18	23 - 56	All
5.	Community Engagement Update	57 - 66	All
6.	Better Care Fund Programme 2016/17 - Quarter 3 Report	67 - 76	
FORWARD PLANNING			
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ITEMS FOR INFORMATION			
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10.	Attendance Report	95 - 96	-

AGENDA ITEM	REPORT TITLE	PAGE	WARD
SUMMARY			
11.	Actions discussed and agreed tonight	-	-
12.	What do we want to achieve at the next meeting?	-	-
13.	Date of Next Meeting - 10th May 2017	-	-

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.

The Council allows the filming, recording and photographing at its meetings that are open to the public. By entering the meeting room and using the public seating area, you are consenting to being filmed and to the possible use of those images and sound recordings. Anyone proposing to film, record or take photographs of a meeting is requested to advise the Democratic Services Officer before the start of the meeting. Filming or recording must be overt and persons filming should not move around the meeting room whilst filming nor should they obstruct proceedings or the public from viewing the meeting. The use of flash photography, additional lighting or any non hand held devices, including tripods, will not be allowed unless this has been discussed with the Democratic Services Officer.

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Slough Wellbeing Board – Meeting held on Thursday, 26th January, 2017.

Present:- Councillors Hussain (Chair), Naveed Ahmed (Vice-Chair), Nicola Clemo, Rodney D'Costa (deputising for Jo Moxon), Ramesh Kukar, Lise Llewellyn, Lloyd Palmer (until 6.20pm), Roger Parkin (until 6.23pm), Colin Pill, Alan Sinclair and Superintendent Wong

Apologies for Absence:- Dr Jim O'Donnell and Les O'Gorman

PART 1

39. Declaration of Interest

No declarations were made.

40. Minutes of the last meeting held on 16th November 2016

Resolved – That the minutes of the meeting held on 16th November 2016 be approved as a correct record.

41. Local Plan (2016-2036) Issues and Options Consultation Document

The Board considered the Local Plan 2016-2036 'Issues and Options' document that was undergoing a six week period of public consultation. The engagement of stakeholders was an important part of the consultation and partners were invited to comment on the issues and spatial options set out.

The Council's Planning Policy Lead Officer, Paul Stimpson, gave the Board an overview of the key aspects of the document, including major strategic issues for Slough such as meeting future identified housing need; how the creation of an additional 15,000 jobs could be supported; how Slough town centre could be revitalised; and how best to deal with the problems of traffic congestion. It was recognised that the target of providing 927 new houses each year over the next twenty years was particularly challenging both in terms of volume and to ensure an appropriate mix of housing types and tenures was provided.

(Lise Llewellyn joined the meeting)

The Board discussed both the content of the Issues and Options document and the consultation process. A wide range of mechanisms were being utilised to raise awareness of the consultation such as libraries, press and social media. Partners were encouraged to raise awareness and Thames Valley Police, Healthwatch and Royal Berkshire Fire & Rescue Service all expressed an interest in receiving and distributing Local Plan leaflets. Partners who had specific issues they wished to raise could meet separately with the planning policy team to discuss in more detail.

Members discussed several housing related issues including affordability, mix and the provision of the transport infrastructure and health services required to support the growing population. It was recognised that the One Public Estate approach provided an opportunity to more effectively engage and co-ordinate property and asset management across the public sector in the future. Asked about the proposal to provide some of the required housing in South Buckinghamshire, Mr Stimpson explained the process undertaken as part of the duty to cooperate. There was significant opposition to the proposal for a garden suburb and Slough would need to make a strong case when the plans were tested at a public inquiry.

At the conclusion of the discussion, the Board noted the Issue and Options document and relevant partners agreed to receive and circulate some of the consultation documents.

Resolved –

(a) That the Local Plan “Issues and Options” document be noted;

(b) That partners be encouraged to participate and contribute to consultation process.

(c) That copies of the Planning Slough’s Future – Issues and Options magazine and leaflet be made available to partners for circulation.

42. Improving mental health and wellbeing

The Board received a comprehensive presentation from Susanna Yeoman of Berkshire Healthcare Foundation NHS Trust and Geoff Dennis, Head of Mental Health, on the theme of mental health and wellbeing that had been identified as one of the four key priorities of the Slough Joint Wellbeing Strategy. The presentation included contributions from two mental health peer mentors who shared their experiences with the Board including their views on service provision.

The presentation covered the national policy context around mental health; stigma; duel diagnosis; links to isolation and loneliness; and the impact on other social and economic issues such as housing and employment. The themed discussion provided an opportunity for the Board to consider what more could be done in partnership to improve and co-ordinate services; identify links between the mental health priority and other strategies such as the emerging housing strategy; and to promote the specific initiatives such as Slough Fest and mental health first aid training.

The Board welcomed the many positive examples of excellent work being undertaken locally, although it was recognised that further progress needed to be made. The following areas were agreed as important priorities for further action:

- Early intervention and prevention to help people before they needed more support could be improved by working with employers to promote campaigns such as Time to Change and in schools to raise awareness.
- Ensuring the section on vulnerable people in the Council's new housing strategy properly reflected the needs of people experiencing mental health issues.
- Wellbeing should be a key consideration in the Local Plan as the design of place could encourage social connection and help tackle isolation.
- Partners needed to work closely together on assets and facilities planning through One Public Estate to ensure that such resources were maximised.
- The benefits of peer to peer support were recognised and there was support from Board members to consider how such activity could be extended.

(Lloyd Palmer and Roger Parkin left the meeting at this point)

The Board discussed a range of other issues including the prevalence of mental health in both young people and adults; changing attitudes to mental health and the parity of esteem with physical conditions; and the impacts of funding constraints. Whilst members recognised that budgets were under pressure, the view was expressed that this underlined the importance of working together to maximise the resources available and improving the design of services could further improve outcomes. It was agreed that some of good practice in Slough should be highlighted at the next partnership conference in September.

At the conclusion of the discussion, the Board thanked the presenters and peer mentors for their contribution to the meeting. A number of strategic issues and specific suggestions had been made which would be further considered and would provide a focus for the Board in delivering the mental health priority of the Joint Wellbeing Strategy.

Resolved –

(a) That the presentation be noted.

(b) That further consideration be given to the practical issues and actions raised during the course of the discussion with a report back to the Board at a future meeting.

(c) That consideration be given to showcasing some of the excellent work being done locally to support people with mental health conditions at the next annual partnership conference.

43. Forward Work Programme

The Slough Wellbeing Board Work Programme for the period between March 2017 and November 2017 was reviewed. It was confirmed that the themed

discussion at the next meeting on 29th March would focus on the priority of protecting vulnerable children and would be led by the Interim Director of Children's Services and the Chief Executive of Slough Children's Services Trust.

A request had been made to include an item at the meeting in May on the annual report of the SPACE consortium and future plans. This would be considered prior to finalising the agenda.

Resolved – That the work programme be agreed.

44. Frimley Sustainability & Transformation Plan - feedback from workshop held on 19th January 2017

The Director of Adult Social Care briefly updated the Board on the workshop held on 19th January on the Frimley Sustainability and Transformation Plan. It was agreed to circulate a further reminder to Board members seeking their views on the three questions posed at the end of the workshop.

Resolved –

(a) That the update be noted; and

(b) That the follow up questions asked of partners at the STP workshop held on 19th January 2017 be re-circulated to the Board.

45. Housing Strategy update

An information report updating the Board on the development of the Council's Housing Strategy was noted. The public consultation period remained open until 17th February and partners were encouraged to contribute.

Resolved – That the report be noted.

46. Community Engagement Update

The Head of Policy, Partnerships and Programmes introduced an information report on the further work being undertaken by partners to develop the approach to community engagement. The follow up session held on 11th January to the Board's themed discussion on this issue had been considered to be helpful in shaping the approach and a note summarising the discussion was received. A more detailed discussion would be held at the next meeting of the Board in March.

Resolved – That the report of the community engagement follow up session held on 11th January 2017 be noted and that a further report be considered at the next meeting.

47. Slough Wellbeing Board Annual Report 2016/17

An information report on the current draft of the Wellbeing Board's Annual Report 2016/17 was received. Members were invited to provide comments and input to the draft by the end of February prior to it coming back to the Board for agreement in May 2017.

Resolved – That the first draft of the SWB Annual Report be noted and that Board members be asked to submit any further comments or ideas by the end of February 2017.

48. Refresh of the Council's Five Year Plan 2017-2021

The Board noted an information report on the review of the Council's Five Year Plan, particularly the refreshed priority outcomes and ongoing commitment to partnership working.

Resolved – That the refreshed of the Council's Five Year Plan 2017-2021 be noted.

49. Attendance Report

Resolved – That the report be noted.

50. Meeting Review

The Board reviewed key outcomes from the meeting and learning points for future meetings.

51. Date of Next Meeting

The date of the next meeting was confirmed as 29th March 2017.

Chair

(Note: The Meeting opened at 5.00 pm and closed at 7.11 pm)

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SLOUGH BOROUGH COUNCIL

REPORT TO: Slough Wellbeing Board **DATE:** 29 March 2017

CONTACT OFFICER: Jo Moxon, Interim Director of Children's Services
Nicola Clemo, Chief Executive, Slough Children's Services Trust
(For all Enquiries): 01753 875751
01753 875395

WARD(S): All

PART I
COMMENT & CONSIDERATION

PROTECTING VULNERABLE CHILDREN

1. Purpose of Report

1.1 This report provides an overview of the work amongst partners which contribute to the safeguarding of children and young people; and emergent work on establishing Early Help Collaboratives. Work undertaken by partners is crucially important in safeguarding the most vulnerable children and what matters most is that this work translates into the achievement of outcomes. The report therefore also includes a presentation by young people: Living in Slough – a young person's perspective.

2. Recommendation(s)/Proposed Action

2.1 The Slough Wellbeing Board is recommended to note and comment as appropriate on:

(a) The work amongst partners in Slough to safeguard children and young people;
(b) A presentation by young people "Living in Slough – a young person's perspective".

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

"Protecting Vulnerable Children" is one of four key priorities in the Slough Joint Wellbeing Strategy (SJWS). In turn the SJWS is based on an analysis of needs contained in the Joint Strategic Needs Analysis (JSNA), specifically children in need and children / young people subject to a Child Protection Plan. The Council's Five Year Plan priorities "*Putting People First"* and specifically seeks an Outcome that *"Our children and young people will have the best start in life and opportunities to give them positive lives"*. Slough Children's Service Trust's social work model is reflected in its vision statement "*Safe, Secure and Successful".*

4. Other Implications

4.1 Financial – None directly related to this paper.

4.2 Risk Management – None directly related to this paper.

4.3 Human Rights Act / Other Legal Implications – None directly related to this paper.

4.4 Equalities Impact Assessment – None directly related to this paper.

4.5 Workforce – None directly related to this paper.

5. Supporting Information

5.1 The Slough Local Safeguarding Children's Board (SLCSB) plays a key role in coordinating the work of statutory partners in helping, protecting and caring for children in Slough. For example, its remit includes: monitoring the effectiveness of local arrangements; that multi-agency training in the protection and care of children is effective; that policies and procedures in respect of thresholds for intervention are understood and operate. The LSCB also has a challenge role in terms of practice between and amongst partners, including casework auditing, and that serious case reviews, management reviews and reviews of child deaths are used by SBC / SCST and other partners as opportunities for learning and feedback that drive improvement. The relationship between the LSCB and other Boards including the Wellbeing Board has been set out and agreed by all partners in the protocol Sloughs Safeguarding People Protocol (see Appendix).

5.2 The SLSCB Business Plan is currently being refreshed for 2017/18Partners have agreed to focus on the following 6 key priorities:

- Theme 1 – Revise and implement multi-agency threshold guidance ***(key impact is less variation in quality of safeguarding amongst partners)***
- Theme 2 – Establish a programme of effective monitoring and quality assurance of multi-agency safeguarding practice ***(key impact are performance framework helps promote quality of practice, and voice of the child is given due prominence)***
- Theme 3 – Take action to strengthen the LSCB's oversight and scrutiny of the effectiveness of the local multi-agency response to children at risk of exploitation including Child Sexual Exploitation and Missing ***(key impacts are children at risk of CSE, Missing and FGM are better identified and protected)***
- Theme 4 – Develop and implement a funding agreement to ensure the LSCB has sufficient resources to undertake its core business ***(key impact is delivery of the LSCB business / work plan is assured)***
- Theme 5 – Undertake a training needs analysis and regularly evaluate the quality and impact of training including e-learning ***(key impact is targeted training leads to improvement in learning and practice)***
- Theme 6 – Engage the wider community in the work of the LSCB by ensuring that the Board has lay member representation and through engagement with local faith groups ***(key impact is that an inclusive approach heightens and improves public understanding of SLSCB's child protection work and enforces the message that "safeguarding is everyone's business")***

5.3 In addition to the core work of the LSCB there is significant work being undertaken in other forums. A good example is that of work overseen by the Joint Improvement Board (JIB), and emergent work on Early Help, as discussed below.

5.4 The JIB has responsibility for the oversight and management of the Ofsted Delivery Pan. This is a joint Board between the Council and the Trust with DfE and partner agencies as key members on the Board. Its principal task is to ensure that Slough is

on track to deliver all the improvements required post the Ofsted inspection in 2015. Whilst the lead agency for safeguarding children rests with the Trust this cannot be achieved without the support and action of partner agencies and therefore the Board also has a responsibility to identify blocks and barriers to success across the whole system. The LSCB Chair sits on this Board to ensure that there is no duplication of effort and to ensure that the work of the two Boards is integrated.

5.5 Universal services play a fundamental role in protecting children and are key to ensuring children are safe. The revised LSCB threshold has improved the understanding across all agencies and contacts and referrals for social care intervention are much more appropriate and timely. The increase in capacity within the Trust in the Early Help Teams has also resulted in an improved response from the Trust. This will be further supported by the success of Sloughs bid for Innovation grant monies to develop early help hubs.

5.6 However there is still a considerable way to go to influence strategic priorities particularly within the health systems and the Well Being Board may be able to assist improvements in this area.

Early Help

5.7 The concept of 'Early Help' is about providing support when needs are first identified, and when the right intervention or assistance can prevent matters escalating. Effective early help can prevent families from experiencing crises, can prevent problems deepening or becoming entrenched and can help build resilience. Developing an Early Help Strategy (EHS) is a requirement of the Ofsted Delivery Plan (Ofsted Recommendation 9 – Early Help Strategy to be developed with key partners, including the Slough Children's Services Trust).

5.8 Work is therefore underway to develop an EHS which will underpin work in SCST as well as in a wider Slough context. This context includes launching of Local Area Collaboratives, which are about building closer local working between our schools, nursery providers, children centres, health services, family support services, and other key partners so we can deliver more effective interventions to support families, raise our children's outcomes, and reduce levels of inequality. Each Collaborative is therefore locally driven, focused on local need, and chaired by a local Service Manager or Head.

5.9 The success of the EHS and Collaboratives will be measured by criteria that are still being developed. Draft proposals include:

- The number of referrals to high cost and specialist services reduces
- More children, families and adults can have their needs met within universal services
- Family focused services, working with children, young people and their families and involving them in service planning to meet their needs
- Good coordination of family focused work across a wide range of agencies
- Family resilience is increased and the capacity to help families find their own solutions is enhanced
- Children, young people and families are satisfied with and positively endorse the help and support they receive

- Risk is managed by all agencies who clearly understand their role in the delivery of Early Help Services

“Living in Slough – a young person’s perspective”

5.10 (Oral presentation by Slough young people to Slough Wellbeing Board.)

6. Comments of Other Committees

Not Applicable.

7. Appendix

Protocol – Slough Wellbeing Board and LSCB / SAVB.

8. Background Papers

None.

APPENDIX A

SLOUGH'S SAFEGUARDING PEOPLE PROTOCOL

A protocol outlining the relationship between Slough's Wellbeing Board, Slough's Local Children's Safeguarding Board, Slough's Adult Safeguarding Board, Safer Slough Partnership, Preventing Violent Extremism Group and Slough's Joint Parenting Panel

Date created: November 2016
Date of next review: November 2017

SLOUGH'S SAFEGUARDING PEOPLE PROTOCOL

1) Background

Where the term safeguarding is used in this document it means:

- Protecting people from abuse, maltreatment or neglect
- Preventing impairment of health or neglect
- Ensuring that children, young people an adults have safe and effective care
- Taking action to enable people to have better life chances.

2) Aim

Safeguarding is everyone's responsibility. This protocol aims to ensure:

- There is clarity around the roles and responsibilities of the Partnerships and Boards who are working to safeguard children, young people and adults to be vulnerable to abuse in Slough.
- That services are well organised, planned and coordinated with no duplication of effort.
- Partnerships and Boards achieve more by working together.
- That working together has a positive impact on outcomes for Slough residents.
- There is effective challenge and scrutiny of safeguarding arrangements across Slough.

3) Purpose

This protocol sets out:

- The distinct roles, responsibilities and inter-relationships between each of the Boards and Partnerships covered by this protocol, including their specific roles and responsibilities in relation to safeguarding.
- How they work together to plan and coordinate services that safeguard and promote the welfare of people living in Slough.
- The governance, accountability and coordination arrangements for areas that are relevant to more than one Partnership and Board.

As a result of this protocol the public should experience more joined up, planned and coordinated services from the Local Authority, the NHS and other local partners in the future.

4) Scope

The following Partnerships and Boards are included in this protocol:

- Slough Wellbeing Board (SWB)
- Slough's Local Children's Safeguarding Board (SLCSB)
- Slough's Adult Safeguarding Board (SASB)
- Safer Slough Partnership (SSP)
- Preventing Violent Extremism Group (PVEG)
- Joint Parenting Panel (JPP)

5) Roles, responsibilities and governance arrangements

The roles and responsibilities that each of the Partnerships and Boards covered by this protocol have in relation to safeguarding are summarised in Annex A.

6) How the Partnerships and Boards will work together

All of the Partnerships and Boards covered by this protocol have distinct, yet complementary functions. Safeguarding is not the core purpose for all of these Boards, but it is a key theme that unites them all. The next section sets out how we will work together to safeguard and promote the welfare of children and vulnerable adults in Slough:

7) Key principles

- **We will reflect 'safeguarding is everyone's business' in our health and related wider determinants of health related policies, strategies and plans**.

- **We will focus on outcomes for children, young people and vulnerable adults**
  We will ensure that our work remains focused on achieving the best possible outcomes for children, young people and vulnerable adults.

- **We will work together on themes of common interest**
  There are a number of pieces of work or themes which are relevant to more than one Partnership and Board. In such cases the default position should be that we seek to work together to achieve the best outcomes and reduce duplication of work. The table at Annex B sets out those themes where there has already been discussion and agreement on how we will work together (as at October 2016). At each revision of this document, any new areas will be added and decisions made on how this will be taken forward.

- **We will adopt common reporting arrangements that support closer partnership working**
  In order to support closer working arrangements between the Partnerships and Boards we will adopt the reporting arrangements summarised at Annex C. These reports will clearly state the response and / or action that is required from the receiving Partnership/Board and what reports will be tabled with sufficient time for appropriate discussion and challenge, for issues relevant to that Partnership/Board to be identified and necessary action agreed.

- **We will talk to each other about areas of risk**
  We will share information on key risks or concerns. This will help the different Partnerships and Boards maintain a good understanding of any emerging risks that may be relevant to our/their work.

- **We will offer mutual challenge and support**
  The SLSCB and SASB have a specific remit to ensure the effectiveness of safeguarding arrangements across partners. As such, they will work with and

where necessary offer challenge to, the SWB, SSP, JPP and the PVEG to ensure that we all safeguard and promote the welfare of children and vulnerable adults in the work that we do. Independent of the scrutiny roles of the SLSCB and SASB, we will also offer each other mutual challenge and support in order to optimise our safeguarding arrangements and ensure we collectively achieve the best possible outcomes for our children, young people and vulnerable adults.

- **We will share good practice and resources**
  In order to help us develop and improve, we will share relevant good practice and resources, where appropriate. This could include policies and practices, including those identified in other authorities, or providing training and development opportunities across the wider partnership.

- **We will contribute information for the Slough's Joint Needs Assessment (JSNA)**
  In respect of the health and well-being of children, young people (their parents/carers) and adults on at least an annual basis.

- **We will evaluate the impact of the Slough's Wellbeing Strategy on safeguarding outcomes, and of safeguarding on the wider determinants of health outcomes**
  We will also share information about our performance, specifically against the priorities and outcomes in Slough's Wellbeing Strategy at least annually.

- **We will communicate relevant information across the partnerships**
  Where there is common membership between the Partnerships and Boards, these members will ensure relevant information is communicated across the Partnerships. They will also raise relevant issues with the appropriate Partnership or Board's Chair.

- **Our Chairs (and our coordinators) will meet on an annual basis**
  This will enable greater understanding of each other's structures, reporting mechanisms and shared priorities. It will also provide an opportunity to debate, question and share insights about the latest strategies, policies and programmes to safeguard and protect children, young people and adults vulnerable to abuse in Slough.

- **We will build relationship with other partnership forums**
  In order to ensure that 'safeguarding is everyone's business' we will explore similar links with other partnership forums within the borough as and where appropriate.

8. Resolution

Where an area of concern cannot be resolved within the above arrangements, a meeting will be held between the Chairs of the respective Boards, Slough Borough Council's Directors of Children's Services and Adult Social Care and the Assistant Director of Public Health where appropriate.

9. Review arrangements

This protocol will be reviewed on an annual basis, unless new legislation or national guidance necessitates an earlier review. Members may also request an extraordinary review of this protocol at any time should they consider it necessary.

Annex A: Summary of roles, responsibilities and governance arrangements

Name	Purpose and function	Governance and accountability
Slough Wellbeing Board	The Health and Social Care Act 2012 sets out the statutory functions of Health and wellbeing Boards. The SWB's role is to take the lead in improving health and wellbeing outcomes for people in Slough. Children and young people's safeguarding and the safeguarding of adults at risk of harm are key elements of this. It ensures relevant consideration is given to safeguarding for both children and vulnerable adults by: • Addressing safeguarding holistically in local needs assessments; including by considering and addressing information provided by the SLSCB and SASB on safeguarding priorities. • Integrating safeguarding into the development of the Joint Strategic Needs Assessment and the Slough Wellbeing Strategy • Having oversight and receiving assurance from the SLSCB, SASB and SSP that safeguarding is being integrated into commissioning arrangements at both strategic and operational levels.	• The SWB is a committee of Slough Borough Council and is accountable for its actions to the Council and to its individual member organisations. • There is sovereignty around decision making processes. • Representatives are accountable through their own organisation's decision making processes for the decisions they take. • It is expected that Members of the SWB will have delegated authority from their organisations to take decisions within the terms of reference.
Slough's Local Children's Safeguarding Board	Section 14 of the Children Act 2004 sets out the statutory objectives and functions of the SLSCB, which are: • To co-ordinate what is done by each person or body represented on the Board for the purposes of safeguarding and promoting the welfare of children in the area; and • To ensure the effectiveness of what is done by each such person or body for those purposes. Regulation 5 of the Local Safeguarding Children Boards Regulations 2006 sets out that the functions of the SLSCB, are as follows: 1. Develop policies and procedures for safeguarding and promoting the welfare of children in Slough. 2. Communicate to people and organisations in Slough the need to safeguard and promote the welfare of children, raising their awareness of how this can best be done and encouraging them to do so. 3. Monitor and evaluate the effectiveness of what is done by the authority and their Board partners individually and collectively to safeguard and promote the welfare of children and advising them on ways to improve 4. Participate in the planning of services for children in Slough. 5. Undertake reviews of serious cases and child deaths and advise	• The SLSCB is independent – it is not subordinate to, nor subsumed within, other local structures. • The Chair of the SLSCB is independent of local agencies so that it can exercise its local challenge function effectively. • The Independent Chair is appointed by and is accountable to, the Chief Executive of Slough Council. • The Board holds organisations, individually and in partnership, to account for their performance in this respect. However, it is not accountable for their operational work and each Board partner retains their organisational lines of accountability for safeguarding. • The SLSCB discharges many of its responsibilities on behalf of its statutory partners and as such is held to account by each of these organisations for its performance. The agreement of statutory partners is required for any work that has implications for policy, planning or the allocation of resources. • Slough Borough Council's Director for Children's Services (DCS) ensures that all appropriate local authority services engage effectively with the SLSCB. • The DCS is accountable to the Chief Executive of Slough Borough Council, and where appropriate the Lead Member for

	the authority and their Board partners on lessons to be learned. 6. Publish an annual report on the effectiveness of child safeguarding and promoting the welfare of children in Slough. 7. Provide challenge to ensure that there is a comprehensive, effective and adequately resourced early intervention strategy for the provision of services to children and young people in Slough.	Children's Services for the effective working of the SLSCB. • Where appropriate the Lead Member for Children's Services holds the Independent Chair to account for the effective working of the SLSCB.
Slough's Adult Safeguarding Board	Section 14 of the Care Act 2015 sets out the objectives of adult safeguarding boards, which are: • To co-ordinate and ensure effective and proportionate multi-agency responses to concerns around adult safeguarding or the protection of adults at risk of harm. • To ensure the effectiveness of what is done by each such person or body for those purposes. • To hold partners to account for their activity in relation to the safeguarding of vulnerable adults. • To use data, information and intelligence to effectively identify risk and act on it. • To undertake Safeguarding Adult Reviews as required using an appropriate methodology determined by the circumstances of each review. • To produce an annual report and an annual work plan which it consults on with Healthwatch. • The above includes a requirement to work effectively with partners across geographical borders.	• Slough Borough Council's Director for Adult Social Care (DASC) ensures that all appropriate local authority services engage effectively with the SASB. • The DASC is accountable to the Chief Executive of Slough Borough Council, and where appropriate the Lead Member for Adults Services for the effective working of the SASB. • The Chair of the SASB is independent of local agencies so that it can exercise its local challenge function effectively. • The Chair is appointed by and is accountable to, the Chief Executive of Slough Borough Council. • Although the SASB produces a multi-agency adult safeguarding policy and procedure, it is the responsibility of each partner to develop their own organisational policy in relation to adult safeguarding which complies with the multi-agency policy. • There is sovereignty around decision making processes. Partners are accountable through their own organisation's decision making processes for the decisions they take. • SASB members have delegated authority from their organisations to take decision within the terms of reference.

Safer Slough Partnership	• The purpose and priorities of the Safer Slough Partnership (SSP) is to meet the statutory duties of Community Safety Partnerships (CSP) and Slough Borough Council's strategic commitments.
	• The 2006 review of the Crime and Disorder Act and subsequent amendments to legislation resulted in an approach to CSP's that is more flexible and allows more local discretion. However, there remain some key statutory responsibilities which must be met. These are:
	  ○ A 'strategy' group to be made up of senior representatives from the 'Responsible Authorities' (i.e. local authorities, police and other key local agencies)
	  ○ To prepare, implement and performance manage an evidence-led annual strategic assessment and three-yearly partnership plan for the reduction of crime and disorder in the area
		• Each member of the SSP is responsible for discharging the statutory duties of the CSP: setting strategy and challenging on performance.
		• The SSP is not accountable for member's operational work and each member retains their organisational lines of accountability.
		• The SSP is currently chaired by the Chief Executive of Slough Borough Council and subject to scrutiny by the Council's scrutiny arrangements.
		• Where there is cross-over of membership between various boards individual members are responsible for making the links required to join-up priorities with the SLSCB, SASB and the SWB in order to ensure that any relevant safeguarding issues raised at these boards feed into and are addressed by the SSP.

	○ To consult the community on the levels and patterns of crime, disorder and substance misuse and on matters that need to be prioritised by the partnership. ○ To reduce reoffending ○ To coordinate Domestic Homicide Reviews ○ To share information among the responsible authorities within the CSP ○ To have a crime and disorder scrutiny committee with the power to review and scrutinise decisions made and action taken by the CSP. ○ To assess value for money of partnership activities. • The CSP's role is to promote safer and stronger communities and help reduce crime and disorder (including Domestic Abuse, Violence and fear of crime) at a local level. • The CSP's key functions in relation to safeguarding are to ensure that relevant consideration is given to safeguarding for children, young people and vulnerable adults. It does this by: ○ Addressing relevant safeguarding issues in local needs assessment; ○ acting on information provided by the SLSCB and SASB on safeguarding priorities, Including relevant safeguarding issues in its Community Safety Strategy; and ○ Integrating safeguarding into local commissioning arrangements at strategic, tactical and operational levels.	
Preventing Violent Extremism Group	• The PVEG's role is to provide a strategic overview of Prevent work within the borough and to coordinate delivery of the Prevent action plan. • The Group also fulfills the responsibility of the Prevent Duty as a local authority as per the Counter Terrorism and Security Act (CTSA) 2015. • Its specific responsibilities with regard to safeguarding are "*To ensure that preventing violent extremism forms part of safeguarding work within relevant agencies e.g. local schools, including supplementary schools and colleges".* Part of the way it does this is by ensuring that employees of local statutory organisations are trained and that this training is set within a safeguarding context.	• The PVEG holds organisations, individually and in partnership, to account for their performance in respect of its safeguarding agenda. • However, it is not accountable for their operational work and each partner retains their organisational lines of accountability for safeguarding. • It is accountable to the SWB and is chaired by the Chief Executive of Slough Borough Council.
Slough's Joint Parenting Panel	Slough Borough Council's Joint Parenting Panel role is to deliver better outcomes for children in care and care leavers. It considers all matters relating to the Council's role as the Corporate Parent including keeping them safe during their transition to adulthood	• The Panel is the primary vehicle for Slough Borough Council and Slough's Children's Services Trust to demonstrate their commitment to deliver better outcomes for children and young people in care and care leavers.

	(and where necessary on to adult services).	• Its role is to hold services (including the council's aftercare services) to account so that they meet the needs of the boroughs looked after children and care leavers. • It is made up of representatives from Slough Borough Council, Slough's Children's Services Trust and local partners. • It is co-chaired by Slough Borough Council's Commissioner for Education and Children and a Non-Executive Director of Slough Children's Services Trust.

Anenx B: Working together on themes of common interest

Some areas in the table below are more developed than others. As relationships between the Boards and Partnerships covered by this Protocol develop, these areas will be developed further.

When a new piece of work or theme is identified that is likely to have relevance across more than one partnership:

- The other partnerships should be contacted to discuss the relevance of the theme / piece of work.
- There should be agreement across those partnerships for whom the theme / piece of work is relevant on the following:
  - The approach to be taken
  - Which partnership will lead and how all partners will contribute
  - Responsibility and accountability for that particular piece of work / theme
  - Communication / reporting arrangements

This is likely to require formal discussion and decision making at partnership meetings. However, in most cases this should not delay work from starting.

Theme	Lead	Work being carried out
Radicalisation and terrorism (the new Prevent Statutory duty)	PVEG	The PVEG has a strategic oversight and coordination role with regards to the Prevent Duty, including about the work of the Channel Panel. This includes: a) Receiving anonymised information about the cases considered by the Channel Panel and updates on referral numbers. b) Overseeing communications both within and external to the Slough partnership network. c) Receiving quarterly updates on the Prevent Action Plan. d) Taking a check and challenge approach to partners' engagement activity around this agenda. e) Working with other agencies that are subject to the Prevent Duty, such as schools, HE/FE establishments and VCS organisations to share learning and evidenced good practice. f) Providing a single point of contact on this issue for the SLSCB and SASB.
Child Sexual Exploitation (CSE)	SLSCB	• The SLSCB is the lead for the strategic development and overview of Slough's multi-agency response to CSE. It has a CSE and Trafficking Strategic Sub Group which oversees the Slough CSE Strategy. This describes both strategic and operational level arrangements for CSE across partners and includes a multi-agency action plan. The SLSCB is also responsible for ensuring that the JSNA includes robust and up to date profiling relating to CSE given that this is the starting point for many commissioning decisions. • CSE is also an important theme for the SSP, particularly in relation to prevention, disruption and enforcement against perpetrators. The SLSCB and SSP provide challenge and support to each other around CSE, with a particular focus on ensuring there is a coordinated, partnership approach. Community Safety partners sit on the CSE Sub Group and contribute to the development of the CSE Sub Group work plan. The SLSCB provides regular updates on CSE to the SSP. • The SASB also has a role in ensuring that there is appropriate provision in place for children who continue to be exploited as they transition into adulthood, and for adults disclosing CSE in their past.
Female Genital Mutilation(FGM)	SLSCB	• The SLSCB is lead for the strategic development and overview of Slough's multi-agency response to FGM. It has a FGM Sub Group which oversees the Slough FGM Strategy. The Sub Group is responsible for raising awareness across partners and the wider community, in order to ensure that there is a clear understanding of the issue and situation locally. It provides guidance for professionals on how to respond to a child who may be

		at risk of FGM, or who has undergone the procedure in a sensitive manner, whilst emphasising the legal and health implications of FGM. • Community safety partners also sit on the FGM Sub Group to ensure regular updates are provided to the SSP.
Human trafficking and modern slavery	SSP	• The SSP is the lead for the strategic development and overview of Slough's multi-agency response to human trafficking and modern day slavery. • The links between human trafficking, modern day slavery and CSE are recognised by means of representation on the CSE and Trafficking Strategic Sub Group from community safety partners. This allows relevant information from the SSP to be cascaded to the Sub Group, and where necessary escalated to the SLSCB. • Both the SLSCB and the CSE and Trafficking Strategic Sub Group offer relevant challenge to the SSP on the work that is being done around human trafficking and modern day slavery, and the outcomes this is achieving for children and young people.
Domestic abuse	SSP	The SSP takes the lead on domestic abuse and oversees a multi-agency Domestic Abuse core Group and wider stakeholder world café sessions.
Forced marriage and honour based violence	SSP	The SSP takes the lead on forced marriage and honour based violence.
Hate crime	SSP	The SSP takes the lead on hate crime.

Annex C: Reporting arrangements

	SWB	SLSCB	SASB	SSP	PVEG	JPP
Slough Wellbeing Board (SWB)						
Slough Joint Wellbeing Strategy (SJWS)		Consult (For annual update of priorities)	Consult (For annual update of priorities)	Consult (For annual update of priorities)	Consult (For annual update of priorities)	Consult (For annual update of priorities)
Slough Joint Needs Assessment (JSNA)		Consult (each year for annual update)	Consult (each year for annual update)	Consult (each year for annual update)	Consult (each year for annual update)	Consult (each year for annual update)
Annual Report		Inform (Spring)	Inform (Spring)	Inform (Spring)	Inform (Spring)	Inform (Spring)
Slough's local Children's Safeguarding Board (SLSCB)						
Annual Report	Present (Autumn)		Present (Autumn)	Present (Autumn)	Present (Autumn)	Present (Autumn)
Slough's Adult Safeguarding Board (SASB)						
Annual Report	Present (Autumn)	Present (Autumn)		Present (Autumn)	Present (Autumn)	Present (Autumn)
Safer Slough Partnership (SSP)						
Rolling Strategic Assessment	Inform	Inform	Inform		Inform	Inform
Preventing Violent Extremism Group (PVEG)						
Prevent Action Plan	Inform (Spring & Autumn)	Inform (Spring & Autumn)	Inform (Spring & Autumn)	Inform (Spring & Autumn)		Inform (Spring & Autumn)
Joint Parenting Panel (JPP)						
Annual Report (on its work to deliver the Corporate Parenting Panel)	Inform	Inform	Inform			

Where issues or reports fall outside of these arrangements, any of the Chairs can:

- Make a written request to another Partnership for information or consideration of any area of concern.
- Make a request for an item to be placed on another Partnerships meeting agenda.
- Request a meeting with one or more of the other Partnership Chairs to consider and agree a way forward regarding specific issues.

SLOUGH BOROUGH COUNCIL

REPORT TO: Slough Wellbeing Board **DATE:** 29th March 2017

CONTACT OFFICER: Dr Lise Llewellyn (Strategic Director of Public Health)
(For all enquiries) 01344 355218

WARD(S): All

PART I
FOR DISCUSSION

STRATEGIC DIRECTOR OF PUBLIC HEALTH's ANNUAL REPORT 2016-17

1. Purpose of Report

This report is the annual independent report from the Strategic Director of Public Health. It focuses on the causes of early deaths (<75 years) which lead to inequalities in outcomes for our communities. It summarises improvements made in reducing infant mortality and focuses on the preventable lifestyle risk factors which require further improvement to reduce health inequalities in adults.

2. Recommendation(s)/Proposed Action

The Board is requested to:

1) Note the reduction in infant mortality and in early deaths from cardiovascular disease (although the latter remains above the England average);
2) Debate the current partnership actions underway to address the lifestyle factors that are amenable to change; and
3) Approve the draft annual report (at Appendix A).

3. The Slough Joint Wellbeing Strategy (SJWS) 2016 – 2020, the Joint Needs Assessment (JSNA) and the Five Year Plan

3a. Slough Joint Wellbeing Strategy (SJWS) 2016 – 2020 Priorities

The annual report directly reflects the Slough Joint Wellbeing Strategy's (SJWS's) priority of increasing life expectancy by focusing on inequalities. More broadly, this report and the work conducted under the Public Health Grant, support the SJWS priorities in the following ways:

- Vulnerable children through the universal and targeted 0-19/25 programme
- Health – supporting the emotional and physical health of children, young people and adults to encourage healthy eating, safe alcohol consumption and tackle poor cardiovascular health
- Safer Communities –supporting the Safer Slough Partnership through the work of the drug and alcohol team's commissioned services

3b. **The JSNA**

The JSNA highlights the importance of lifestyle factors on health, and the rising rates of cardiovascular disease and diabetes in Slough which impact on premature death rates.

3c. **Five Year Plan Outcomes**

The annual report outlines the impact of premature deaths in Slough. Actions to tackle these issues, and the Public Health Grant more broadly, supports the following outcomes of the Slough Borough Council's Five Year Plan:

- 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

4. **Other Implications**

(a) Financial - None

(b) Risk Management - None

(c) Human Rights Act and Other Legal Implications - There are no Human Rights Act implications to the proposed action.

(d) Equalities Impact Assessment (EIA) - Not required. The key theme of the report is early deaths under the age of 75 years. The inequalities in terms of lifespan begin at birth and are affected by the medical provision in the person's country of origin as well as the risk factors shown here.

5. Summary

- The Director of Public Health's annual report is a professional statement about the health of local communities, based on sound epidemiological evidence, which is interpreted objectively.
- It focuses on tackling premature mortality, deaths that occur before 75 years (avoidable deaths) and highlights how this is a key driver for improving life expectancy and reducing health inequalities.
- It also briefly shows how major improvements would be achieved through systematically and visibly addressing preventable causes of death.

6. **Supporting Information**

6.1 There is a statutory requirement for the Director of Pubic Health to produce a publically available annual report that:

- Contributes to improving the health and well-being of local populations, and tackling health inequalities
- Promotes action for better health, through measuring progress towards health targets.
- Assists with the planning and monitoring of local programmes and services that impact on health over time.

Aims of the 2016-17 Annual Report

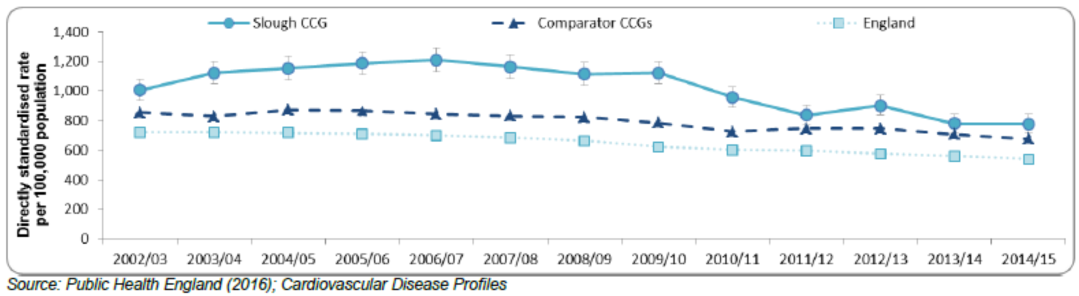
6.2 Tackling premature mortality, deaths that occur before 75 years (avoidable deaths) is a key driver for improving life expectancy and reducing health inequalities. Avoidable deaths include those categorised as: *amenable deaths,* those driven by problems/reduced access to health care and *preventable deaths,* those driven by wider public health issues.

6.3 In Slough, mortality rate from causes considered preventable are increasing in males and higher than England average, while for females they are decreasing and similar to England average. Preventable deaths are more common in men.

6.4 The annual report briefly shows how major improvements would be achieved through systematically and visibly addressing preventable causes of death. Ischaemic heart disease is the single disease where prevention would have the biggest impact. Unsurprisingly, the prime causes of avoidable deaths also cause significant number of hospital admissions.

Rates of early death from cardiovascular disease in Slough CCG

Emergency admissions for cardiovascular disease per 100000 population directly standardised rate (2010/11-2015/16)



Source: Public Health England (2016); Cardiovascular Disease Profiles

6.5 The annual report summarises the key public health issues that impact on preventable deaths. It highlights the impact that lifestyle factors have on the health of our residents. The STP in Frimley has identified those approaches from national evidence that will make an impact on health outcomes and care over the next 5 years.

6.6 It presents more fully the evidence behind these lifestyle factors, the impact that these factors have on the individual in terms of health risks and the impact these factors have in driving demand for care.

6.7 It also presents some of the evidence for action. Hopefully the annual report will provide professionals with new information on lifestyle factors and a different perspective on drivers for increasing demand that will change the nature of the conversation about prevention and self care.

6.8 f we are to make a difference to our health and our subsequent need for health care then we need to make a radical change in how we as individuals and communities

take responsibility for our own health but also as professionals support individuals and communities in addressing quite entrenched habits and lifestyles.

Children and Avoidable Deaths

6.9 Whilst the annual report is focussed on adults, where lifestyle factors have measurable impact, there are still avoidable deaths in children.

6.10 In 2014, just under a third of deaths (32% or 1,443 out of 4,571) in children and young people aged 0 to 19 years in England and Wales were from causes considered avoidable through good quality healthcare (amenable) and wider public health interventions (preventable).

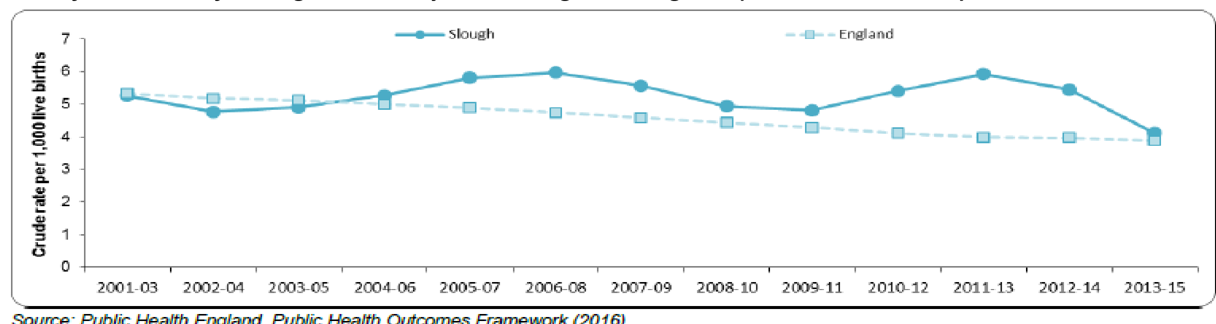
6.11 Avoidable deaths in children and young people made up 1% of all avoidable deaths in 2014. Similarly to adults, males aged 0 to 19 years were more likely to die from avoidable causes than females. Male deaths accounted for around 63% (911 out 1,443) of avoidable deaths in children and young people.

6.12 Nationally the single cause with the highest number of avoidable deaths in children and young people was accidental injuries (195 deaths; 14% of all avoidable deaths in this age group). This was followed by complications during the perinatal period (childbirth), suicides and self-inflicted injuries, transport accidents and congenital malformations of the heart.

6.13 The Child Death Overview Panel continues its work to review each child's death within Berkshire and to identify and take action on any emerging underlying themes. The trend for reducing number of child deaths continued during 2015/16. In Slough the majority of child deaths under the age of 1 year are due to low birth weights, congenital anomalies and are avoidable through continued work on smoking cessation in pregnancy, foetal monitoring, genetic counselling and high quality obstetric care.

6.14 Injuries which are the prime cause of avoidable deaths in children also cause a significant number of admissions nationally, whereas admissions for children from Slough are now significantly better than the England average.

Rate of deaths in infants aged under 1 year in Slough and England (2001-03 to 2013-15)



Source: Public Health England, Public Health Outcomes Framework (2016)

Update on last year's SDPH annual report (2015-16)

6.15 Last year's annual report focussed on children and the major causes of ill health, but also on how education and life chances had complex but interlinked relationships with health. It stated that the transfer of health visiting services into local authority commissioning was an opportunity to link all early year's services and maximise the support given to all families through the mandated services but also to pay close attention to those families with more vulnerability. The new specification for 0-19/25y services makes those links.

6.16 With regard the wider determinants of health and its impact on children, last year we noted the key role education plays in promoting good health. This year Slough remains the similar to, or better than, England average on all Public Health Outcome Framework education-related indicators, from school readiness at the end of Reception to attainment of 5 GCSEs (A*-C).

6.17 In last year's report we also noted that children are high users of services, sometimes for conditions that could be prevented. With regards to hospital admissions, admission for lower respiratory tract infection and overall admissions from epilepsy, asthma and diabetes have both reduced in Slough following peaks in 2014/15.

7. Comments of Other Committees

7.1 The annual report has not been considered by any other Committees.

8. Conclusion

8.1 This year's annual report allows for a debate on the work underway across organisations, communities and individuals to:

- Tackle the risk factors that drive ill health
- Promote action currently underway and planned; and
- Generate a new momentum to tackle these risk factors

9. Appendices

A - Annual Strategic Director of Public Health's Report 2016-17

10. Background Papers

Slough Clinical Commissioning Group (CCG) locality profile 2016
http://www.slough.gov.uk/council/joint-strategic-needs-assessment/jsna-summary-and-why-we-need-it.aspx

Public Health Outcomes Framework http://www.phoutcomes.info/public-health-outcomes-framework#page/0/gid/1000049/pat/6/par/E12000008/ati/102/are/E06000039

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Appendix A
Annual report 2016

Avoidable and preventable mortality

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

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

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

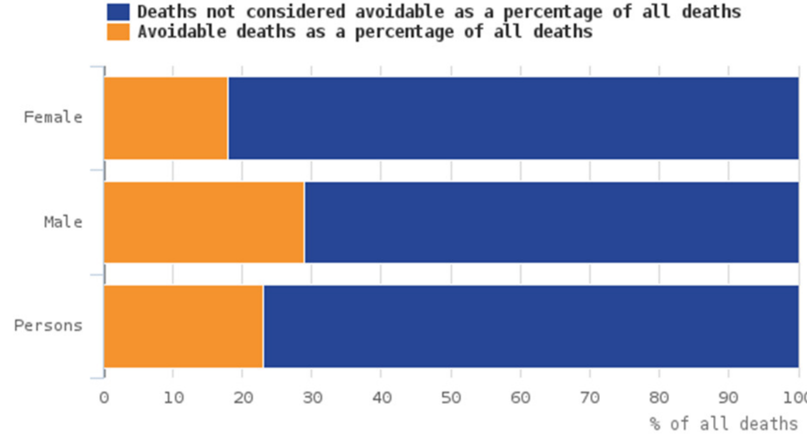
In 2014, nearly a quarter of all deaths (23%; 116,489 out of 501,424) in England and Wales were from causes considered potentially avoidable either through timely and effective healthcare (amenable) or public health interventions (preventable)(2)

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

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

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

FIG 1: % age of deaths nationally hat are avoidable



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

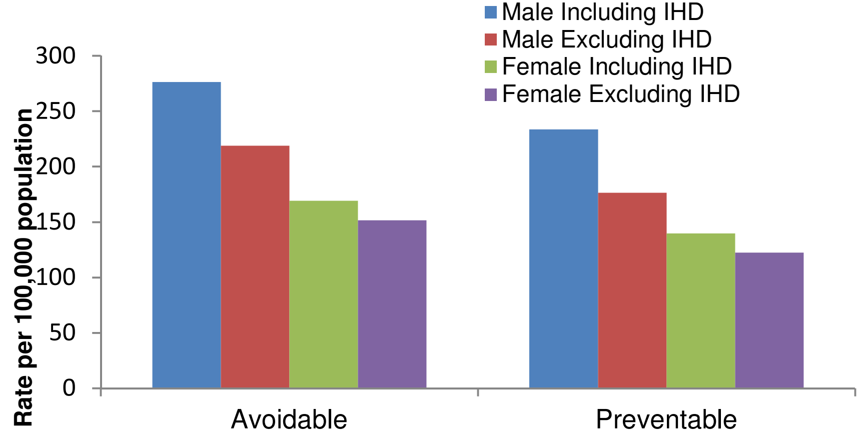
Ischaemic heart disease is the most common single disease that leads to avoidable disease

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

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

Local preventable deaths

Fig 2 Rates of avoidable and preventable deaths

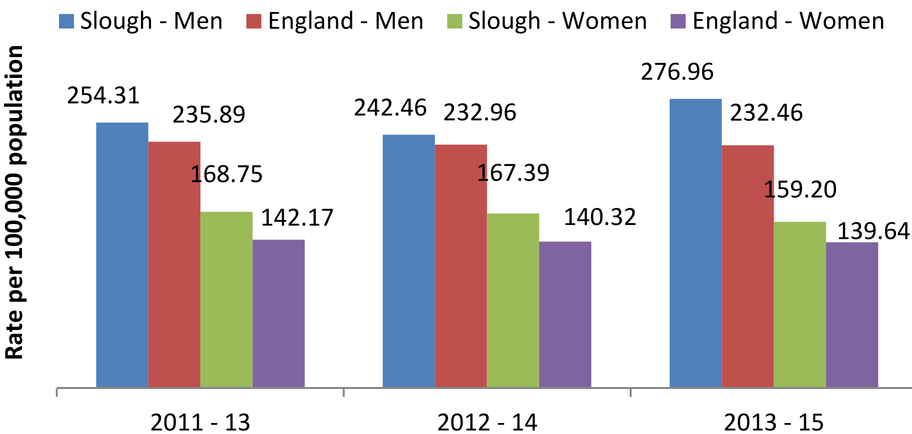


As shown in fig 2 addressing these would have the biggest impact on reducing total numbers of avoidable deaths – sadly though the emphasis does appear to be on increasing health care interventions

We can measure preventable deaths rates in our own community. The England age standardised rate for preventable deaths is 184 deaths per 100,000, with the rate in Slough being higher at 215.5 /100,000 (2013-2015) i.e more preventable deaths in Slough. Fig 3

We can see that in men the rate of preventable deaths are higher than the national average, with perhaps a worsening trend, whilst the impact in women is also worse than the England average but perhaps decreasing : so the impact on health, early death and use of health care by more sustained application of public health measures by health and social care organisations, communities and individuals will reduce early deaths and hence also the demand of our services, and improve health considerably at the local level .

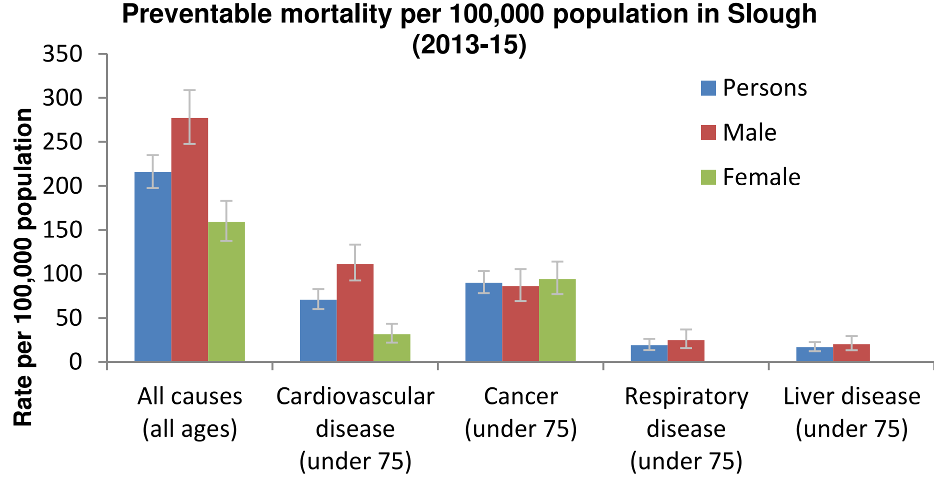
Fig 3



If we look at the major causes of early preventable death within Slough, we see a similar picture to that seen nationally with the biggest single generic cause being cancer for all persons and impact being greater for all preventable causes on male deaths in Slough the impact of cardiovascular disease on men is the highest single cause. fig 4

Slough has the highest preventable mortality rate across Berkshire and if we examine premature preventable mortality in Slough in more detail by clinical groups then we see that mortality rates are higher in men for all causes except cancer

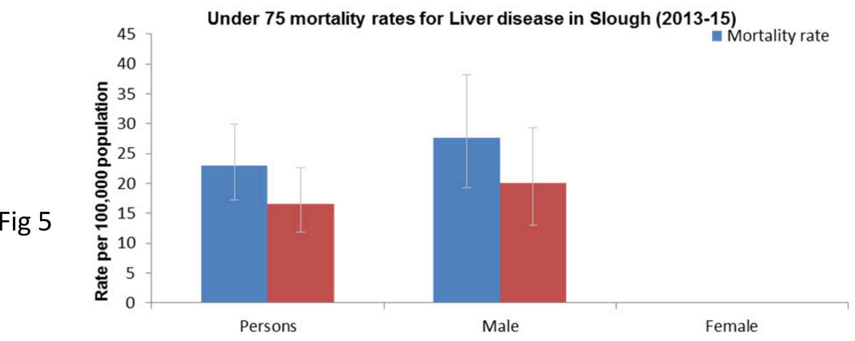
Local preventable deaths



For cardiovascular causes, male preventable mortality rate is 3.6 times that of females : and 70% of premature cardiac deaths in men are preventable .

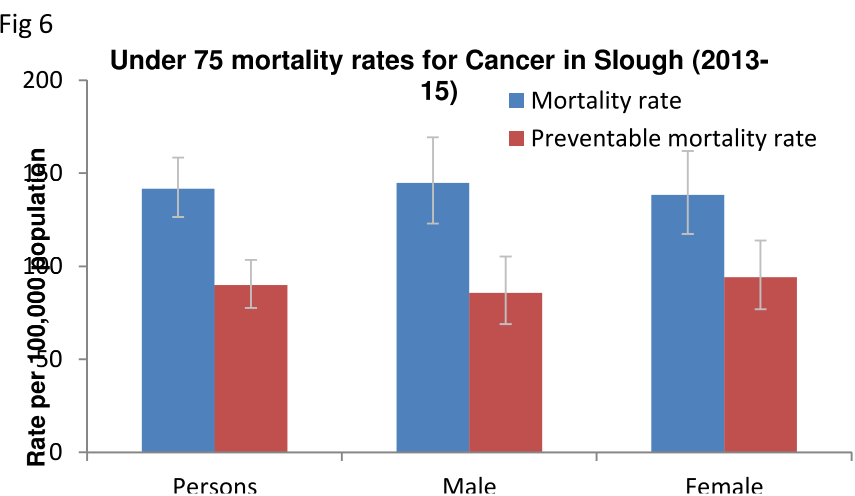
In Slough we see the highest overall liver disease on all persons in Berkshire (23 per 100,000 pop) – 70% of male mortality being preventable

Fig 5



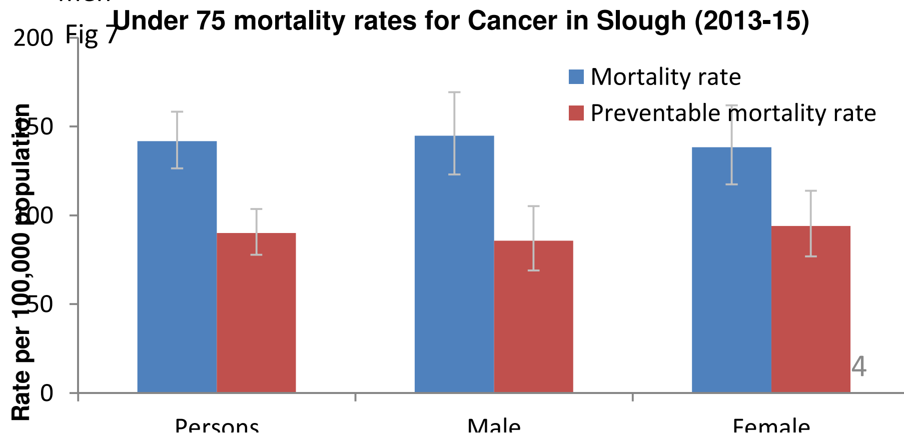
In respiratory disease the numbers of preventable deaths in females is too small to be calculated

Fig 6



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

Fig 7

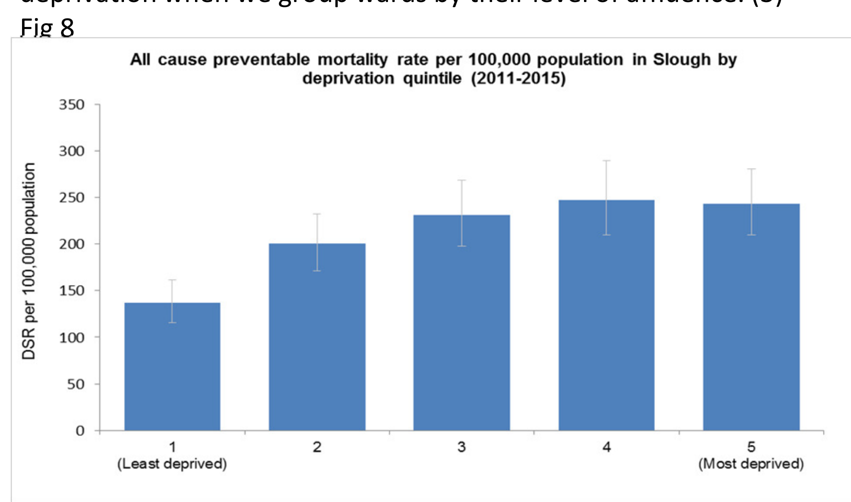


Preventable deaths

The impact of premature mortality from preventable causes can be examined by geography and deprivation.

Across all preventable deaths there is a definite link with deprivation when we group wards by their level of affluence. (3)

Fig 8



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

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

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

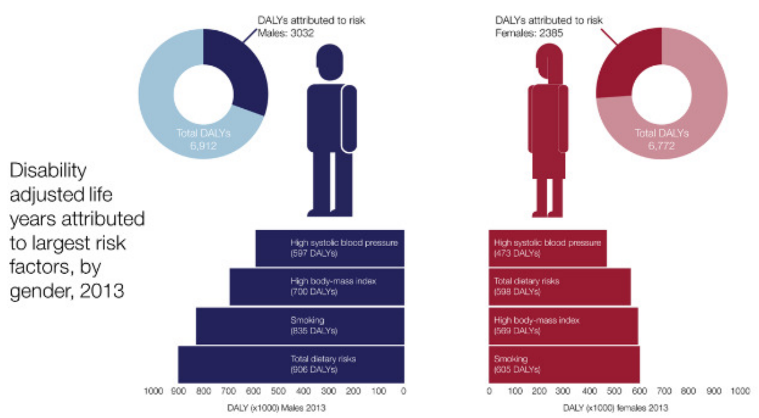
Whilst the strongest risk factors for avoidable hospital admission are age and deprivation (5)

Clustered poor health behaviours are associated with increased risk of hospital admission among older people in the UK. Life course interventions to reduce number of poor health behaviours could have substantial beneficial impact on health and use of healthcare in later life (6). Studies have shown that among men and women, increased number of poor health behaviours was strongly associated ($p<0.01$) with greater risk of long stay and emergency admissions, and 30-day emergency readmissions. Those with three/four poor health behaviours were in men, 1.37[95%CI:1.11,1.69]; women, 1.84[95%CI:1.22,2.77] times more likely to be admitted to hospital than those with no poor health attributes. . Associations were unaltered by adjustment for age, BMI and comorbidity.

The impact of improving lifestyle behaviours is not restricted. In a study of over 65 year olds whilst that higher self-care confidence and being an exercise program decreased avoidable hospitalizations, starting exercise program at an older age decreased hospital admissions and also decreased utilization of emergency services in the short and medium term.(7)

Action to address early preventable deaths

There are 8 commonly agreed : alcohol use, tobacco use, high blood pressure, high body mass index, high cholesterol, high blood glucose, low fruit and vegetable intake, and physical inactivity that would reduce preventable death rates



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

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

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

In the following section we will briefly review 5 of the major lifestyle and risk factors for preventable deaths in whom there is significant evidence regarding interventions that make a difference. We will briefly describe the pattern of these factors in our community, the impact of each in terms of illness and death, but also in terms of impact on our services.

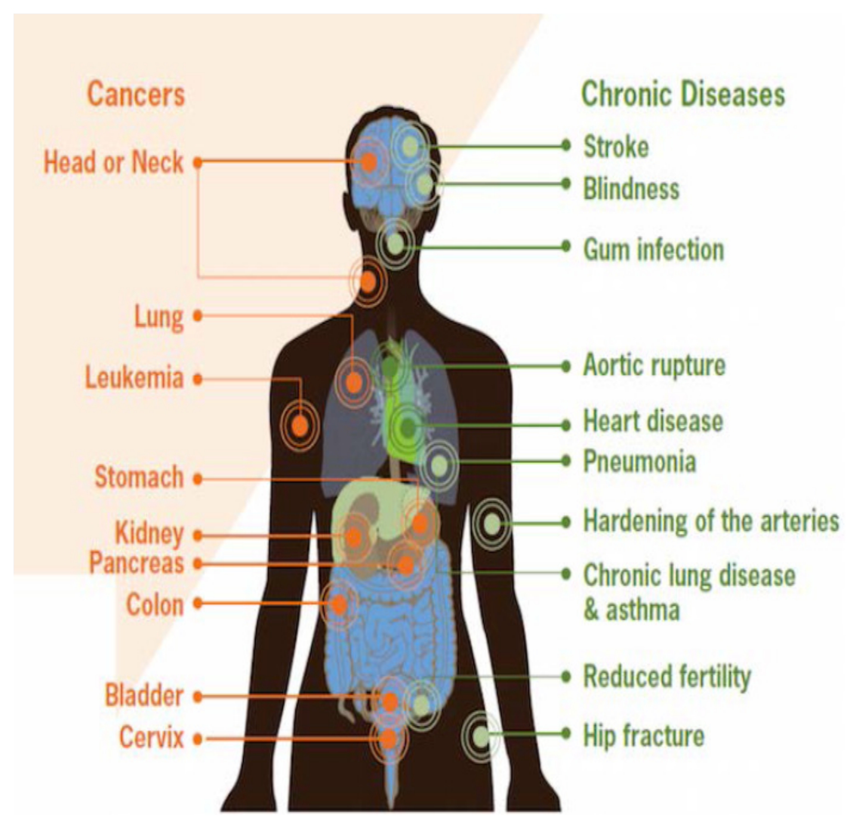
It should be noted that whilst we look at each individually there is data that shows that risky health behaviours interact and have a multiplicative rather than simply additive impact. That is, they have a greater effect together than the sum of each individual risk. For example obesity and alcohol consumption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

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

Smoking

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

Its impact is seen on every organ of the body.



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

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

2015/16	Slough BC	England
Never smoked	60.8%	48.6%
Adults resident smoking rate	18.3%	16.9%
Manual and routine smoking rate	27.1%	26.5%
Young people under15 regular smoker	4%	5.5%
Smoking in residents with severe mental illness	36.8%	40.2%

It is recognised that smoking has a profound impact on health inequalities. -, there is greater health inequality between smokers and people who have ever smoked than between people of the same sex and smoking status but different social positions.
In both women and men, people in the lowest social positions who had never smoked had substantially better survival rates than smokers in even the highest social classes. (12) 85% of the observed inequalities between socioeconomic groups can be attributed to smoking (13)

Smoking - impact –

In 2012-14, there were 275 smoking-attributable deaths per 100,000 population in England. In Slough 2012 -14 the rate is 275 / 100,000.

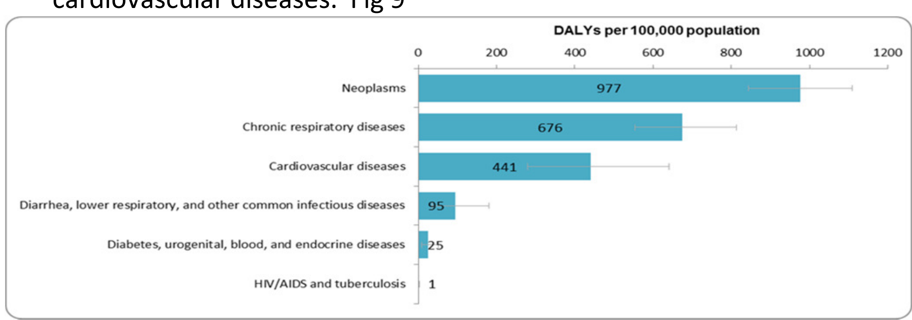
In Slough 383 deaths each year are caused by smoking – 2.5 deaths a week

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

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

This figure shows the wide impact of tobacco in the South East
Source: Global Burden of Disease (2013) (14)

The largest numbers of DALYs attributable to smoking in general causes were for cancers, chronic respiratory diseases and cardiovascular diseases. Fig 9



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

23% of DALYs for neoplasms were attributable to smoking. Again, this was higher for certain cancers:

- 79% of DALYs for tracheal, bronchus and lung cancer
- 54.1% lip and oral cavity cancer
- 53% oesophageal cancer

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

If we look at men aged 55-79, smoking is ,as could be expected the single largest cause of DALYS but now accounts for the 12 – 14% of DALYS in the least deprived areas but is in the most deprived communities accounts for 19 – 21% of DALYS : 1 in 5 of DALYs - significantly more than in wealthier areas. (A similar pattern is seen in women)

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

Tobacco accounts for 90% of health inequalities

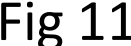
Smoking - impact

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

There were 1.7 million admissions in 2014/15 across the UK for conditions that could be caused by smoking, an increase of 22% from 2004/5. With 475,000 hospital admissions attributable to smoking in 2014/15, up from 452,000 in 2004/05.

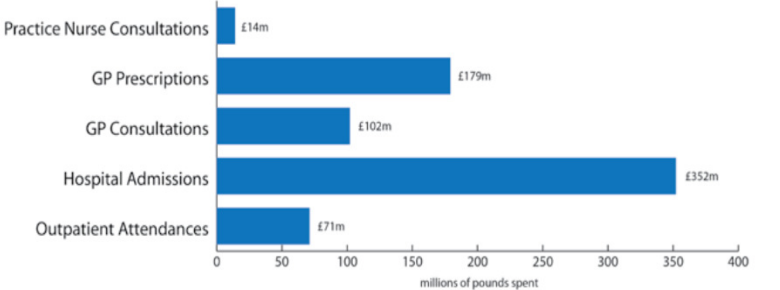
This represents 4% of all hospital admissions (6% of male admissions and 3% of females.) (14,16)

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



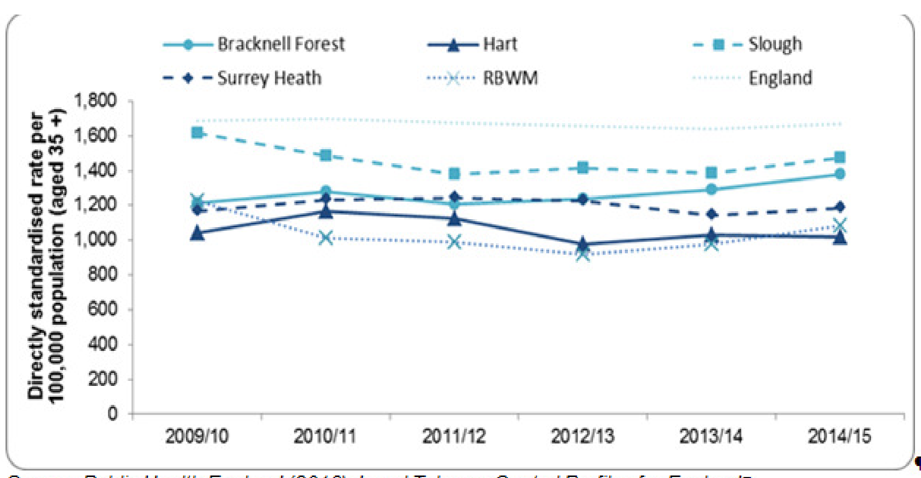
Individuals with mental health problems smoke more heavily than the general population, thus contributing to as much as 43% of tobacco consumption in the UK (16) and it is estimated 3 million UK adults with mental disorders and also smokers incur total smoking-attributable costs of £2.34 billion . A total of £719 million was spent treating smoking-related disease among people with mental health disorders of which £352m were due to hospital admissions, while other cases were treatments of cancer, cardiovascular disease and respiratory diseases (18,)

Fig 10



Locally in line with the lower prevalence of smoking (and our lower than average admissions in general) our rates of smoking related admissions are lower than the England average..(15,17)

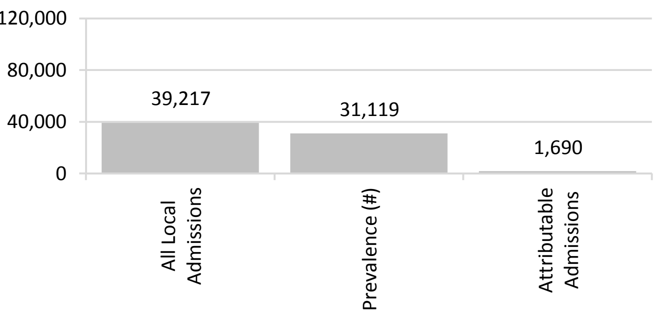
Fig 11



Source: Public Health England (2016); Local Tobacco Control Profiles for England

Though in Slough it can be seen that 1700 admissions a year are solely attributable to the effects of smoking. (16)

Smoking



Smoking - impact

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

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

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

Interventions

What Works The biggest short-term savings opportunity lies in helping smokers who are in contact with the NHS; the greatest long-term savings would come from preventing people from ever smoking altogether

Prevention of smoking requires strong partnership working e.g promoting smoke free environments, reducing counterfeit and illegal tobacco sales.

Smoking cessation services are widely available and the local council service continues to see more residents than the England average. In 2015/6 1,404 per 100,000 in 2015/6 set a quit date (v 862 England) and 918 /100,000 reporting quitting at 4 weeks (v 440 England) (20)

2015/16	Rates per 100,000 population (actual numbers)		
	Setting quit date	Successful quitters	Validated quitters (CO)
England	862	440	314
South East	674	375	271
Slough BC	1,404 (1,526)	918 (998)	459 (499)

Local Gaps However whilst we offer some support to patients within health care settings to give up smoking we have still to maximise this approach.

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

For those unable / unwilling to stop smoking permanently then temporary abstinence supported by nicotine replacement medication will deliver harm reduction. Smokers having elective surgery are 6 times more likely to have a surgical site infections and so have lengthier post operative stays and recovery periods. Simply supporting abstinence prior to surgery can reduce this risk, improve outcomes and reduce costs associated with care .

Lifestyles – High blood pressure

Blood pressure is recorded with two numbers.

The systolic pressure (higher number) is the force at which your heart pumps blood around your body.

The diastolic pressure (lower number) is the resistance to the blood flow in the blood vessels. They're both measured in millimetres of mercury (mmHg). As a general guide:

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

Risk factors for high blood pressure

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

Overweight or obese
Poor diet : high salt & Less than 5 a day fruit and vegetables
Low Physical activity
High alcohol
Smoker
are over the age of 65
don't get much sleep or have disturbed sleep
are of African or Caribbean descent
Family history of high blood pressure

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

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

Lowering blood pressure per se reduces risk for myocardial infarction by 20% - 25%,(23).

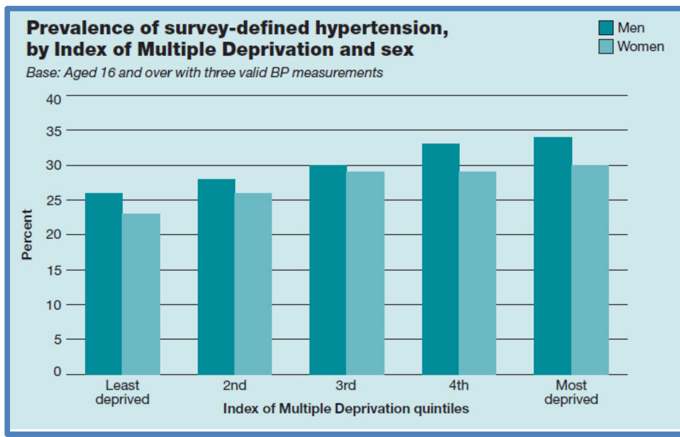
High BP costs the NHS an estimated £2bn, while social care and productivity costs are likely to be much higher High blood pressure causes stroke, myocardial infarction, heart failure, chronic kidney disease, vascular dementia and premature death

High BP is much more common in deprived communities. The Department of Health's 2010 'Health Survey for England' noted that prevalence increased from

26% of men and 23% of women in the least deprived quintile

34% and 30% respectively in the most deprived quintile.

Fig 13



High blood pressure

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

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

(25)

13.1% of all deaths in South East England were attributable to high blood pressure (14)

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

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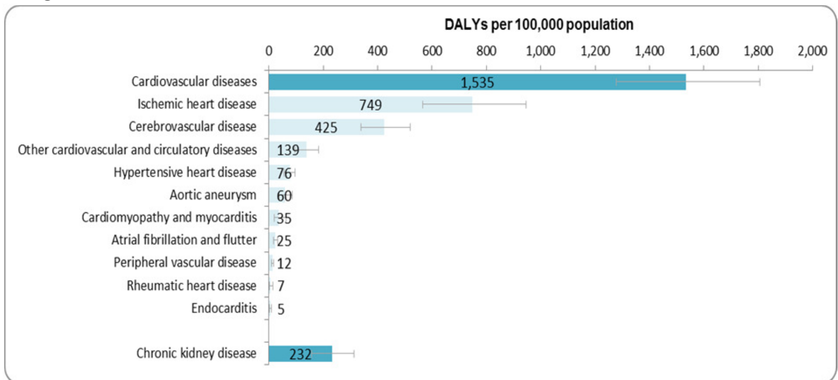
The largest number of DALYs attributable to high blood pressure were for cardiovascular diseases and chronic kidney disease. Within the cardiovascular diseases group, ischemic heart disease and cerebrovascular disease had the largest number of DALYs attributable to high blood pressure

Fig 14



Source: Global Burden of Disease (2013)

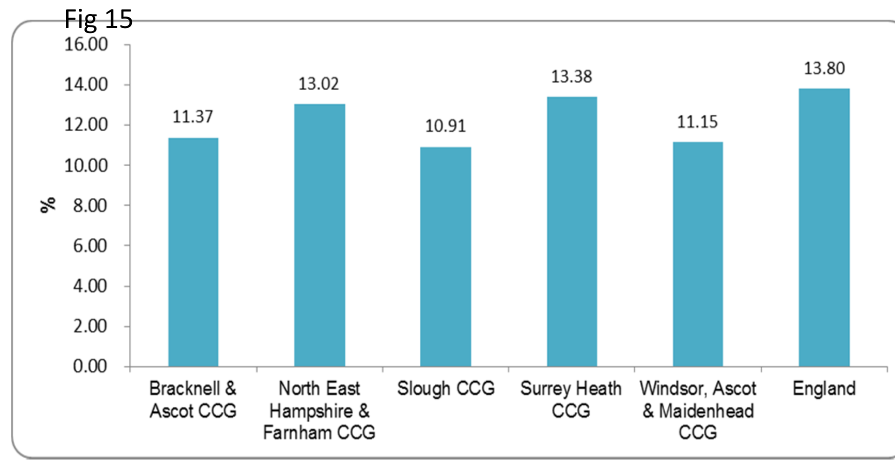
For all cardiovascular events High systolic BP accounts for 43% DALYs; 1,535 per 100,000

In reviewing premature deaths (deaths before age 75) Reading fares badly with regards heart disease and stroke -being ranked 97 out of all authorities, with 85 deaths per 100,000 (2013-2015) and ranked 14 out of 15 in comparison to similar local authority areas. (26)

High BP –Impact

Across Slough CCG there are estimated to be 30,000 people with high BP , with 16,800 currently being treated -this means that there are 12,900 people unaware of their high BP (27).

Fig 15



In addition, of those that are being treated by their GP not all are achieving target BP control: 466 patients (27)

Locally it is possible to measure the impact high BP has on disease and deaths but also the impact on reducing high BP in those with high BP by 10 mm HG in Slough.

Every 10 mmHg reduction in systolic BP reduces the risk of major cardiovascular events by 20% . We can calculate the impact of this improvement in treatment on CVD disease.

Condition	Current number of events	Current number if treated	Reduction in number of deaths
Stroke	141	103	38
Heart failure	133	96	37
cvd	226	186	40
Deaths	819	713	106

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

Of those who address lifestyle after 10 weeks a significant percentage achieve a 10 mm reduction in BP : (28)

- Weight 40%
- Exercise 30%
- Relaxation 25%
- Alcohol 30%
- Salt 25%

Advice given during the consultation for high BP is likely to be acted upon. Compared with those who did not recall being given advice, hypertensive adults who recalled being given advice were more likely to change their eating habits, reduce salt, exercise ,and reduce alcohol consumption (28).

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

High BP - Intervention

High blood pressure management in the community from a long term perspective is focussed on reducing the risk factors within the community : obesity, physical inactivity, smoking and high slat intake etc . However in the short and medium term there are clear programmes that can reduce the impact of this risk factor (21)

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

A key part is wider use of self-monitoring by patients to help eliminate false readings and provide a the skills of the patient to know and monitor blood pressure in daily living to minimise false readings

Of course it is also key to identify residents in the community who are unaware that they have high blood pressure. Programmes to identify high blood pressure before organ damage occurs through . lifestyle changes and or drug treatment will of course reduce demand for care and costs for health and social care.

Alcohol

It is known that alcohol is harmful to health and the CMO guidelines to reduce risk state that it is safest not to drink more than 14 units a week on a regular basis. And these should be spread over 3 or more days (29,30)

Alcohol is measured in units - one unit is 10ml or 8g of pure alcohol. Since drinks differ in the proportion of alcohol the number of units varies.

Alcohol drinks are often described as alcohol by volume percentage : some wines are 11% ABV - this means that a 1 litre bottle contains 11 units .

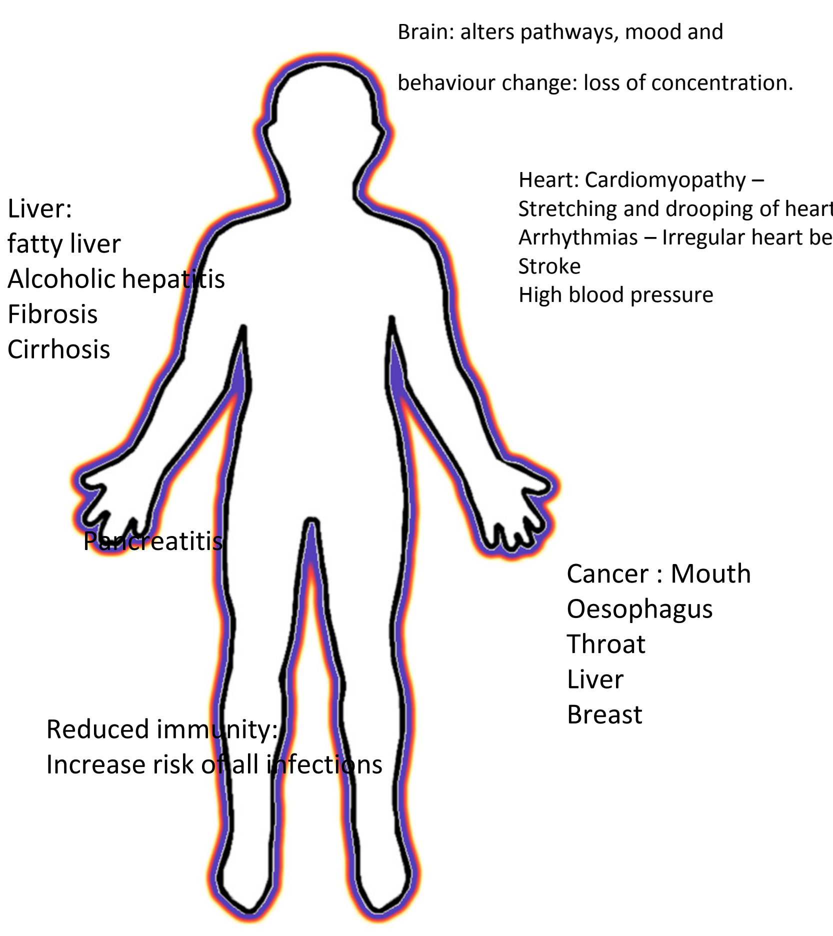
Therefore one 125 ml glass contains 1.64units : a 175 ml glass has 1.9 units and 250 ml glass has 2.5 units

Beer : a pint of 4% beer has 2.3 units

(30)

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

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



Alcohol

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

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

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

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

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

With increasing dose, there is increasing risk. For example, all alcohol-related cancers exhibit this relationship (33)

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

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

the volume of alcohol consumed

the frequency of drinking occasions

the quality of alcohol consumed

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

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

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

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

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

Alcohol

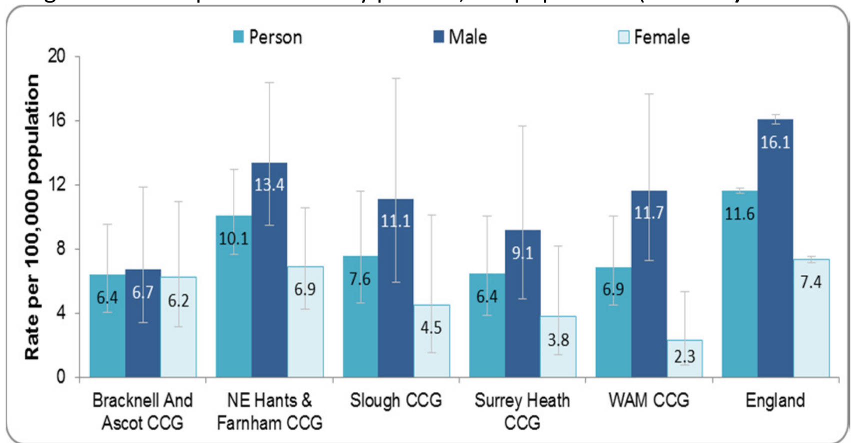
Cause of death	No. of deaths	Average age at death
All causes (England & Wales	501,424	77.6
All alcohol-specific causes	4,329	54.3
Mental and behavioural disorders due to use of alcohol	489	57.5
Toxic effects of alcohol (unspecified)	395	42.4
Accidental poisoning by exposure to alcohol	369	49.1

3.9% of all early death and poor health (DALYs) in the South East Region were attributable to alcohol use in 2013 (965 per 100,000 population).(14)

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

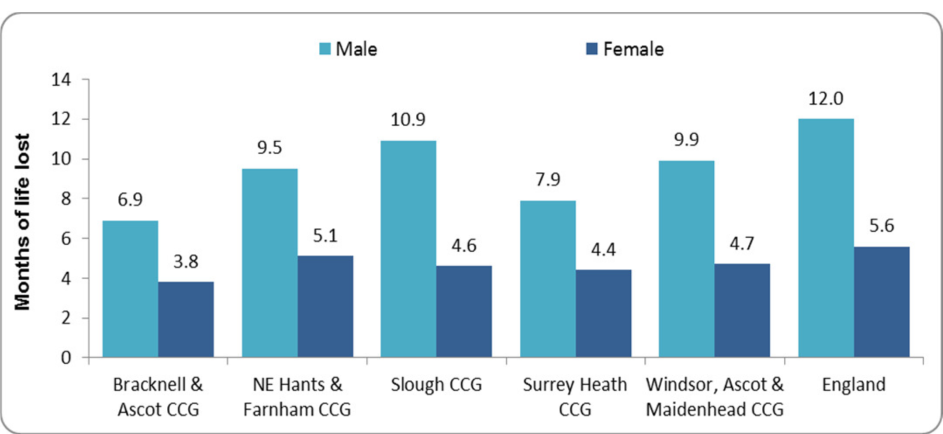
In 2012-14, 153 people died from alcohol-specific conditions in the Frimley Heath STP footprint, 75% of these were men. The rate of deaths per 100,000 population varied in the area from 6.4 per 100,000 population in Bracknell & Ascot CCG to 7.6 per 100,000 in Slough CCG. (16)

Fig 16 Alcohol-specific mortality per 100,000 population (2012-14)



If we look at the months of life lost due to alcohol locally then we can see a similar picture where men in S lough lose 11.1 months – (115,17)

Fig17 Months of life lost due to alcohol (2012-14)



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

Alcohol

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

Within Slough Borough we can that there are over 25,000 drinkers and that there are almost 9,000 admissions annually due to alcohol - not unexpected since alcohol accounts for 3% of all NHS costs. (18)

Fig 18

Alcohol

	Value
All Local Admissions	39,217
Prevalence (#)	25,505
Attributable Admissions	8,850

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

The public health ambition for alcohol is to reduce excessive alcohol consumption and therefore the associated burden on NHS and local authorities and wider society with consequent (31) :

Reduction in alcohol-related hospital admissions, re-admissions, length of stay and ambulance call-outs

Reduction in the burden on NHS, police and social care services from high volume service users

Reduction in the impact of parental alcohol misuse on children

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

However there are key actions that can be taken forward locally:

Brief intervention and advice throughout health care that raise knowledge on safe alcohol levels screening patients and providing brief advice on alcohol consumption to cover potential harm and ways to reduce alcohol intake (21)

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

Physical Activity

Physical activity is defined as any bodily movement produced by skeletal muscles that requires energy expenditure.

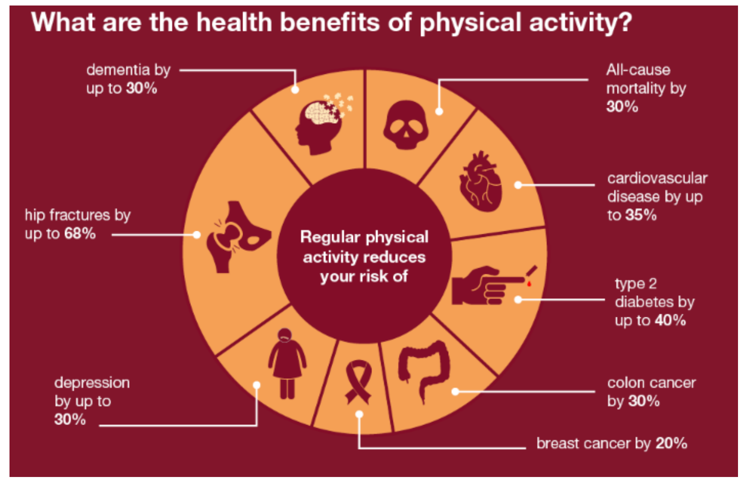
Physical activity levels can be measured either through asking people to report how much exercise they do, or by objectively measuring the amount of exercise a person is doing. Most reports use self reported activity

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

Adults (19 to 64) should aim for at least 150 minutes of moderate intensity activity, in bouts of 10 minutes or more, each week

The link between physical inactivity and obesity is well known, but physical activity is not, just a way of addressing obesity.

Low physical activity is one of the top 10 causes of disease and disability in England.



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

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

Physical activity is also important for people diagnosed with cancer and cancer survivors. Not only increasing ability to manage recovery but also reducing rate of recurrence in key cancers. Macmillan has estimated that in the 2 million cancer survivors in the UK - 1.6 million do not meet the recommended levels of physically active (37)

Physical Activity

In in 4 women and 1 in 5 men are inactive : only 24% of women and 34% of men do muscle strengthening exercises twice a week . Men are more likely to be sedentary for more than 6 hours a day(36).

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

People living in in the least prosperous areas are twice as likely to be physically inactive as those living in more prosperous areas(38)

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

Age

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

Disability

Disabled people are half as likely as non-disabled people to be active

Only 1 in 4 people with learning difficulties take part in physical activity each month, compared to over half of people without a disability

Race

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

Sex Men are more active than women in virtually every age group, with 6 in 10 women not participating in sport or physical activity (38)

Sexual orientation and Gender Identity

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

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

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

Physical inactivity : developed countries is responsible for :
an estimated 22-23% of CHD,
16-17% of colon cancer,
15% of diabetes,
12-13% of strokes and
11% of breast cancer (16)

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

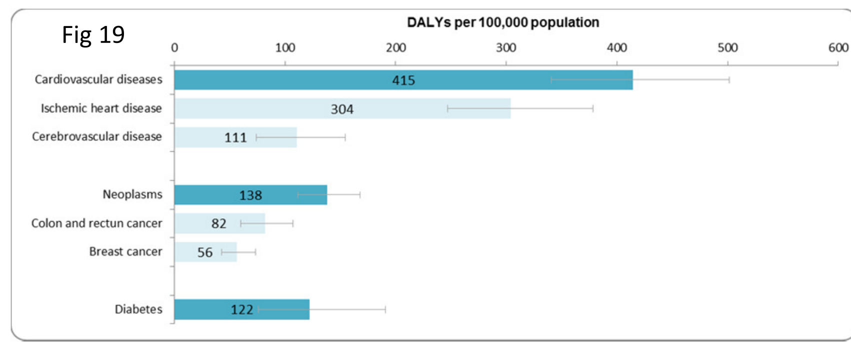
Persuading inactive people (those doing less than 30 minutes per week) to become more active could prevent:
one in ten cases of stroke and heart disease in the UK and
one in six deaths from any cause.(38)

Physical activity: Interventions

In the UK the Global Burden of Diseases found physical inactivity and low physical activity to be the fourth most important risk factor in the UK for limiting illness and early death (14)

In the South East 2.8% of all disability-adjusted life years (DALYs) in the South East Region were attributable to low physical activity in 2013 (675 per 100,000 population).(14)

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



The Health Impact of Physical inactivity (HIPI) tool quantifies the impact of physical inactivity for people aged 40 – 79.

Within Slough BC each year If 100% of this group were active then:

74 annual deaths (40-79) could be prevented

11/53 annual cases of breast cancer could be averted

And 855 new cases of diabetes could be prevented

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

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

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

The solution is clear: *Everybody needs to become more active, every day*.(36)

Physical activity does not need to be strenuous , it can be a thirty minutes of brisk walking, a swim, gardening or dancing . Each ten-minute bout that gets the heart rate up has a health benefit . Being active is not just about moving more, we need to build our muscle strength and skills.

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

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

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

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

Obesity

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

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

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

For most adults, a BMI of:

- 18.5 to 24.9 means you're a healthy weight
- 25 to 29.9 means you're overweight
- 30 to 39.9 means you're obese
- 40 or above means you're severely obese

Another simple measure of excess fat is waist circumference- men waist size of 94cm / 37in) or more
Women waist size of 80cm / 31.5in) or more a
more likely to develop obesity-related health problems

Obesity prevalence increased steeply between 1993 and 2000,. Rates of obesity and overweight were similar in 2013 to recent years.. H*ealth & Social Care Information Centre (2014); Health Survey for England 2013 (41)*

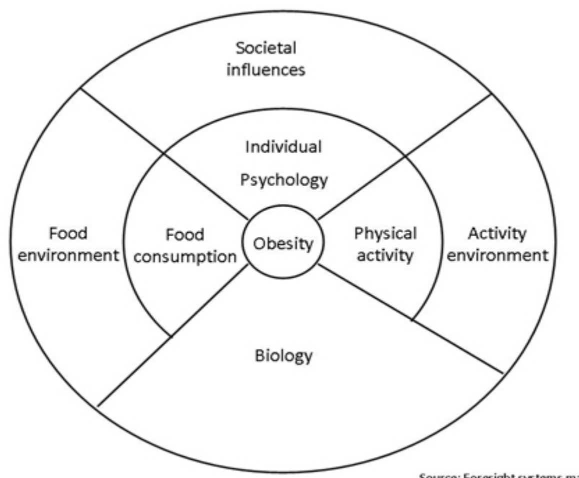
Mortality

9.0% of all deaths in South East England were attributable to a high body-mass index (GBD2013) . This was the 3rd most important risk (smoking and high blood pressure (14)

The impact of weight on life expectancy is linked to levels of excess weight

People with a BMI of 22 – 25 kg/m2 have the best life expectancy:
obese individuals live 2 – 4 years
People with BMI of over 40 - live 8 – 10 years less (42)

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

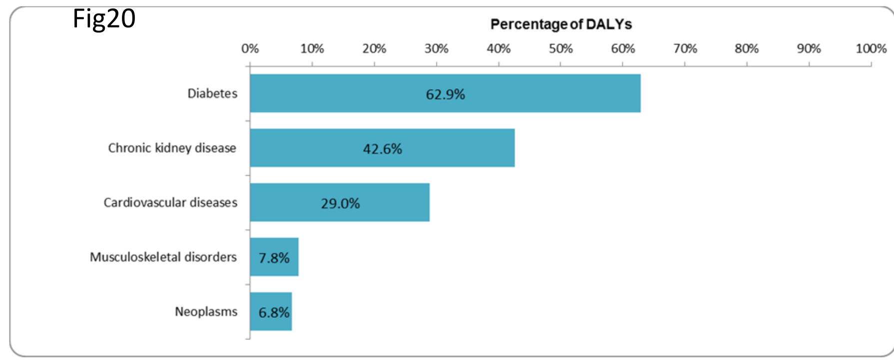


Source: Foresight systems map, 2007

Obesity : Local Impact

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

Fig20



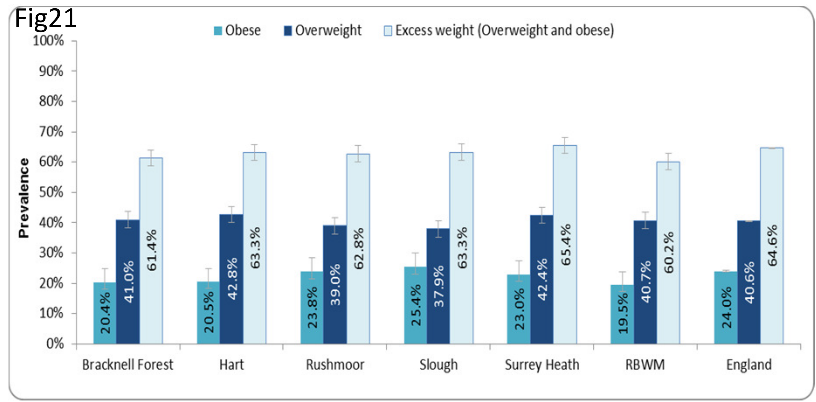
Obesity levels in the community are not uniform : obesity levels increase until late middle age and then reduce in old age. More women in communities with higher deprivation are obese . (NICE guidelines 2014)

Women from the in SEC group 1/ 2 have the lowest prevalence of obesity and those in SEC 4/5 consistently have the highest prevalence of obesity. (42,43). This is not seen in men, though for both men and women obesity is significantly reduced in those with a degree or equivalent.

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

Locally in Slough we can see that we are below the national average with regards obesity levels . However this is not cause for complacency since this may in part be due to the lower age profile of the population in Slough since we know we have a younger age population and obesity increases with age. (42)

Fig21



In our children the figures are more worrying with 23% of children in reception being overweight or obese and 38.9% in year 6 (this exceeds the England average in both age groups).

We would therefore expect that obesity has less of an impact on our adult hospital admissions - but even with our lower than average obesity levels approximately 4270 admissions in Slough have obesity recorded as part of the record each year , with just over 4,800 admissions being attributable to obesity (16).

Obesity: Interventions

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

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

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

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

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

Furthermore Health professionals do not routinely address weight loss issues as some voice concern about the impact of the topic on the clinical relationship. However research shows that patients less than 2% of people found it to be not acceptable or unhelpful (46) and over 40% very helpful. Moreover 77% accepted the referrals to weight management services and nearly 50% completing the course

Recent evidence shows the cost benefits of weight management services even in the short – medium term. The net health and care savings: over a 5 year period, are c£30 p.a. per person enrolled (ie cumulative saving of c£150 per person over 5 years). This intervention could be cost saving to the health and care system by year 2. (21).

But it should be remembered that weight management interventions aim to have lifelong benefits.

Locally in Berkshire the second year of Eat for Health 529 people have attended courses with more than 50% more than 3% of their weight .

Of the 197 people with high BP attending , in 55 (28%) residents losing weight resulted in their BP returning to normal levels with no need for ongoing medication and significant on going health benefits.

- 1 A brief history of life expectancy in britain *by tim lambert*
- *2* Statistical bulletin : Avoidable mortality in England and Wales: 2014
- 3 LOCAL
- 4 *11 Source: Buck, D et al (2012); Clustering of unhealthy behaviours over time: Implications for policy and practice; The King's Fund*
- 5 Purdey S[1], Huntley A. Predicting and preventing avoidable hospital R Coll Physicians Edinb 2013; 43:340–4
- *6* Understanding poor health behaviours as predictors of different types of hospital admission in older people: findings from the Hertfordshire Cohort Study Holly E Sydell, PhD,[1] Leo D Westbury, MSc, Shirley J Simmonds, MSc, Sian Robinson, PhD, Professor of Human Nutrition, Cyrus Cooper, DM FRCP FMedSci, Professor of Rheumatology, Director,[1,2,3] and Avan Aihie Sayer, PhD FRCP, Professor of Geriatric Medicine[1,2,4,5,6]
- 7 Effects of self-care behaviors on medical utilization of the elderly with chronic diseases - A representative sample study.
- Chen IH[1], Chi MJ[2].
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- 9] Hart CL, Morrison DS, Batty GD, Mitchell RJ, Davey Smith G. Effect of body mass index and alcohol consumption on liver disease: analysis of data from two prospective cohort studies. BMJ. 2010;340:c1240.
- 10 Tuyns AJ, Esteve J, Raymond L, Berrino F, Benhamou E, Blanchet F, et al. Cancer of the larynx/hypopharynx, tobacco and alcohol: IARC International Case–control Study in Turin and Varese (Italy), Zaragoza and Navarra (Spain), Geneva (Switzerland) and Calvados (France). Int J Cancer. 1988;41:483–91.
- 11NHS digital report on smoking cessation services
- 12 Effect of tobacco smoking on survival of men and women by social position: a 28 year cohort study *BMJ 2009; 338 doi: http://dx.doi.org/10.1136/bmj.b480 (Published 18 February 2009) Cite this as: BMJ 2009;338:b480* Laurence Gruer, Carole L Hart, David S Gordon,, Graham C M Watt,
- 13*Law M, Morris J. Why is mortality higher in poorer areas and in more northern areas in England and Wales? J Epidemiol Community Health1998;52:344-52*
- 14 Global Burden Of Disease 2015
- 15 Berkshire shared service report on lifestyle and DALYS
- *16 PHE attributable admissions analysis 2106 KIT*
- *17 PHOF outcomes*

18 Tobacco Control (Wu et al, 2014)

19 *The Cost of Smoking to the Social Care System in England* January 2017, ASH in 2014 Carole L Hart, research fellow, David S Gordon, Graham C M Watt,

20 Local tobacco profiles and Berkshire contract data

21 PHE menu of interventions
22British Hyper tension society
23 Blood pressure lowering for prevention of cardiovascular disease and death: a systematic review and meta-analysis Dena Ettehad,Connor A Emdin,Amit Kiran,Simon G Anderson,Thomas Callender,Jonathan Emberson,, Prof John Chalmers,Prof Anthony Rodgers, Prof Kazem Rahimi, http://dx.doi.org/10.1016/S0140-6736(15)01225-8
24 *Effect of social deprivation on blood pressure monitoring and control in England: a survey of data from the quality and outcomes framework* Mark Ashworth,Jibby Medina,, Myfanwy Morgan, *BMJ 2008;337:a2030*

25 Prevalence, awareness, treatment, and control of hypertension in rural and urban communities in high-, middle-, and low-income countries CK Chow, KK Teo, S Rangarajan, S Islam, R Gupta… JAMA. 2013;310(9):959-968. doi:10.1001/jama.2013.184182

26 PHE longer lives

27 British Heart foundation : how can we do better CCG profile 2016

28 Lifestyle modifications to lower or control high blood pressure: is advice associated with action? The behavioral risk factor surveillance survey.Viera AJ[1], Kshirsagar AV, Hinderliter AL.

29 UK CMO guidelines on alcohol intake 2016

30 Drinkaware.co.uk

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33 National Cancer Institute

34 Global status report on alcohol and health World Health Organization; 2014

35 Health matters: getting every adult active every day July 2016

36 Everybody Active Everyday PHE UK

37 Macmillan UK cancer and physical activity

38 Physical Activity Statistics 2015 British Heart Foundation Centre on Population Approaches for Non-Communicable Disease Prevention. Nuffield Department of Population Health, University of Oxford

39 Disease activity and low physical activity associate with number of hospital admissions and length of hospitalisation in patients with rheumatoid arthritis George S Metsios Antonios Stavropoulos-Kalinoglou, Gareth J Treharne, Alan M Nevill, Aamer Sandoo, Vasileios F Panoulas, Tracey E Toms, Yiannis Koutedakis and George D Kitas

40 Objectively Assessed Physical Activity and Subsequent Health Service Use of UK Adults Aged 70 and Over: A Four to Five Year Follow Up Study Bethany Simmonds , *fox, davies, powen ku, gray et al

41 HSCIC Health survey England 2013

42 NOO : Obesity And Health Matters 2016

43 General household survey 2014

44 Meta analysis of weight intervention Hartmann-Boyce, Johns, Jebb, Summerbell, Aveyard. Obes Rev. 2014 Nov;15(11):920-32

45 Jebb et al Lancet. 2011;378(9801):1485-92

46 DPP. Lancet, 14 (2009), pp. 1677–1686

47 *Ettehad et al 2016:

http://dx.doi.org/10.1016/S0140-6736(15)01225-8 Dta -NHS digital 2015

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SLOUGH BOROUGH COUNCIL

REPORT TO: Slough Wellbeing Board

DATE: 29 March 2017

CONTACT OFFICER: Dean Tyler, Head of Policy, Partnerships & Programmes
(For all enquiries) (01753) 875847

WARD(S): All

PART I
FOR DISCUSSION

COMMUNITY ENGAGEMENT UPDATE

1. Purpose of Report

1.1 To provide the Wellbeing Board with an opportunity to discuss proposals to develop our approach to community engagement.

2. Recommendation(s)/Proposed Action

2.1 To note the attached summary report of a workshop held on 11 January and to agree ways in which we can work together to improve community engagement.

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

3.1 The Wellbeing Strategy states that "we will look for ways in which we can build on how we currently engage with people as individual agencies and look for opportunities to coordinate this." Being able to do this effectively will ensure that we are collectively working to achieve the priorities and outcomes in the Wellbeing Strategy and Five Year Plan.

3.2 The Five Year Plan is clear about the Council's ongoing commitment to "listen to and work with our communities, customers and partners" and "to working with our key partners to develop a more integrated way of working with our residents."

4. Other Implications

a) Financial - There are no financial implications associated with the proposed actions.
b) Risk Management - There are no identified risks associated with the proposed actions.
c) Human Rights Act and Other Legal Implications - There are no direct legal implications. There are no Human Rights Act Implications.

d) Equalities Impact Assessment - There is no requirement to complete an Equalities Impact Assessment (EIA) in relation to this report.

5. Summary

This item provides an opportunity for the Board to discuss ways in which we can improve our collective approach to community engagement.

Following the initial themed discussion on engaging people at the Wellbeing Board's November meeting members of the Board attended a workshop in January to look at the issues in more detail and a summary report is attached. This was shared for information at the Board's 26 January meeting.

We now need to agree next steps so that we are able to point to tangible progress in this area by the time of our 2017 Annual Conference which has been provisionally booked for **Thursday 21 September.**

6. **Supporting information**

6.1 Improving the ways in which we engage with communities was identified as an important issue in the Wellbeing Strategy when it was launched in September 2016.

6.2 The Board had a themed discussion at its November meeting following which it was agreed that further work needed to be undertaken to look at the issues in more detail and identify ways in which partners could improve how they work together.

6.3 A workshop was held on 11 January which addressed the following questions:

1. Why do we do community engagement and what are our strategic objectives?
2. What issues are we focussing on when we are engaging with the community and how are these to be measured?
3. Who is involved with community engagement, is there scope for collaboration and a need for a central body/individual/entity who can help streamline the approach, hold it together and be accountable for the outcomes going forward?
4. What examples if any are available where community engagement has worked well and perhaps not worked so well? Sharing best practice
5. When do we need to start something more collaboratively and how will the Wellbeing Board manage the outcomes and expectations?

6.4 A summary report of the workshop is attached.

6.5 In the meantime the council has been developing a 'one council' approach to working with communities. This will review our existing Community Engagement Policy and better help to meet the priorities of the council by:

- Enabling our communities to do more for themselves
- Building community resilience
- Ensuring meaningful engagement with our communities

6.6 This will inform the council's future programme of community development and engagement work and will incorporate 3 main projects under a single community development programme, these are:

A. Hubs – Building based assets from which council priorities can be achieved,
B. Community Development – ensuring better coordination and integration of our direct work with communities and improve community resilience
C. Integrated Community Working – Council, NHS and voluntary sector staff working in multi disciplinary environments in order to maximise early intervention solutions for the citizens of Slough.

7. **Comments of Other Committees**

7.1 None at this stage.

8. **Conclusion**

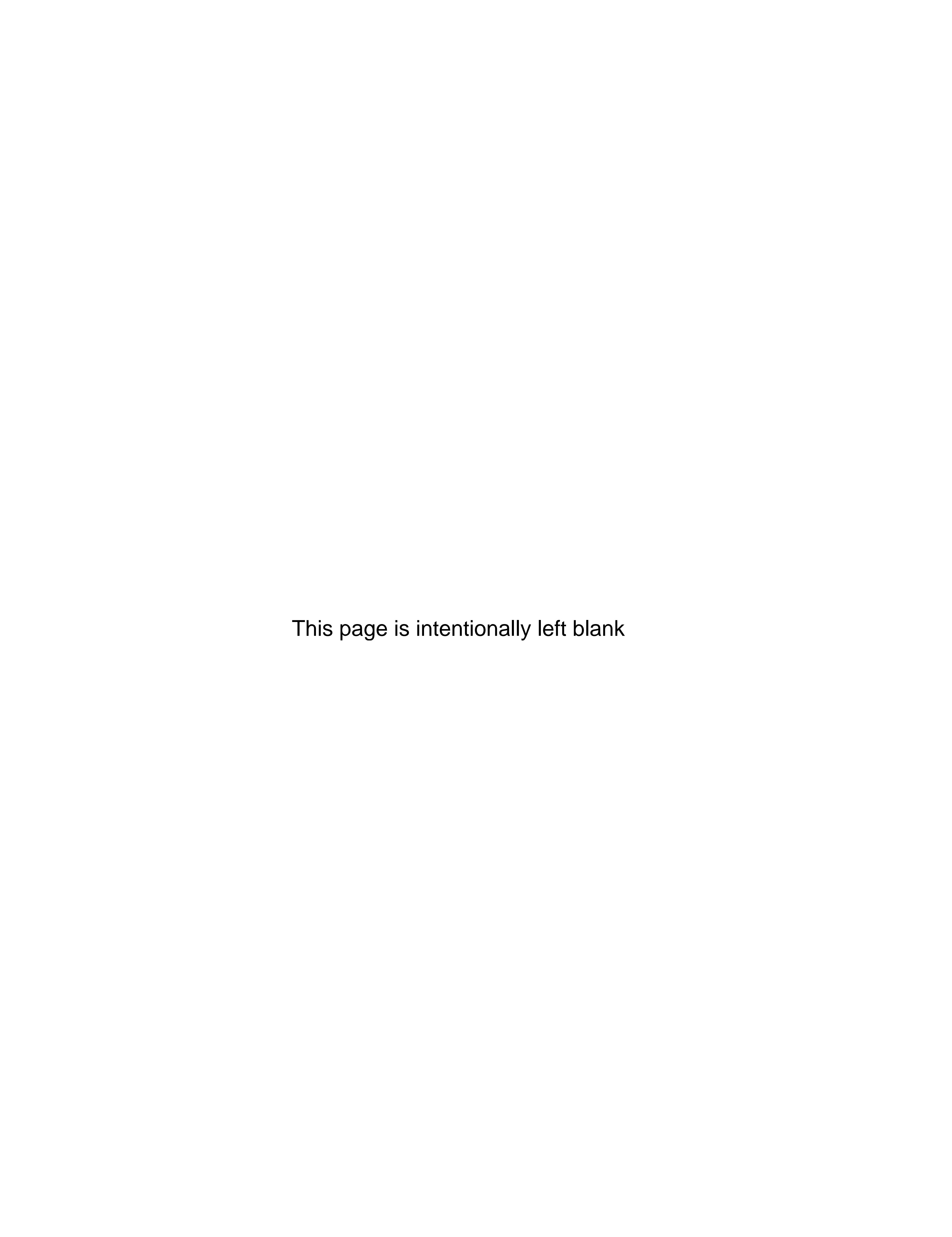
8.1 The attached summary report is intended to provide members of the Board with an update on the ongoing work to improve community engagement. We need to agree next steps so that we can report back to the wider partnership at our Annual Conference, provisionally planned for Thursday 21 September.

9. **Appendices Attached**

'A' Community engagement workshop summary report

10. **Background Papers**

None.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SLOUGH WELLBEING BOARD
FOLLOW UP SESSION ON COMMUNITY ENGAGEMENT

Wednesday 11th January 2017

Summary

This session was held to allow more time to explore the issues raised during the discussion on community engagement at the Slough Wellbeing Board on 16 November 2016. This report captures the key issues raised and how we can build on best practice examples to support the delivery of our priorities as a Wellbeing Board to improve outcomes for Slough. A proposal would be brought back to the Wellbeing Board to recommend how best to capture opportunities for future collaboration between partners where we are engaging with the community.

Introduction

The session was structured to consider why we do community engagement; the issues we focus on; who is involved; examples of good practice and when and how we need to start doing something more collaboratively as a Board.

This report summarises the discussion at the workshop session but is by no means intended to be exhaustive. Feedback is therefore welcomed to add to the content and development of more collaborative working. Comments should be sent to dean.tyler@slough.gov.uk

This report is being presented to the Wellbeing Board's meeting on 26 January for information with further work to follow as directed.

Summary of discussion

1. Why do we do community engagement and what are our strategic objectives?

The group concluded that community engagement was important if we are to ensure that we are designing services to meet the needs of the community.

Involving the community in identifying local issues will help to build on our existing knowledge of need and demand which is based on data and facts (e.g. JSNA). If we are able to make the community part of the process (i.e. co-production of services) rather than imposing services that suit the needs of organisations we would have a better chance of realising our strategic objective to develop trust and confidence. Some of the best practice examples point to evidence of how increased community participation leads to capacity and community resilience to deliver better outcomes and reduce demand on services.

We can measure the effectiveness of our approach in time with public satisfaction, feedback on services and how relations with the community have improved.

2. What issues are we focussing on when we are engaging with the community and how are these to be measured?

There was an initial discussion on scope and whether we are looking at the 'health and wellbeing' agenda or something else. We wouldn't be constrained by health specific issues although we agreed that most issues could be described as the wider determinants of health – housing, employment, leisure etc.

The 'five questions' about wellbeing were a good starting point and if used consistently across organisations so that we share answers could also help as a measure of how we can grow satisfaction with services. *[insert 'five questions']*

However the questions we use will change depending on the nature of the conversation and whether we are engaging to:

- Inform
- Consult
- Involve
- Collaborate
- Empower

In some cases we may not label activity as 'community engagement' specifically but what we are doing will provide a window of opportunity to share messages with elements of the community.

3. Who is involved with community engagement, is there scope for collaboration and a need for a central body/individual/entity who can help streamline the approach, hold it together and be accountable for the outcomes going forward?

The simple answer is 'all of us are involved.' There is therefore scope for collaboration and it was agreed that the Wellbeing Board could facilitate this. There was caution about assigning a single point of accountability as, depending on the nature of the issue, this could sit in a number of places.

Given its strategic membership the Wellbeing Board would trial the introduction of a shared calendar to capture opportunities for collaboration and was well placed to hold this together. The onus would be on all partners to contribute.

We would also explore how to better coordinate and share intelligence we already have, building on the best practice in the joint protocols that have been developed.

4. What examples if any are available where community engagement has worked well and perhaps not worked so well? Sharing best practice

Police – starting 'intensive engagement' to identify people in the community to work with the police to take ownership and find solutions to local issues

Youth Voice – This incorporates various youth voice mechanisms including the youth parliament. A key to the success here is the collaborative approach between the Council, the voluntary sector through the YES consortium and young people.

Slough Allotments – collaborative working between the council's parks & open spaces team and Slough Allotments Federation. In early 2016 a joint working group was established between the Council and the Slough Allotments Federation which has transformed the relationship between the Council and the federation (who represent allotment holders) and has led to significant progress being made.

Leisure – Involving communities to influence the Leisure Strategy and service design
Parks & open Spaces – a variety of 'friends of' groups or similar mechanisms helping to ensure our parks are of a good standard and have community ownership; examples include Baylis Park and Hershel Park

Langley community project – coproduction with community on adult social care

Neighbourhood Services Resident Board and Housing Service work with tenants on RMI contracts

Fire service – trusted more than some other organisations

Private sector examples [to add e.g. O2]

Co-production: the ladder of participation – see link to increasing levels of engagement http://www.thinklocalactpersonal.org.uk/Latest/Co-production-The-ladder-of-participation/]

An example of a communication that hasn't worked so well was the campaign to discourage people to seek antibiotics which the Wellbeing Board supported at its November meeting. Evidence seems to suggest that demand for antibiotics has increased over the winter with people asking for treatment for colds whereas the campaign sought to assure people that antibiotics would not help and just adds demand on GP's and the health service at a very busy time of year.

5. When do we need to start something more collaboratively and how will the Wellbeing Board manage the outcomes and expectations?

We should start now. Initially we will trial a shared calendar to look at forthcoming opportunities and prioritise these – see proposal below.

We need to be realistic in what we can achieve so should be initially focussed for example on the 4 priorities in the Wellbeing Strategy which was launched in September 2016.

This will be a partnership effort and while the Council may facilitate a good deal of activity it is expected that partners will work with each other to collaborate on their priorities for Slough where this will add value. This will build on good frontline partnership experience that we have in Slough.

The nature of the Wellbeing Board in having representatives that go beyond statutory requirements means we have a more strategic partnership and so have opportunities to collaborate on issues of importance across the borough.

The Board will hold itself to account and review the success of collaboration during the year, including at the annual conference in September.By the end of the year we should be able to start to look at what has changed and what we have learnt - whether services have improved, levels of uptake, % returns etc.

Proposed format for shared calendar

Month	**Lead partner**	**Issue / priority**	**Engaging with – all residents or a section of the community**	**Duration**
February	E.g. SBC with Slough Urban Renewal	E.g. proposed new housing development (Housing priority in Wellbeing Strategy)	E.g. Britwell residents, businesses and community organisations	E.g. 6 weeks
March				
April etc.				
Activity planned by timing not yet scheduled				

The session was attended by:

Slough Wellbeing Board representatives:

- Naveed Ahmed (Vice-Chair) - Business representative
- Roger Parkin – Interim Chief Executive, Slough Borough Council
- Nicola Clemo - Slough Children's Services Trust
- Superintendent Gavin Wong - Thames Valley Police
- Ramesh Kukar – Slough CVS
- Jesal Dhokia – Slough CVS
- Lise Llewellyn - Director of Public Health, Berkshire
- Les O'Gorman - Business representative
- Colin Pill - Slough Healthwatch
- Alan Sinclair - Director of Adult Social Services, SBC
- Councillor Wayne Strutton (Health Scrutiny Panel)

Slough Borough Council officers:

- Ketan Gandhi
- Zulf Awan
- Amanda Renn
- Sally Kitson
- Beth Reed
- Simon Hall
- Dean Tyler

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SLOUGH BOROUGH COUNCIL

REPORT TO: Slough Wellbeing Board

DATE: 29th March 2017

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

(For all Enquiries) (01753) 875752

WARD(S): All

PART I
FOR DECISION

BETTER CARE FUND PROGRAMME 2016-17 – QUARTER 3 REPORT

1. Purpose of Report

The purpose of this report is to inform the Slough Wellbeing Board (SWB) of the quarter three position for the Better Care Fund (BCF) programme for 2016/17.

This report also informs the Board on the process on BCF planning for 2017-19 and requests that the Board agree to delegate a final decision on the signing off of the Better Care Fund Plan 2017-19 to the Director of Adult Social Care

2. Recommendation(s)/Proposed Action

The Wellbeing Board is requested to:

i) note the progress against this year's plan for quarter three and
ii) agree to delegate the sign off of the final BCF plan for 2017-19 to the Director of Adult Social Care

3. The Slough Joint Wellbeing Strategy (SJWS) 2016 – 2020, the JSNA and the Five Year Plan

3a. Slough Joint Wellbeing Strategy (SJWS) 2016 – 2020 Priorities

The Better Care Fund programme is developed and managed between the local authority and CCG together with other delivery partners aims to improve, both directly and indirectly, the wellbeing outcomes for the people of Slough in the areas of:

i) increasing life expectancy by focussing on inequalities and
ii) Improving mental health and wellbeing.

3b. The JSNA

The BCF programme is broad in scope and aims to address, or contribute significantly to a number of areas of need identified in the JSNA. This includes the improvement of health in Slough's adult population through risk stratification and proactive early interventions with people at risk of disease and ill health.

BCF also encompasses enabling people to age well by promoting good health and maximising independence but also providing short-term support and reablement when required, or help navigate to other sources of support.

There are also elements included that support children and young people in areas such as asthma and support to young carers.

3c. **Five Year Plan Outcomes**

The Slough BCF programme contributes to achieving the five year plan outcome of more people will take responsibility and manage their own health, care and support needs.

4. **Other Implications**

(a) Financial

The size of the Pooled Budget in 2016-17 is £9.035m. The expenditure plan is across 31 separate schemes between the partners of the pooled budget agreement. These are listed within the finance summary in appendix A.

(b) Risk Management

The Joint Commissioning Board continues to oversee and monitor a risk register for the BCF programme. The register identifies and scores risks of delivery of the programme together with actions to mitigate or manage the risks. These are summarised below:

High Risk	• Improvements in delivery don't translate into required reductions in acute and social care activity impacting on funds available to invest in further capacity • Financial outlook continues to be uncertain impacting on ability to invest on a sustained basis to alter patterns of care
Medium Risk	• Complex and changing environment across health and social care systems means BCF has interdependency with other programmes across Slough, East Berks and new STP area which have potential to impact, possibly duplicate, conflict or delay progress. • Change to population and patterns of demand exceed projections resulting in greater demand. • Cultural change and change management take longer to achieve due to operational pressures on staff • Information Governance – difficulties sharing patient/service user data across health and social care • Workforce planning – insufficient capacity with requisite skills to both plan and deliver services
Low Risk *(previously assessed as*	• Impact of the Care Act The statutory requirements of the Care Act are in place. Further changes are underway through Social Care Reform programme

'medium' but now reduced)	to ensure services able to meet further demand and meet saving requirements on local authority. Financial risks above will also impact on ability to meet Care Act requirements.

These risks will be reviewed again as part of the new planning round for 2017-19.

(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

As previous reports have highlighted there will be significant workforce development implications as we move forward towards integration for Health and Social Care by 2020. This will lead to new ways of working in partnership with others which 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, the Sustainability and Transformation Plan (STP) and the Social Care reform programme within Adult Social Care services in SBC.

5. **Summary**

The Board is asked to note the progress of the BCF in quarter three. A progress report template is completed and returned to NHS England from each Wellbeing Board area each quarter and this was submitted by on 3rd March 2017. The summary of this is provided within this report.

A section 75 agreement is in place and funds held within a pooled budget arrangement, hosted by SBC. All funds are committed as outlined in the expenditure plan in appendix 1. Overall the forecast is for an underspend of £411k from the quarter three position. A summary of the finance is described below.

The Joint Commissioning Board agreed at the end of this quarter to invest underspend from two of the schemes into commissioning of adult social care in order to maintain delivery of social care services in this year (£322k), together with further funds to support additional activity arising from winter pressures (£150k).

The BCF programme is delivering on the national conditions it is required to deliver as

part of access to the funds. Where it is not there is work in progress to achieve these.

Slough's position on non-elective admissions to hospital continues to be above plan and whilst there is evidence of impact within individual schemes they have not been sufficient in scale to reduce this overall activity.

Delayed Transfers of Care are also over the targets set out within the plan; partly due to capacity within the system to both move people back into the community and in the capacity to undertake clinical assessments within Wexham Park.

NEL and DTOC performance continue to be scrutinised monthly at BCF Delivery Group meetings and within the A&E Delivery Board to keep a grip on the impact BCF schemes are having on levels of activity and better outcomes for residents.

At a joint meeting of BCF managers from East Berks with Kevin Johnson from NHS England, there was encouraging reassurance that overall we are performing well as a system in comparison to other areas. There was agreement that intensifying our focus on Delayed Transfers of Care will require a collective approach across the East of Berkshire intermediate care and reablement teams. The benefits of collaborative working and synergies across BCFs being embedded in financial planning for 2018/19 and beyond.

6. Supporting Information

6.1 Finance summary

Most schemes are forecast to be fully spent by the year end.

However, underspends are expected against the following schemes:

- Enhanced 7-day working: £99k (going forward this will be used in support of Out of Hospital Transformation)
- Proactive Care (children): £124k
- Single point of access: £60k following approval of the 3-year business case
- Care Homes - enhanced GP support: £40k
- Integrated Cardiac prevention programme: £89k following evaluation of tenders.

The BCF Joint Commissioning Board agreed in December for underspends on Out of Hospital Transformation (integrated short term services) and Integration (local wellbeing hubs) to be used for additional investment to maintain social care services.

Falls prevention: following evaluation of the six-month pilot it has been agreed to continue funding for a further year at a full year cost of £90k, and a further £25k has been agreed to the end of the financial year.

It is anticipated that the Contingency (risk share) will be fully spent based on current performance on the reduction of non-elective admissions.

6.2 National Conditions

There are a number of national conditions to the BCF that areas are expected to address through their programme activities. The majority of these are being met with the following exceptions:

I. *Are support services both at hospital and in primary, community and mental health settings available seven days a week to ensure that the next steps in the patients care pathway, as determined by the daily consultant led review, can be taken (standard 9)?*

This is in progress and pathways are being systematically reviewed in the light of 7 day response and clinical oversight to identify any that do not have consultant led review. Local plans are being put in place where necessary to address this.

II. *Is the NHS number being used as the consistent identifier for health and social care services?*

SBC are using a matching service in order to check and match NHS numbers safely and securely with our social care records and are now at an improved position from last quarter; now 76.67% of all records.

III. *Ensure a joint approach to assessments and care planning and ensure that, where funding is used for joint packages of care, there will be an accountable professional.*

This is happening in parts of the system but not consistently across all services. There are some joint funded packages of care and there is a lead agency and worker for these.

The system wide 'New Vision of Care' programme aims to support the delivery of joint assessment and care planning. Timescales have slipped for the piloting of a shared assessment as part of our Out of Hospital Transformation programme which increased its scope from Slough alone to across East of Berkshire. A trusted assessor approach for access into intermediate care services is part of this work.

IV. *Agreement on the consequential impact of the changes on providers that they are predicted to be substantially affected by the plans.*

SRG (now A&E avoidance group) and STP planning programme group is working through impact of changes and mitigations needed.

6.3 Performance against BCF metrics

Non-elective admissions

Non-elective admissions have continued to rise in quarter three to 9.9% above plan. This is despite positive impact on reducing non-electives in the cohorts of people through schemes such as falls prevention and complex case management. A significant proportion of these continue to be admissions of children into the Paediatric Assessment Unit at Wexham Park hospital.

Table 1. Non- elective admissions to hospital (total, all ages) – performance against plan

Year	Forecast	Pop	Year Plan	Activity Forecast	Qtrly Rate FOT	Var FOT
2016/17	**Full Year**	**147,821**	**16,517**	**18,200**	**3,078**	**+10.2%**

Year	Forecast	Pop	Quarter Plan	Activity Forecast	Qtrly Rate FOT	Var FOT
2016/17	**Q3**	**147,821**	**4,373**	**4,807**	**3,252**	**+9.9%**

Year	Quarter	Pop	Activity Plan	Activity Actual	Rate Actual	Variance
2014/15	Q1	144,575	4,147	3,916	2,709	-5.6%
2014/15	Q2	144,575	4,297	4,066	2,812	-5.4%
2014/15	Q3	144,575	4,441	4,279	2,960	-3.6%
2014/15	Q4	146,304	3,798	3,780	2,584	-0.5%
2015/16	Q1	146,304	3,991	3,742	2,558	-6.2%
2015/16	Q2	146,304	4,161	3,844	2,627	-7.6%
2015/16	Q3	146,304	4,294	4,355	2,977	+1.4%
2015/16	Q4	147,821	3,665	4,384	2,966	+19.6%
2016/17	Q1	147,821	4,007	4,354	2,945	+8.7%
2016/17	Q2	147,821	4,142	4,489	3,037	+8.4%
2016/17	Q3	147,821	4,373	4,807	3,252	+9.9%
2016/17	Q4	149,285	3,995			

Delayed Transfers of Care

Delayed Transfers of Care continue to be significantly higher than our planned performance in this year. These have risen further in this third quarter to 112.7% above plan. Main reasons attributable to these delays is in capacity to complete clinical assessments and capacity in community to which to safely discharge. This includes care homes, particularly nursing EMI beds, as well as within reablement services. The additional investment from BCF to fund additional social care capacity over the winter period and this has been effective in keeping delays related to social care in Slough to a minimum (graph 2).

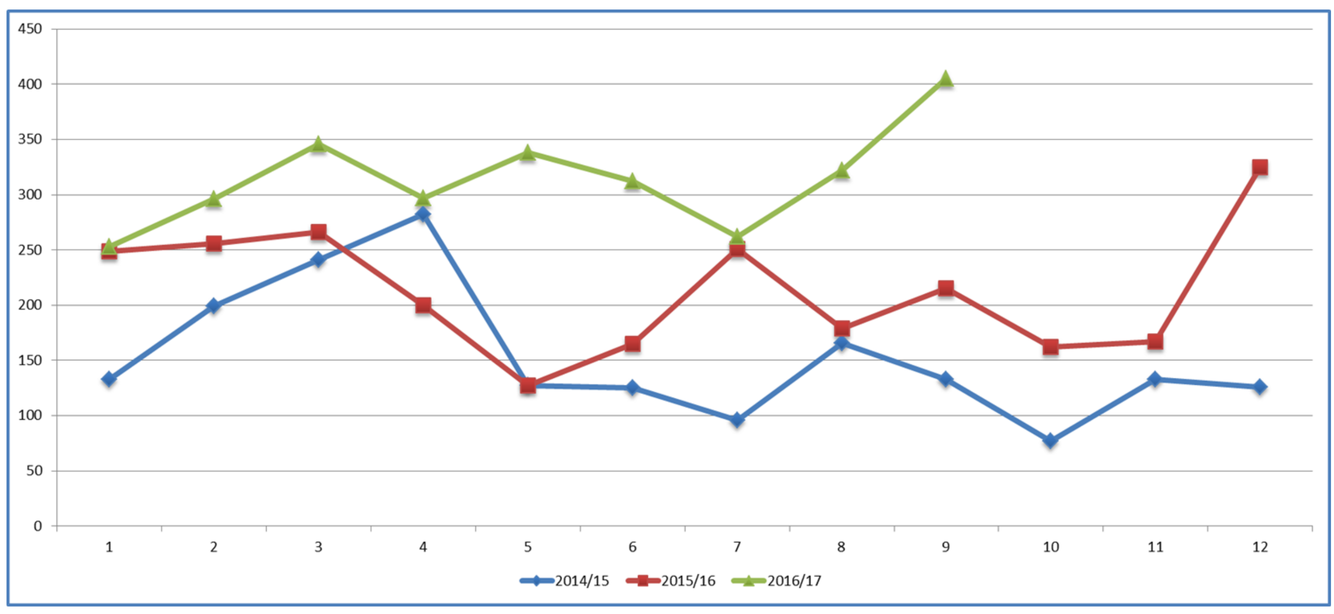
Table 2 – Delayed transfers of care (total no. of delayed bed days in all acute hospitals, all ages)

Year	Forecast	Pop	Year Plan	Activity Forecast	Qtrly Rate FOT	Var FOT
2016/17	**Full Year**	**106,723**	**1,870**	**3,775**	**884**	**+101.9%**

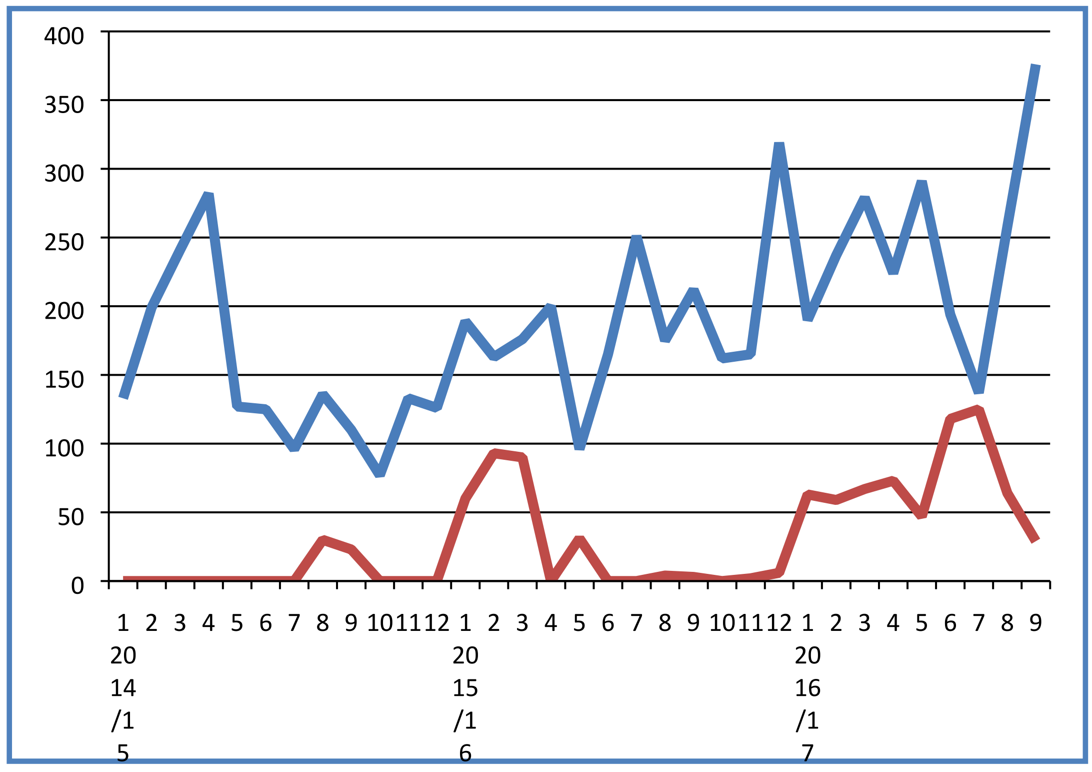
Year	Forecast	Pop	Quarter Plan	Activity Forecast	Qtrly Rate FOT	Var FOT
2016/17	**Q3**	**106,723**	**465**	**989**	**927**	**+112.7%**

Year	Quarter	Pop	Activity Plan	Activity Actual	Rate Actual	Variance
2014/15	Q1	104,708	490	573	547	+16.9%
2014/15	Q2	104,708	490	534	510	+9.0%
2014/15	Q3	104,708	490	395	377	-19.4%
2014/15	Q4	105,864	480	336	317	-30.0%
2015/16	Q1	105,864	496	771	728	+55.4%
2015/16	Q2	105,864	493	492	465	-0.2%
2015/16	Q3	105,864	496	645	609	+30.0%
2015/16	Q4	106,723	490	654	613	+33.5%
2016/17	Q1	106,723	470	895	839	+90.4%
2016/17	Q2	106,723	465	947	887	+103.7%
2016/17	Q3	106,723	465	989	927	+112.7%
2016/17	Q4	107,546	470			

Graph 1 – Total number of delayed bed days (all patients by month)



Graph 2 – NHS and Social Care responsible delays



Data on activity on Admissions to Care Homes and Reablement is not currently available in this quarter but will be included in the quarter four annual report.

6.4 BCF Planning 2017-19

As at 16th March 2017 the planning guidance for the Better Care Fund from the Department of Health/NHS England has not been published. It is likely that the guidance will be published within the next two weeks but has been subject to delay since the start of this year. It is understood that the final submission will be required

within six or seven weeks of the guidance being published. A national condition of the process is that the Health and Wellbeing Board for each area approve their local plan.

This tight timeline means that the planning will still be in development at the time that the Wellbeing Board reports are despatched for the May meeting. It is therefore requested that delegated authority from the Chair of the Wellbeing Board is sought to enable the Director of Adult Social Care to submit the plan on behalf of the Wellbeing Board.

The BCF programme is governed by a BCF Delivery Group, the Joint Commissioning Board, and the Slough Wellbeing Board. Highlight reports together with performance, finance and risk updates are reported quarterly to the JCB and a summary progress report each quarter to the SWB.

Webinar guidance received from NHS England for the BCF 2017-19 has indicated that when published, the guidance is likely to reduce the National Conditions from 8 to 3; these being for 2017/18

- Plans to be jointly agreed
- Maintain provision of social care services
- Agreement to invest in NHS commissioned out-of-hospital services

The announcement of additional social care funding as part of the Spring Budget will be introduced as Improved Better Care Fund (IBCF) allocations to LAs. For Slough this is an additional £4.362m over the next three years.

The grant conditions for the IBCF will require councils to include this money in the local BCF Plan, and is intended to enable areas to take immediate action to fund care packages for more people, support social care providers, and relieve pressure on the NHS locally by implementing best practice set out in the High Impact Change Model for managing transfers of care.

There will be a continued requirement to submit quarterly reports on performance, against certain key national indicators; these being:

- Non elective admissions
- Admissions to residential home
- Effectiveness of reablement
- Delayed Transfers of Care

The guidance is also expected to require that the BCF submission clearly demonstrates and links to the overarching vision for Health and Social care integration and addresses how the local vision will move services towards being more community based and preventative in approach. The plan will therefore need to show a coherent linkage to the Frimley Health and Care System Sustainability and Transformation Plan, as well as the "New Vision of Care" model.

7. **Comments of Other Committees**

None

8. **Conclusion**

This report outlines the quarter three position on the Slough BCF programme and the progress reported to NHS England as part of its regular monitoring.

A decision delegating the sign off of the Better Care Plan to the Director of Adult Social Care will enable us to meet our required deadline for submitting the 2017-19 plan to NHSE if this falls ahead of the next SWB meeting in May.

9. **Appendices attached**

'A' - Slough BCF financial report to end of December 2016

10. **Background Papers**

'1' - Slough Better Care Fund plan 2016-17

Appendix 1

SLOUGH BETTER CARE FUND FINANCIAL REPORT £'000

Workstream	No.	Scheme	Area of spend	Commissioner	Risk	Category	9 December 2016 YTD Plan	YTD Actual	Variance	Financial Year 2016-17 Plan	Forecast	Variance
Proactive Care	1	Enhanced 7 day working	Other	CCG	CCG	1	-	-	-	99	-	99
	2	Complex Case Management	Primary Care	CCG	CCG	1	45	45	-	60	60	-
	3	Falls Prevention	Other	Local Authority	SBC	3	75	75	-	75	75	-
	4	Stroke	Other	Local Authority	SPLIT	1	43	43	-	57	57	-
	5	Dementia Care Advisor	Other	Local Authority	SBC	1	23	23	-	30	30	-
	6	Children's Respiratory Care	Community Health	CCG	CCG	1	71	71	-	95	95	-
	7	Proactive Care (children)	Other	CCG	CCG	1	11	-	11	127	3	124
Access	8	Single Point of Access	Health	CCG	ALL	2	113	68	45	150	90	60
Integrated Care	9	Telehealth	Social Care	Local Authority	SBC	1	38	38	-	50	50	-
	10	Telecare	Social Care	Local Authority	SBC	3	47	47	-	62	62	-
	11	Disabled Facilities Grant	Social Care	Local Authority	SBC	4	581	581	-	775	775	-
	12	RRR Service (reablement and intermediate care)	Social Care	Local Authority	SBC	3	1,638	1,638	-	2,184	2,184	-
	13	Joint Equipment Service	Social Care	CCG	SPLIT	1	595	595	-	793	793	-
	14	Nursing Care Placements	Social Care	Local Authority	SBC	3	300	300	-	400	400	-
	15	Care Homes - enhanced GP support	Primary Care	CCG	CCG	1	83	53	30	110	70	40
	16	Domiciliary Care	Social Care	Local Authority	SBC	3	23	23	-	30	30	-
	17	Integrated Care Services / ICT	Community Health	CCG	ALL	2	561	561	-	748	748	-
	18	Intensive Community Rehabilitation	Social Care	Local Authority	SBC	3	62	62	-	82	82	-
	19	Intensive Community Rehabilitation	Community Health	CCG	CCG	3	128	128	-	170	170	-
	20	Responder Service	Social Care	Local Authority	SBC	1	60	60	-	60	60	-
	21	Out of Hospital Transformation (integrated short term services)	Social Care	Joint	ALL	2	-	-	-	150	150	-
	22	Integration (local Wellbeing Hubs)	Social Care	Joint	ALL	2	-	-	-	-	-	-
	23	Digital roadmap - Connected Care	Other	Joint	CCG	3	129	129	-	172	172	-
	24	Integrated Cardiac prevention programme	Community Health	Local Authority	SBC	1	-	-	-	151	62	89
Capacity	25	Carers	Social Care	Local Authority	SBC	3	147	147	-	196	196	-
	26	EoL Night Sitting Service	Community Health	CCG	CCG	1	11	11	-	14	14	-
	27	Community Capacity	Social Care	Local Authority	SBC	3	150	150	-	200	200	-
Enablers	28	Programme Management Office & Governance	Other	Joint	ALL	2	195	150	45	260	260	-
Other	29	Contingency (risk share)	Other	CCG	ALL	2	-	-	-	542	542	-
	30	Care Act funding	Social Care	Local Authority	SBC	3	222	222	-	296	296	-
	31	Additional Social Care protection	Social Care	Local Authority	SBC	3	692	692		922	922	-
							6,038	**5,907**	**130**	**9,060**	**8,648**	**411**

Slough Wellbeing Board's Work Programme

May 2017 - November 2017

Slough Wellbeing Board Forward Work Programme (May 2017 – November 2017)

10 May 2017

Subject	Decision requested	Report of	Contributing Committee/ Officers(s)	Key decision *
Discussion				
SPACE annual report 2016 (including 2017 plans for voluntary sector support to Slough CCG & Slough Adult Social Care)	The Board is asked to note the annual report and plans for 2017	Ramesh Kukar	Director, Adult Social Care	No
Annual review of Joint Wellbeing Strategy priorities and preparation for the 2017 Conference	The Board is asked to advise and comment on the early arrangements for the 2017 partnership conference	Dean Tyler, Head of Policy, Partnerships & Programmes		No
Prevention Strategy (tbc)	The Board is asked to comment on the early draft of the Strategy	Alan Sinclair, Director Adult Social Care	Simon Lawrence	No
Forward Work Programme	The Board is asked to review and update the Forward Work Plan	Dean Tyler, Head of Policy, Partnerships & Programmes		No
Themed discussion				
Increasing life expectancy by focussing on inequalities (tbc)		Lise Llewellyn, Strategic Director of Public Health/ /Alan Sinclair, Director Adult Social Care		No
Information				
Slough Local Safeguarding Children's Board (SLSCB) Delivery Plan (update)	The Board is asked to note the progress being made by the LSCB in implementing its Delivery Plan	Nick Georgiou, Independent chair, SLSCB		
Frimley Sustainability and Transformation Plan (STP) integration	The Board is asked to note recent activity under the Frimley Sustainability and Transformation Plan	Alan Sinclair, Director Adult Social Care		
Review of Terms of Reference (TOR) for the Board	To note and agree refreshed TOR for the Board for forthcoming municipal year	Dean Tyler, Head of Policy, Partnerships & Programmes	Democratic Services	No
Sign off of the Board's Annual report for 2016/17	The Board is asked to endorse the final draft of the report	Dean Tyler, Head of Policy, Partnerships & Programmes		No

19 July 2017

Subject	Decision requested	Report of	Contributing Committee/ Officers(s)	Key decision *
Discussion				
Slough CCG Operating Plan 2017/19 (tbc)	The Board is asked to note and comment on Plan	Jim O'Donnell / Fiona Slevin-Brown	Health and Social Care PDG	Yes
Draft BCF Plan for 2017/19 (tbc)	The Board is asked to endorse the final draft of the Plan	Mike Wooldridge, BCF Programme Manager	Health and Social Care PDG	Yes
Healthwatch Slough: Annual Report 2016/17	The Board is asked to note and comment on Healthwatch Slough's annual report	Nicola Strudley, Healthwatch Slough		No
Forward Work Programme	The Board is asked to review and update the Forward Work Plan	Dean Tyler, Head of Policy, Partnerships & Programmes		No
Themed discussion				
Presentation on the Slough Youth Parliament's Manifesto (tbc)				
Information				
Frimley Sustainability and Transformation Plan (STP) integration	The Board is asked to note recent activity under the Frimley Sustainability and Transformation Plan	Alan Sinclair, Director Adult Social Care		
BCF quarterly report: 1st quarter of 2017/18	The Board is asked to note the quarterly report	Mike Wooldridge, BCF Programme Manager	Director Adult Social Care	
Six monthly update focused on one of the five themes of the Housing strategy	The Board is asked to note the progress made in relation to Theme 1 of the Housing strategy - New housing supply (tbc)	Paul Thomas, Interim Head of Housing, Housing Management Housing		
Reprovision of Healthwatch Slough Contract (update)	The Board is asked to note the outcome of the tender process	Ian McIlwain, Interim Contracts Officer - Adults	Director Adult Social Care	

27 September 2017

Subject	Decision requested	Report of	Contributing Committee/ Officers(s)	Key decision *
Discussion				
Revisit "Improving mental health and wellbeing" priority of Wellbeing Strategy (tbc)	The Board is asked to review recent progress against this priority	Alan Sinclair, Director Adult Social Care	Geoff Dennis, Head of Mental Health, Slough Locality	No
Refresh of the JSNA (tbc)		Alan Sinclair Director Adult Social Care	Health and Social Care PDG	
End of year report/review regarding the operation of the Board's Overarching Information Sharing Protocol	The Board is asked to note the impact that the Protocol has had on information sharing between partners and consider what changes (if any) need to be made to the current arrangements	Dean Tyler, Head of Policy, Partnerships & Programmes		No
Forward Work Programme	The Board is asked to review and update the Forward Work Plan	Dean Tyler, Head of Policy, Partnerships & Programmes		No
Themed discussion				
Feedback from the 2017 Partnership Conference		Dean Tyler, Head of Policy, Partnerships & Programmes		No
Information				
Frimley Sustainability and Transformation Plan (STP) integration	The Board is asked to note recent activity under the Frimley Sustainability and Transformation Plan	Alan Sinclair, Director Adult Social Care		
Prevent Action Plan	The Board is asked to note recent activity by the Prevent Violent Extremism Group	Naheem Bashir, Prevent Coordinator	Assistant Director, Strategy and Engagement	

15 November 2017

Subject	Decision requested	Report of	Contributing Committee/ Officers(s)	Key decision *
Discussion				
Slough Safeguarding Adult's Board (SSAB) Annual Report 2016/17	The Board is asked to note and comment on the SSAB's annual report	Nick Georgiou, Independent Chair of SSAB		No
Slough Local Safeguarding Children's Board (SLSCB) Annual Report 2016/17	The Board is asked to note and comment on the SLSCB's annual report	Nick Georgiou, Independent Chair of SLSCB		No
End of year report/review regarding the operation of the Board's (a) Safeguarding People's Protocol (b) Scrutiny Protocol	The Board is asked to note the impact that the Protocols have had on improving partnership working and consider what changes (if any) need to be made to the current Protocols	Dean Tyler, Head of Policy, Partnerships & Programmes		No
Forward Work Programme	The Board is asked to review and update the Forward Work Plan	Dean Tyler, Head of Policy, Partnerships & Programmes	Democratic Services	No
Themed discussion				
Information				
Frimley Sustainability and Transformation Plan (STP) integration	The Board is asked to note recent activity under the Frimley Sustainability and Transformation Plan	Alan Sinclair, Director Adult Social Care		
BCF quarterly report: 2nd quarter of 2017/18	The Board is asked to note the quarterly report	Mike Wooldridge, BCF Programme Manager	Director Adult Social Care	

Criteria

Does the proposed item help the Board to:

1) *Deliver one its statutory responsibilities?*
2) *Deliver agreed priorities / wider strategic outcomes / in the Joint Wellbeing Strategy?*
3) *Co-ordinate activity across the wider partnership network on a particular issue?*
4) *Initiate a discussion on a new issue which it could then refer to one of the key partnerships or a Task and Finish Group to explore further?*
5) *Respond to changes in national policy that impact on the work of the Board?*

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SLOUGH BOROUGH COUNCIL

REPORT TO: Slough Wellbeing Board **DATE:** 29th March 2017

CONTACT OFFICER: Alan Sinclair Acting Director Adult Social Care
(For all Enquiries) (01753) 875752

WARD(S): All

PART I
FOR INFORMATION

LOCAL HEALTHWATCH FOR SLOUGH

1. Purpose of Report

To inform and consult the Slough Wellbeing Board about the recommissioning process of the local Healthwatch service.

2. Recommendation(s)/Proposed Action

That the Committee is requested to note the approach to recommissioning.

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

3a. Slough Joint Wellbeing Strategy Priorities

Local Healthwatch (LHW) contributes to the delivery of the Slough Wellbeing Strategy priorities by providing an independent consumer voice. This gives residents more choice and contributes to reducing inequalities and improving the health and wellbeing of our residents helping them live more positive, active and resilient lives. Consumer engagement in health and social care decision making is also a key element of people having more control over their own lives and contributing to improving the quality of services received by the whole community locally.

3b. Five Year Plan Outcomes

LHW contributes to the delivery of the Five Year Plan outcome that more people will take responsibility and manage their own health, care and support needs through addressing cross cutting themes such as prevention, early intervention and facilitating the integration of services.

4. Other Implications

(a) Financial - The annual funding amount for 2016/17 is £95,000. This includes a 17% efficiency saving on the previous year. The funding is comparable with other Berkshire authorities with the unit cost just below the average for the region. Funding for LHW is from Government grant. The bulk of the funding is through the formula grant with an additional top up through the Local Reform and Community Voices Grant (LRCV) from the Department of Health DH.

LHW expenditure	Population	2015/16	£per head 15/16	2016/17	£per head 16/17	LRCV allocation 16/17
Slough	145,734	£113,163	£0.78	£95,000	£0.65	£31,200
TOTAL BERKSHIRE	889,635	£674,179	£0.76	£588,764	£0.66	*c£105,773*

The LRCV is to take account of the additional statutory responsibilities placed on LHW compared to the previous LINKS provision. Currently the LRCV amount for 2017/18 has not been notified to local authorities by the DH.

The total cost of the current contract from 1st April 2013 to 30th June 2017 is £458,257.

(b) Risk Management

Risk	Mitigation(s)	Opportunities
Legal The Council must comply with EU Procurement Directives	Legal and procurement expertise will be available to the Project Board and will be included as part of project planning	Effective local healthwatch will give strategic commissioners intelligence on consumer views about health and care services
Property There are no Property issues	None Required	
Health and safety There are no Health and Safety issues	None Required	
Employment	Subject to procurement route. Provider employees protected under Transfer of Undertakings Regulations	Will allow continuity
Equalities issues	For recommissioning an impact assessment to be completed and reviewed as part of the Project Plan	. Increased engagement with hard to reach groups and individuals
Community Support	To be included within the commissioning and procurement process (see Section 5)	Opportunity to more effectively include the consumer views into the commissioning process
Communications	To be included within the commissioning and procurement process (see Section 5)	Implementation of the quality standards will develop the effectiveness of communications
Community safety	None Required	
Financial	Will be recommissioned within funding envelope	Will contribute to the efficiency savings
Timetable for delivery	1st July 2017.	Seamless transfer from

		one service to another
Project capacity	Within existing resources	

(c) Human Rights Act and Other Legal Implications - There are no Human Rights Act implications arising from this report.

(d) Equalities Impact Assessment (EIA) - An EIA is being completed as part of the commissioning process. From the information so far the impact will be neutral to all protected characteristic groups.

(e) Workforce - Subject to the procurement result, TUPE may possibly apply to provider employees.

5. **Summary**

The report sets out the background to the creation of local healthwatch and the contractual arrangements under which it operates.
It details the commissioning and procurement process to have a new service in place for when the current service ends on 30th June 2017.

6. **Supporting Information**

6.1 The Health and Social Care Act 2012 established Healthwatch England in October 2012 and local Healthwatch organisations from April 2013. Under the Act Local authorities have a statutory duty to commission a local Healthwatch organisation which in turn is contracted to undertake a number of statutory activities in relation to local health and care services across three broad areas:

1) Providing information and advice
2) Gathering intelligence about people's views and experiences
3) Influencing the provision and commissioning of services

6.2 Local Healthwatch organisations are required to be social enterprises, though there is no prescribed model under which they are required to function. In practice, this flexibility has resulted in a number of different models being employed, including the Community Interest Companies (CIC) model adopted by Healthwatch Slough.

Local Healthwatch in Slough

6.3 Following a tender process the Council entered into a contract with Healthwatch Slough CIC for a two year fixed term with the option to extend. The contract formally ends on 30th June 2017.

6.4 Formal performance monitoring between officers of the Council, Slough Clinical Commissioning Group (CCG) and Healthwatch Slough takes place on a quarterly basis and in accordance with the contract. Performance has generally been satisfactory with no formal enforcement action required under the terms of the contract.

6.5 In addition to the performance monitoring Healthwatch Slough produces an annual report and forward facing action plan setting out their priorities for the following year.

6.6 In 2016 Healthwatch England introduced a set of Quality Standards that LHW organisations should meet. The standards have been incorporated into the new specification along with the following elements identified as areas of improvement through the current provision

- A requirement to sign up to the joint working protocol to improve partnership working with Wellbeing Board, Health Scrutiny and to ensure LHW intelligence is fed into the JSNA and Joint Wellbeing Strategy
- Shaping engagement activities and priorities in line with the Wellbeing Strategy to drive service improvement and transformation.
- Improving governance arrangements

Re-commissioning

6.7 During 2016 the Council explored the feasibility of a number of commissioning options for LHW meeting with commissioners from the other Berkshire unitary authorities, holding a joint meeting with all the Berkshire LHW organisations and commissioners (including attendance by a delegate of Healthwatch England) and meeting separately with commissioners from the East Berkshire unitary authorities. The options explored included:

a) A pan Berkshire wide solution – not feasible at this time because of the different commissioning programmes in each area, potentially complex TUPE arrangements and little appetite for such an approach from providers;
b) An East/West Berkshire split which it was felt would have fitted better with the Clinical Commissioning Group structures than the pan Berkshire approach. However it was felt that the additional resources needed to develop the partnership approach would offset any savings arising from scale. Also the need for LHW to have a strong local presence to work effectively would need careful development and implementation;
c) Ad hoc partnership with other local authorities – given the contract value there was insufficient resources locally to explore this approach in detail; and
d) Continue with the status quo individually commissioning a LHW for Slough only.

6.8 Taken everything into account the options appraisal concluded that option 4 was the most advantageous approach to improving value for money, facilitating future innovation and retaining a strong local presence.

Procurement approach

6.9 The service will be recommissioned using an open tender process. Selection will primarily be based on quality including ability to be effective strategic partner and critical friend, social value and approaches to improve engagement. An open tender approach will maximise competition and Best Value as well as providing the opportunity for innovative solutions. There is a small risk in using an open tender that a large number of tenders will need to be evaluated, although in the case of local healthwatch this is unlikely because of the specialist nature of the provision and the need to have local knowledge to be effective.

6.10 A Prior Information Notice (PIN) seeking expressions of interest has been posted on the SE Intend E tendering portal seeking expressions of interest. The term of the contract is for one year nine months with the option to extend for a further two one year periods subject to satisfactory performance. The duration has been aligned with the

advocacy services contract so that the option of combining some element of the two can be explored.

6.11 Prior to going out to tender soft market testing exercise will be undertaken so that providers and other stakeholders can contribute to the design of the final specification.

7. Comments of Other Committees

None at this stage

8. Conclusion

This report outlines the background to local healthwatch, how the service was set up in Slough in 2013 and the intention to recommission the service from 1st July 2017 and the preferred approach that will be employed.

9. Appendices Attached

None

10. Background Papers

None

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SLOUGH BOROUGH COUNCIL

REPORT TO: Slough Wellbeing Board **DATE:** 29th March 2017

CONTACT OFFICER: Alan Sinclair, Director Adult Social Care SBC
John Lisle, Accountable Officer Slough, Windsor, Ascot and Maidenhead, Bracknell and Ascot CCG's
(For all Enquiries): (01753) 875752

WARD(S): All

PART I
FOR INFORMATION

PROGRESS UPDATE ON THE FRIMLEY HEALTH & CARE SUSTAINABILITY AND TRANSFORMATION PLAN

1. Purpose of Report

This report provides the Slough Wellbeing Board with an update on the progress being made to deliver the Sustainability and Transformation Plan (STP) for the Frimley footprint.

2. Recommendation(s)/Proposed Action

The Slough Wellbeing Board is recommended to note the report and the good progress being made in developing the STP and comment on any aspect of the plan where appropriate.

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

The priorities in the STP reflect the need to improve the health and wellbeing of the population. The STP focuses on those priorities that can be delivered across the system and local areas will continue to address their own local priorities.

3a. Slough Joint Wellbeing Strategy Priorities

The STP meets several of the Joint Slough Wellbeing Strategy 2016 - 2020 priorities including:

- Protecting vulnerable children and young people
- Improving healthy life expectancy
- Improving mental health wellbeing

The STP will do this by delivering across five **priority** areas:

1	Making a substantial step change to improve wellbeing, increase prevention, self care and early detection.
2	Improve long term conditions outcomes including greater self management and proactive management across all providers for people with single long term conditions.
3	Proactive management of frail patients with multiple complex physical and mental health long term conditions, reducing crises and prolonged hospital stays.

4	Redesigning urgent care, including integrated working and primary care models providing timely care in the most appropriate place.
5	Reducing variation and health inequalities across pathways to improve outcomes and maximise value for citizens across the population, supported by evidence.

3b. Joint Needs Assessment (JSNA)
The Slough JSNA has informed the work of the STP.

3c. Five Year Plan Outcomes
The STP will support the delivery of the following Five Year Plan outcomes:
- 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

4. Other Implications

(a) Financial - To bring financial balance to the Frimley footprint by 2020 – across health and social care. There is a significant financial pressure facing all parts of the system and the plan will address how these pressures will be managed. Any future investment from the NHS in local systems will come via the STP process. A high level financial analysis was included in the June and October submissions of the STP plan.

(b) Risk Management

Risk Area	Risk/Threat/Opportunity	Mitigation(s)
Financial *All parts of the system are facing financial challenge due to increasing demand and rising costs*	*Priority areas do not manage the financial pressures – or actions cause additional financial pressures across one part of the system or service area*	*The STP gives a system wide view and management of the whole of the footprint. The aim is to bring the whole system into financial balance*
Property *Decisions are not made about current or future use of assets that help deliver the STP ambitions*	*Each part of the system or individual service continue to make decisions on their own irrespective of STP ambitions*	*STP will support via system leaders group to have a cohesive view of assets and estates and development of one public estate plan*
Employment Issues *Not having sufficient or trained staff to deliver new ways of working*	*Each organisation already has issues of recruitment and retention of staff*	*STP priority focus on our workforce, health and social care staff will be reviewed as a whole for resident's care optimising workforce with new roles and ways of working considered.*
Equalities issues *Health inequalities*	*The specific health issues of the Slough population will not be met by the STP priorities.*	*STP focusses on the main health issues across the footprint and this will include Sloughs health issues. Slough specific issues will be looked*

		at in a review of areas of heath inequality across the footprint. Non Slough specific issues will still be a priority for the Slough health and care system to deliver.
Communications *The ambitions of the STP are not well understood by all parts of the system*	*Different parts of the system, workforce, residents, providers and communities have differing understanding and knowledge of the changes.*	*An STP newsletter has been established to help inform all parts of the system alongside a series of drop in sessions that will be carried out monthly in 3 separate venues (Health, LA and CCG). Regular communications and workshops, briefings are planned across the system. A unified approach of strategic direction will enable clearer communication to staff and residents.*

(c) Human Rights Act and Other Legal Implications - There are none identified at this point.

(d) Equalities Impact Assessment - This will be undertaken as specific plans are developed to deliver the priorities.

(e) Workforce - There are no specific issues identified at this point but as workforce is one of the enablers for the delivery of the plan this will have significant focus over the coming months.

5. Summary

- Bids submitted for funding from the sustainability and transformation fund
- Frimley system viewed favourably for support and investment with encouragement to transform at scale and rapidly
- Work streams are all under way and at various stages of development and delivery
- Discussions concerning next steps in relation to communication and engagement are ongoing
- Focus on reducing duplication and thinking and planning at system level
- A more joined up, shared approach to quality and finances
- Looking at how new models of care could work across our system
- Development of a single Governing Body in common for the three East Berkshire CCG's

6. Supporting Information

6.1 Progress since last meeting

- Bids have been submitted to NHSE for funding from the sustainability and transformation funding for the prescribed areas:
  - Cancer
  - Mental health

- Diabetes
- Learning disability

We are still awaiting confirmation of these bids but have had encouraging feedback.

- The seven STP work streams are established and are at various stages of development.

Work stream	Progress
Shared Care Record	This work stream will enable the system-wide sharing of patient level information which will underpin the proactive management of frail and complex patients. It is progressing well and connected care as part of the local digital road map is under way across Berkshire Health Foundation Trust, Primary Care and Bracknell Council. All other parts of the system on track for implementation in next two phases. Slough Council will be in phase 3 later this calendar year. This programme was successful in an LWAB (Local workforce Action Board) bid for a £45k leadership programme to work alongside the technical team to ensure staff are fully equipped and informed for moving forward.
Integrated Care Decision Making Hubs	This work stream has been looking at how best to implement and deliver a locally focused integrated care model. There is a particular focus on simplifying access to multi-disciplinary and community based models of care. This will involve the active identification of individuals who are frail or at risk of becoming frail in order to proactively plan and coordinate their care. For Slough this aligns with both the work of the council in delivering community hubs and the one public estate work.
GP Transformation	This work stream is focussed on delivering the NHS Five Year Forward View by developing a sustainable model of general practice including a clinical, business and career model that reduces variation in care, improving outcomes across the STP. This work stream secured funding through a joint LWAB bid with the Integrated Hub work stream for the development of a workforce strategy and transformation plan that can enable the delivery of new models of primary and integrated care by matching current and future workforce capacity to service demand through new and extended professional roles.
Unwarranted Variation	This work stream is utilising the Right Care Approach to reduce variation across the system in five disease areas: Circulation, MSK, Neurology, GU and GI. Clinical and managerial leads have been identified and work is in progress to identify areas of opportunity.
Social Care Support	This work stream will look at three main areas: options for collaborative commissioning and procurement for care and support services; improved commissioning for our most complex/expensive people and improving quality in care homes. Work has started to map the range of care services that each of the 5 councils and the NHS purchase at scale and for individuals. A new care homes quality group has started to look at one best practice model of delivering this improved quality.

Support Workforce	This work stream is aiming to identify where health and social care can work more closely together to create a stable, sustainable and consistent support workforce across the STP footprint. There has been a system wide workshop which has identified some key areas of focus and the steering group is confirming the scope later this month.
Prevention	The aim of this work stream is to ensure people have the skills and support to take responsibility for their own health and well being through a range of initiatives including smoking cessation, alcohol care, hypertension screening, obesity reduction, self care and social prescribing. A bid has been submitted to secure funding to train staff in improving conversations with people to positively impact their health and wellbeing. A social prescribing workshop is being planned for April.

6.2 Governance

- On the basis that this STP is likely to be considered as part of the group of leading STP's to be progressed and will be asked to consider transforming at scale and quickly, with the option of developing an accountable care system/organisation, the three East Berkshire CCG's have been considering their governance arrangement.
- They have agreed that from April 2017 to:
  - Strengthen (GP) member meetings including public involvement
  - Expand clinical leadership capacity
  - Streamline assurance process
  - Operate a financial risk share across all three CCG's
  - Have a single Governing Body in common
  - Have a single primary care commissioning committee in common

7. Comments of Other Committees

None

8. Conclusion

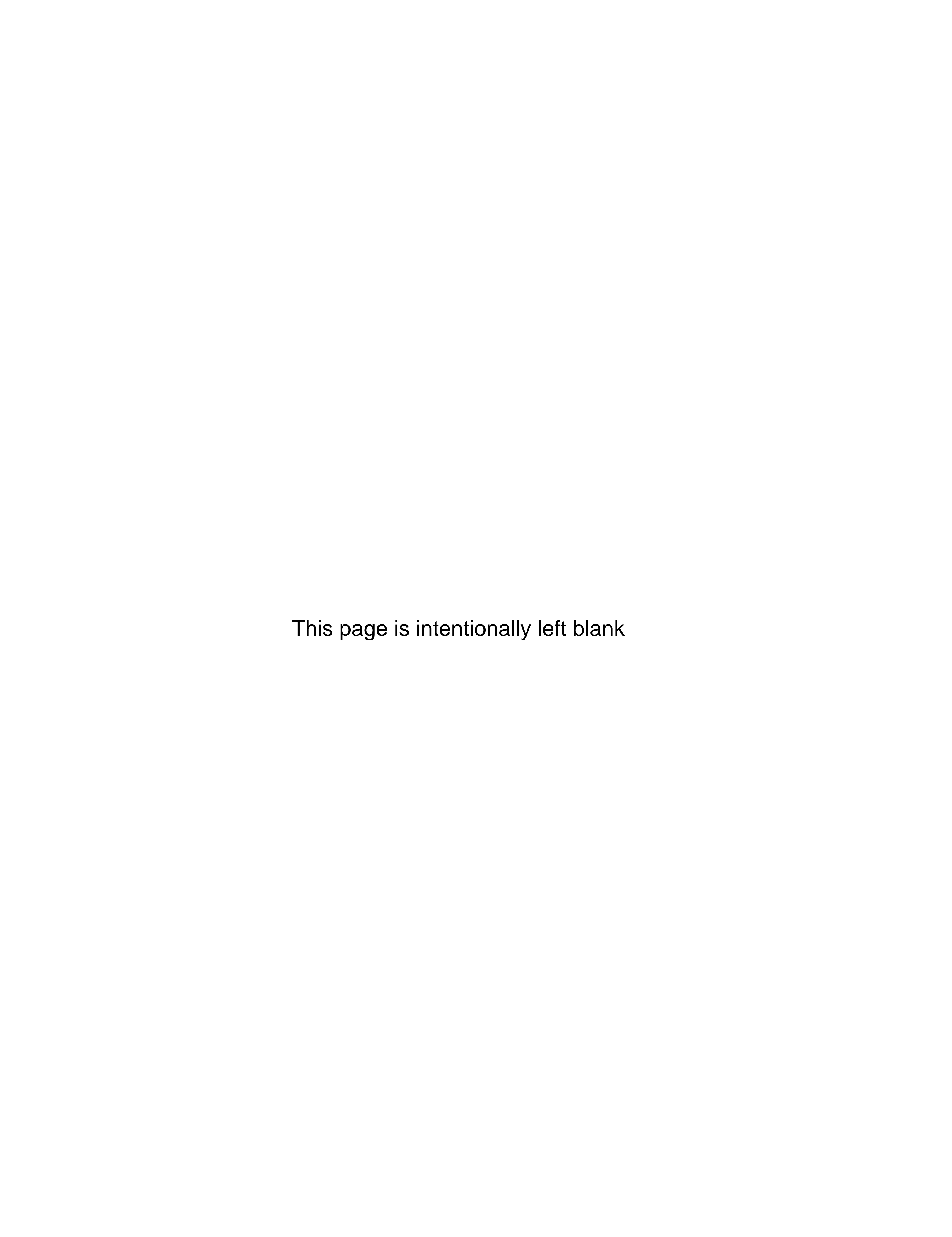
The Slough Wellbeing Board is asked to note the good progress being made since its last meeting on the 26th January 2017 and the proposed changes for the governance arrangements of the local clinical commissioning groups.

9. Appendices

None

10. Background Papers

None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SLOUGH WELLBEING BOARD - ATTENDANCE RECORD 2016/17

MEMBER	20/7	28/9	16/11	26/1	29/3	10/5
Naveed Ahmed	P	P	P	P		
Ruth Bagley	Ap	Ap	Ap			
Roger Parkin				P		
Nicola Clemo				P		
Iain Harrison	Sub (Mark Gaskarth)	Sub (Lloyd Palmer)	P			
Lloyd Palmer				P		
Cllr Sabia Hussain	P	P	P	P		
Ramesh Kukar	P	P	P	P		
Lise Llewellyn	Ab	P	Ab	P		
Cllr Sohail Munawar	Ap	Ab	Ap			
Jim O'Donnell	P	P	P	Ap		
Les O'Gorman	Ap	Ap	Ap	Ap		
Krutika Pau	P	Ab				
Jo Moxon			Ap	Sub (Rodney D'Costa)		
Colin Pill	P	Ap	P	P		
NHS England representative	Ab	Ab	Ab	Ab		
Alan Sinclair	P	P	P	P		
Supt. Wong	P	P	P	P		

P = Present   Sub = Substitute sent   Ap = Apologies given   Ab = Absent, no apologies given

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